Colorado's 1915(C) HCBS WAIVER SERVICES

Service Descriptions for Waiver Modernization Sub-Group

12/27/2012

Colorado Dept of Health Care Policy & Financing

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Overview of the §1915(c) HCBS Waiver Authority

Operating a program of services under the authority of Section 1915(c) of the Social Security Act permits a state to waive certain Medicaid requirements in order to furnish an array of home and community-based services that promote community living for Medicaid beneficiaries and, thereby, avoid institutionalization.

Waiver services complement and/or supplement the services that are available through the Medicaid State plan and other Federal, state and local public programs as well as the supports that families and communities provide to individuals.

States have flexibility in designing waivers, including the latitude to:

- Determine the target group(s) of Medicaid beneficiaries who are served through the waiver;
- Specify the services that are furnished to support waiver participants in the community;
- Incorporate opportunities for participants to direct and manage their waiver services;
- Determine the qualifications of waiver providers;
- Design strategies to assure the health and welfare of waiver participants;
- Manage a waiver to promote the cost-effective delivery of home and community-based services;
- Link the delivery of waiver services to other state and local programs and their associated service delivery systems; and,
- Develop and implement a Quality Improvement Strategy to ensure that the waiver meets essential Federal statutory assurances and to continuously improve the effectiveness of the waiver in meeting participant needs.

CMS recognizes that the design and operational features of a HCBS waiver will vary depending on the specific needs of the target population, the resources available to a state, service delivery system structure, state goals and objectives, and other factors.

STATUTORY SERVICES

Statutory services are services specifically contained in §1915(c) of the Social Security Act and 42 CFR §440.180. A waiver is considered to cover a statutory service as long as the state's definition aligns with the core service definition even though an alternate title may be used (e.g., support coordination instead of case management or attendant care instead of personal care).

Colorado's Statutory Services include:

Case Management
Homemaker
Personal Care
Adult Day Health
Habilitation
Residential Habilitation
Day Habilitation
Prevocational Services
Supported Employment
Respite Care
Day Treatment

CASE MANAGEMENT SERVICES

Waiver	**Children's Home and Community Based Services Waiver**
Waiver Service Definition	Case management is assistance provided by a Case Management Agency on behalf of an eligible child, which includes referral of needed Medicaid services and supports, including In-Home Support Services, to enable the child to remain in his/her community-based setting
Service Limitations	Case Management services are a waiver services and are conducted monthly. Each child's parent and/or legal representative is required to be contacted monthly
Rule	**10 CCR 2505-10 Section 8.506.5** Case management is assistance provided by a case management agency on behalf of an eligible child, which includes referral of needed Medicaid services and supports, including In-Home Support Services, to enable the child to remain in his/her community-based setting. Case management agency is a public, private, or private for non-profit agency which is certified by the State in accordance with procedures found in the General Certification Standards for Case Management Agencies, Section 8.506.97, of the Children's HCBS Waiver Program rules, to provide services throughout the State.
Targeted Population	This waiver is targeted to children, aged 0-17, who are considered medically fragile.
Waiver Manager Comment	None, service works as described above.

HOMEMAKER SERVICES

Waiver	**HCBS-Elderly, Blind and Disabled Waiver**
Waiver Service Definition	Services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities.
Service Limitations	Family members shall not be reimbursed to provide only homemaker services. Homemaker services are limited based on the client's assessed need for services and prior authorization by case managers up to the waiver's cost containment parameters. Clients choosing to have Homemaker services delivered by a Homemaker agency shall have no duplication of these services by an IHSS agency or by CDASS.
Rule	Homemaker Provider Agency means a provider agency that is certified by the state fiscal agent to provide Homemaker Services. Homemaker Services means general household activities provided in the home of an eligible client provided by a Homemaker Provider Agency to maintain a healthy and safe home environment for a client, when the person ordinarily responsible for these activities is absent or unable to manage these tasks. Homemaker Services are available to clients in the Home and Community Based Services waivers for Elderly Blind and Disabled, Persons Living with Aids and Persons with Mental Illness. Homemaker Services are available to clients in the Home and Community Based Services waiver for Persons with Brain Injury when the client is also receiving personal care services. Covered benefits shall be for the benefit of the client and not for the benefit of other persons living in the home. Services shall be applied only to the permanent living space of the client. Benefits include: 1. Routine light housecleaning, such as dusting, vacuuming, mopping, and cleaning bathroom and kitchen areas. 2. Meal preparation. 3. Dishwashing. 4. Bedmaking. 5. Laundry. 6. Shopping. 7. Teaching the skills listed above to clients who are capable of learning to do such tasks for themselves. Teaching shall result in a decrease of weekly units required within ninety days. If such a savings in service units is not realized, teaching shall be deleted from the care plan.

	Benefits do not include: 1. Personal care services. 2. Services the person can perform independently. 3. Homemaker services provided by family members per 10 C.C.R. 2505-10, Section 8.485.200.F Homemakers Services provided in uncertified congregate facilities are not a benefit.
Target Group	Adults 18-64 with physical disabilities and seniors 65+ with functional deficits who require nursing facility level of care.
Waiver Manager Comment	In general, this is a good service that is working well and highly utilized.

Waiver	**HCBS-Persons Living with Aids (HOMEMAKER)**
Waiver Service Definition	Homemaker services means general household activities provided in the home of an eligible client provided by a Homemaker Provider Agency to maintain a healthy and safe home environment for a client, when the person ordinarily responsible for these activities is absent or unable to manage these tasks. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities.
Service Limitations	Legal guardians and/or relatives may only be reimbursed to provide homemaker services when the service is incidental to a personal care service. Spouses may not be reimbursed to provide personal care or homemaker. Homemaker services are limited based on the client's assessed need for services and prior authorization by case managers up to the waiver's cost containment parameters. Clients choosing to have Homemaker services delivered by a Homemaker agency shall have no duplication of these services by an IHSS agency or by CDASS.
Rule	Same as HCBS-EBD/CMHS waivers
Target Group	Persons of any age with a diagnosis of HIV/AIDs who require a nursing facility or hospital level of care.
Waiver Manager Comment	In general, this is a good service that is working well and highly utilized.

Waiver	**HCBS- Community Mental Health Supports Waiver (HOMEMAKER)**
Waiver Service Definition	Services consist of general household activities (meal preparation and routine household care) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him/herself or others in the home
Service Limitations	Relatives shall not be reimbursed to provide only homemaker services. Homemaker services are limited based on the client's assessed need for services and prior authorization by case managers up to the waiver's cost containment parameters. Clients choosing to have Homemaker services delivered by a Homemaker agency shall have no duplication of these services by CDASS. There shall be no duplication of housekeeping chores that are incidental to and reimbursed as personal care. This service can only be participant-directed if the client chooses to participate in Consumer Directed Attendant Support Services (CDASS).
Rule	Same as HCBS-EBD waiver 10 CCR 2505-10 8.490.
Target Group	Persons 18 years and older with a major mental illness who meet nursing facility level of care
Waiver Manager Comment	I don't know if we need to put in the provider type for this service, such as, Homemaker Agency or Home Health Agency. Might want to also state that Personal Care services include assistance in activities of daily living whereas Homemaker services usually are confined solely to the performance of household tasks (I often have to remind myself what the difference is). It is one of the most utilized services in my waiver, with a projection of 793 people using it out of 2954 for this next year (and this is for agency-based Homemaker). Homemaker through the CDASS delivery model is around 56.

Waiver	**HCBS- for Persons with Brain Injury Waiver (HOMEMAKER)**
Waiver Service Definition	May be provided incidental to Personal Care- SEE PERSONAL CARE SERVICE DEFINITION FOR FURTHER INFORMATION
Service Limitations	
Rule	
Target Group	Persons 16 years of age and older with a brain injury sustained before the age of 65 who meet the hospital, nursing facility or ICF/ID level of care.
Waiver Manager Comment	Consider separating out homemaker from a component of personal care.

Waiver	**HCBS-for Persons with Spinal Cord Injury (HOMEMAKER)**
Waiver Service Definition	Same as HCBS-EBD
Service Limitations	Same as HCBS-EBD
Rule	Same as HCBS-EBD
Target Group	Persons 18 years and older with a spinal cord injury who meet nursing facility level of care
Waiver Manager Comment	Keep this service and no additional comments for this service as this waiver has just been implemented and there has not been sufficient data collection

Waiver	**HCBS- Supported Living Services Waiver (HOMEMAKER)**
Waiver Service Definition	Basic Homemaker Services Services that consist of the performance of basic household tasks within the participant's primary residence (i.e., cleaning, laundry, or household care) including maintenance which are related to the participant's disability and provided by a qualified homemaker, when the parent or primary caretaker is unable to manage the home and care for the participant in the home. This assistance must be due to the participant's disability that results in additional household tasks and increases the parent/caregiver's ability to provide care needed by the participant. This assistance may take the form of hands-on assistance (actually performing a task for the participant) or cuing to prompt the participant to perform a task. Enhanced Homemaker Services provided by a qualified homemaker that consist of the same household tasks as described under Basic Homemaker services with the addition of either habilitation or extraordinary cleaning. Habilitation includes direct training and instruction to the participant, which is more than basic cuing to prompt the participant to perform a task. Habilitation shall include a training program with specific objectives and anticipated outcomes. There may be some amount of incidental basic homemaker services that is provided in combination with enhanced homemaker services; however, the primary intent must be to provide habilitative services to increase independence of the participant. Habilitation may include some hands-on assistance (actually performing a task for the participant) or cuing to prompt the participant to perform a task, only when such support is incidental to the habilitative services being provided and the primary duties must be to provide habilitative services to increase independence of the participant. Enhanced Homemaker services also include the need for extraordinary cleaning as a result of the participant's behavioral or medical needs.
Service Limitations	NA

Rule	Homemaker services are provided in the client's home and are allowed when the client's disability creates a higher volume of household tasks or requires that household tasks are performed with greater frequency. There are two types of homemaker services: a. Basic homemaker services include cleaning, completing laundry, completing basic household care or maintenance within the client's primary residence only in the areas where the client frequents. i) Assistance may take the form of hands-on assistance including actually performing a task for the client or cueing to prompt the client to perform a task. ii) Lawn care, snow removal, air duct cleaning, and animal care are specifically excluded under the HCBS-SLS waiver and shall not be reimbursed. b. Enhanced homemaker services includes basic homemaker services with the addition of either procedures for habilitation or procedures to perform extraordinary cleaning i) Habilitation services shall include direct training and instruction to the client in performing basic household tasks including cleaning, laundry, and household care which may include some hands-on assistance by actually performing a task for the client or enhanced prompting and cueing. ii) The provider shall be physically present to provide step-by-step verbal or physical instructions throughout the entire task: 1) When such support is incidental to the habilitative services being provided, and 2) To increase the independence of the client, iii) Incidental basic homemaker service may be provided in combination with enhanced homemaker services; however, the primary intent must be to provide habilitative services to increase independence of the client. iv) Extraordinary cleaning are those tasks that are beyond routine sweeping, mopping, laundry or cleaning and require additional cleaning or sanitizing due to the client's disability.
Target Group	Persons with a developmental disability aged 18 or older who meet ICF/ID level of care
Waiver Manager Comment	**Recommendation: Keep service with the following considerations:** 1. Modify service description to have one level of homemaker. Having two levels is un-necessarily confusing and complicated.
Waiver	**HCBS-Children's Extensive Support Waiver (HOMEMAKER)**
Waiver Service Definition	Basic Homemaker Services Services that consist of the performance of basic household tasks within the participant's primary residence (i.e., cleaning, laundry, or household care) including maintenance which are related to the participant's disability and provided by a qualified homemaker, when the parent or primary caretaker is unable to manage the home and care for the participant in the home. This assistance must be due to the participant's disability that results in additional household tasks and increases the parent/caregiver's ability to provide care needed by the participant. This assistance may take the form of hands-on assistance (actually performing a task for the participant) or cuing to prompt the participant to perform a task. Enhanced Homemaker Services Services provided by a qualified homemaker that consist of the same household tasks as described under Basic Homemaker services with the addition of either habilitation or extraordinary cleaning. Habilitation includes direct training and instruction to the participant, which is more than basic cuing to prompt the participant to perform a task.

	Habilitation shall include a training program with specific objectives and anticipated outcomes. There may be some amount of incidental basic homemaker services that is provided in combination with enhanced homemaker services; however, the primary intent must be to provide habilitative services to increase independence of the participant. Habilitation may include some hands-on assistance (actually performing a task for the participant) or cuing to prompt the participant to perform a task, only when such support is incidental to the habilitative services being provided and the primary duties must be to provide habilitative services to increase independence of the participant. Enhanced Homemaker services also include the need for extraordinary cleaning as a result of the participant's behavioral or medical needs.
Service Limitations	NA
Rule	8.503.40.A. 6. Homemaker Services are provided in the client's home and are allowed when the client's disability creates a higher volume of household tasks or requires that household tasks are performed with greater frequency. There are two types of Homemaker Services: a. Basic Homemaker Services includes cleaning, completing laundry, completing basic household care or maintenance within the client's primary residence only in the areas where the client frequents. i This assistance may take the form of hands-on assistance by actually performing a task for the client or cueing to prompt the client to perform a task. ii. Lawn care, snow removal, air duct cleaning and animal care are specifically excluded under HCBS-CES waiver and shall not be reimbursed. b. Enhanced Homemaker Services include Basic Homemaker Services with the addition of either procedures for habilitation or procedures to perform extraordinary cleaning. i. Habilitation services shall include direct training and instruction to the client in performing basic household tasks including cleaning, laundry, and household care which may include some hands-on assistance by actually performing a task for the client or enhanced prompting and cueing. ii. The provider shall be physically present to provide step by step verbal or physical instructions throughout the entire task: 1) When such support is incidental to the habilitative services being provided, 2) To increase independence of the client, c. Incidental Basic Homemaker Service may be provided in combination with Enhanced Homemaker Services; however, the primary intent must be to provide habilitative services to increase independence of the client. d. Extraordinary cleaning are those tasks that are beyond routine sweeping, mopping, laundry or cleaning and require additional cleaning or sanitizing due to the client's disability.
Target Group	Moderate to High use: FY PD claims unduplicated client count for Homemaker 190; overall waiver unduplicated count 409 Home maker is not available for typical cleaning needs. The service is for those tasks that are above and beyond the typical cleaning needs and must be due to the client's disability. Example: Child has high medical needs; incontinent of bowel and bladder; G-tube, non mobile, linens changed 2-3 times per day, clothing changed 2-3 times per day; towels, etc produce 3 loads of laundry per day for the care of the child. This is beyond typical laundry needs and is directly related to the child's disability, therefore, homemaker services would be justified
Waiver Manager Comment	**Recommendation: Keep service with the following considerations:** 1. Modify service description to have one level of homemaker. Having two levels is un-necessarily confusing and complicated.

PERSONAL CARE

Waiver	**HCBS-Elderly, Blind and Disabled Waiver**
Waiver Service Definition	Assistance with eating, bathing, dressing, personal hygiene, activities of daily living. These services may include assistance with preparation of meals, but does not include the cost of the meals themselves. When specified in the service plan, this service may also include such housekeeping chores as bed making, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the individual, rather than the individual's family. Payment will not be made for services furnished to a minor by the child's parent (or step parent), or to an individual by the person's spouse.
Service Limitations	Personal Care providers may be members of the individual's family. The number of Medicaid personal care units for provided by any single member of the client's family shall not exceed the equivalent of 444 personal care units per annual certification of HCBS-EBD. Payment will not be made for services furnished to an individual by an individual's spouse employed by a Personal Care agency. Personal Care services are limited based on the client's assessed need for services and prior authorization by case managers up to the cost containment parameters. Clients choosing to have Personal Care services delivered by a Personal Care agency shall have no duplication of these services by an IHSS agency or by CDASS.
Rule	**10 CCR 2505-10 Section 8.489: PERSONAL CARE** 8.489.10 DEFINITIONS .11 Personal care services means services which are furnished to an eligible client in the client's home to meet the client's physical, maintenance and supportive needs, when those services are not skilled personal care as described in the EXCLUSIONS section below, do not require the supervision of a nurse, and do not require physician's orders. .12 Personal care provider means a provider agency as defined at Section 8.484.50. P. GENERAL DEFINITIONS, which has met all the certification standards for personal care providers listed below. .13 Personal care staff means those employees of the personal care provider agency who perform the personal care tasks. .14 Skilled personal care means skilled care which may only be provided by a certified home health aide, as further defined at Section 8.526, HOME HEALTH AIDE SERVICES, and in the EXCLUSIONS section below. .15 Unskilled personal care means personal care which is not skilled personal care, as defined above. 8.489.20 GENERAL PERSONAL CARE RULES .21 Personal care services shall include unskilled personal care as defined under INCLUSIONS for each personal care task listed in Section 8.489.30. .22 EXCLUSIONS AND RESTRICTIONS A. Personal care services shall not include any skilled personal care, which must be provided as home health aide services or as nursing services under non-HCBS programs. These services as defined under EXCLUSIONS for each personal care task listed in Section 8.489.30 shall not be provided as

	personal care services under HCBS, regardless of the level of the training, certification, or supervision of the personal care employee. B. Personal care staff shall not perform tasks that are not included under INCLUSIONS for each personal care task listed in Section 8.489.30, or tasks that are not listed. For example, personal care staff shall not provide transportation services and shall not provide financial management services. Clients, family, or others may choose to make private pay arrangements with the provider agency for services that are not Medicaid benefits, such as companionship. C. The amount of personal care that is prior authorized is only an estimate, including estimated travel time. The prior authorization of a certain number of hours does not create an entitlement on the part of the client or the provider for that exact number of hours. All hours provided and reimbursed by Medicaid must be for covered services and must be necessary to meet the client's needs. D. Personal care provider agencies may decline to perform any specific task, if the supervisor or the personal care staff feels uncomfortable about the safety of the client or the personal care staff, regardless of whether the task may be included in the INCLUSIONS section for the task. E. Family members shall not be reimbursed to provide only homemaker services. Family members must provide relative personal care in accordance with SECTION 8.485.200, LIMITATIONS ON PAYMENT TO FAMILY. Documentation of services provided must indicate that the provider is a relative. 8.489.30 SPECIFIC PERSONAL CARE TASKS .31 The specific personal care tasks shall be authorized and provided according to the following rules. A. BATHING 1. INCLUSIONS: Bathing is considered unskilled only when skilled skin care, skilled transfer, or skilled dressing, as described under EXCLUSIONS, is not required in conjunction with the bathing. 2. EXCLUSIONS: Bathing is considered skilled when skilled skin care, skilled transfer or skilled dressing is required, as described under EXCLUSIONS for skin care at 8.489.31,B,2, EXCLUSIONS for transfers at 8.489.31,K,2, or EXCLUSIONS for dressing at 8.489.31,G.2. B. SKIN CARE: 1. INCLUSIONS: Skin care is considered unskilled-only when skin is unbroken, and when any chronic skin problems are not active. Unskilled skin care must be of a preventive rather than a therapeutic nature, and may include application of non-medicated lotions and solutions, or of lotions and solutions not requiring a physician's prescription; rubbing of reddened areas; reporting of changes to supervisor, and application of preventive spray on unbroken skin areas that may be susceptible to development of decubiti. Unskilled skin care does not include any of the care described under skilled skin care in the EXCLUSIONS section below. 2. EXCLUSIONS: Skin care is considered skilled when there is broken skin or potential for infection due to a chronic skin condition in an active stage. Skilled skin care includes wound care, dressing changes, application of prescription medications, skilled observation and. reporting, but does not include use of sterile technique.

	C. HAIR CARE 1. INCLUSIONS: Hair care is considered unskilled only when skilled skin care, transfer, or skilled dressing, as described under EXCLUSIONS-, is not required in conjunction with the hair care. Hair care under these limitations may include shampooing with non-medicated shampoo or shampoo that does not require a physician's prescription, drying, combing and styling of hair. 2. EXCLUSIONS: Hair care is considered skilled when skilled skin care, skilled transfer, or skilled dressing, as described under EXCLUSIONS for skin care at 8.489.313,2, EXCLUSIONS for transfers at 8.489.31,K,2, or EXCLUSIONS for dressing at 8.489.31,G,2, is required in conjunction with the hair care. D. NAIL CARE 1. INCLUSIONS: Nail care is considered unskilled only when skilled skin care, as described under EXCLUSIONS, is not required in conjunction with the nail care; and only in the absence of any medical conditions that might involve peripheral circulatory problems or loss of sensation. Nail care under these limitations may include soaking of the nails, pushing back cuticles, and trimming and filing of nails. 2. EXCLUSIONS: Nail care is considered skilled when skilled skin care, as described under EXCLUSIONS for skin care at 8.489.31, B, 2 is required in conjunction with the nail care; and in the presence of medical conditions mat may involve peripheral circulatory problems or loss of sensation. E. MOUTH CARE 1. INCLUSIONS: Mouth care is considered unskilled only when skilled skin care, as described under EXCLUSIONS, is riot required in conjunction with the mouth care. Mouth care under these limitations may include denture care and basic oral hygiene. 2. EXCLUSIONS: Mouth care is considered skilled when skilled skin care, as described under EXCLUSIONS for skin care at 8.489.31, B, 2, is required in conjunction with the mouth care; or when there is injury or disease of the face, mouth, head or neck; or in the presence of communicable disease; or when the client is unconscious; or when oral suctioning is required. F. SHAVING 1. INCLUSIONS: Shaving is considered unskilled only when skilled skin care, as described under EXCLUSIONS, is not required in conjunction with shaving; and only an electric razor may be used. 2. EXCLUSIONS Shaving is considered skilled when skilled skin care, as described under EXCLUSIONS for skin care at 8.489.31, B, 2, is required in conjunction with shaving.

	G. DRESSING 1. INCLUSIONS: Dressing is considered unskilled only when skilled skin care or skilled transfer, as described under EXCLUSIONS, is not required in conjunction with the dressing. Unskilled dressing may include assistance with ordinary clothing; application of support stockings of the type that can be purchased without a physician's prescription; application of orthopedic devices such as splints and braces, or of artificial limbs, if considerable manipulation of the device or limb is not necessary, and if the client is fully trained in the use of the device or limb and is able to instruct the personal care staff. 2. EXCLUSIONS: Dressing is considered skilled when skilled skin care or skilled transfer, as described under EXCLUSIONS for skin care at 8.489.313, 2 or EXCLUSIONS for transfers at 8.489.31, 0, is required in conjunction with the dressing. Skilled dressing may include application of anti-embolic or other pressure stockings that can be purchased only with a physician's prescription; application of orthopedic devices such as splints and braces, or of artificial limbs, if considerable manipulation of the device or limb is necessary, or if the client is still learning to use the device or limb. H. FEEDING I. INCLUSIONS: Feeding is considered unskilled only when skilled skin care or skilled dressing, as described under EXCLUSIONS, is not required in conjunction with the feeding, and when oral suctioning is not needed on a stand-by or other basis. Unskilled feeding includes assistance with eating by mouth, using common eating utensils, such as forks, knives and straws. 2. EXCLUSIONS: Feeding is considered skilled when skilled skin care or skilled dressing, as described under EXCLUSIONS for skin care at 8.489.313,2 or EXCLUSIONS for dressing at 8.489.31,0,2, is required in conjunction with the feeding, and when oral suctioning is needed on a stand-by or other basis. Syringe feeding is also considered skilled. Feeding is skilled if there is a high risk of choking that could result in the need for emergency measures such as CPR or Heimlich maneuver. I. AMBULATION 1. INCLUSIONS: Assistance with ambulation is considered unskilled only when skilled transfers, as described under EXCLUSIONS, are not required in conjunction with the ambulation. In addition, when assisting a client with adaptive equipment, the client must be fully trained in the use of such equipment; and when assisting someone in a cast, there must be no need for observation and reporting to a nurse, and no need for skilled skin care, as described under EXCLUSIONS. Adaptive equipment may include, but is not limited to, gait belts, walkers, canes and wheelchairs. 2. EXCLUSIONS: Assistance with ambulation is considered skilled when skilled transfers, as described under EXCLUSIONS for transfers at 8.489.31, K, 2, are required in conjunction with the ambulation. In addition, when assisting a client with adaptive equipment, it is considered skilled if the client is still being trained in the use of such equipment; and assisting someone in a cast is considered skilled there is a need for observation and reporting to a nurse, or if there is a need for skilled skin care, as described under EXCLUSIONS for skin care at 8.489.31, B, 2. J. EXERCISES

	1. INCLUSIONS: Assistance with exercises is considered unskilled only when the exercises are not prescribed by a nurse or other licensed medical professional. Unskilled assistance with exercise is limited to the encouragement of normal bodily movement, as tolerated, on the par: of the client. Personal care staff shall not prescribe nor direct any type of exercise program for the client. 2. EXCLUSIONS: Assistance with exercises is considered skilled when the exercises are prescribed by a nurse or other licensed medical professional. This may include passive range of motion. K. TRANSFERS 1. INCLUSIONS: Assistance with transfers is considered unskilled only when the client has sufficient balance and strength to assist with the transfer to some extent. Except for Hoyer lifts, adaptive equipment may be used in transfers, provided that the client is fully trained in the use of the equipment and can direct the transfer step by step. Adaptive equipment may include, but is not limited to, gait belts, wheel chairs, tub seats, grab bars. EXCLUSIONS: Assistance with transfers is considered skilled when the client is unable to assist with the transfer. Use of Hoyer lifts is considered skilled, and use of other adaptive equipment is considered skilled if the client is still being trained in the use of the equipment. L. POSITIONING 1. INCLUSIONS: Positioning is considered unskilled only when the client is able to identify to the personal care staff, verbally, non-verbally or through others, when the position needs to be changed; and only when skilled skin care, as described under EXCLUSIONS, is not required in conjunction with the positioning. Positioning may include simple alignment in a bed, wheelchair, or other furniture. 2. EXCLUSIONS: Positioning is considered skilled when the client is not able to identify to the caregiver when the position needs to be changed, and when skilled skin care, as described under EXCLUSIONS for skin care at 8.489.31, B, 2, is required in conjunction with the positioning. M. BLADDER CARE 1. INCLUSIONS: Bladder care is considered unskilled only when skilled transfer or skilled skin care, as described under EXCLUSIONS, is not required in conjunction with the bladder care. Unskilled bladder care may include assisting the client to and from the bathroom; assistance with bed pans, urinals, and commodes; and changing of clothing and pads of any kind used for the care of incontinence. Emptying of Foley catheter bags or suprapubic catheter bags is considered unskilled only if there is no disruption of the closed system; the personal care staff must be trained to understand what constitutes disruption of the closed system. 2. EXCLUSIONS: Bladder care is considered skilled whenever it involves disruption of the closed system for a Foley or suprapubic catheter, such as changing from a leg

	bag to a night bag. Care of external catheters is also considered skilled. N. BOWEL CARE 1. INCLUSIONS: Bowel care is considered unskilled only when skilled transfer or skilled skincare, as described under EXCLUSIONS, is not required in conjunction with the bowel care. Unskilled bowel care may include assisting the client to and from the bathroom; assistance with bed pans and commodes; and changing of clothing and pads of any kind used for the care of incontinence. Emptying of ostomy bags and assistance with other client-directed ostomy care is unskilled only when there is no need for skilled skin care or for observation and reporting to a nurse. 2. EXCLUSIONS: Bowel care is considered skilled when skilled transfer or skilled skin care, as described under EXCLUSIONS for transfers at 8.489.31, K, 2, or EXCLUSIONS for skin care at 8.489.3 LB-2. is required in conjunction with the bowel care. Skilled bowel care includes digital stimulation and enemas. Skilled bowel care may include care of ostomies that are new and care of ostomies when the client is unable to self-direct the care, provided that sterile technique is not required. O. MEDICATION REMINDING 1. INCLUSIONS: Medication reminding is allowed as unskilled personal care only when medications have been preselected, by the client, a family member, a nurse, or a pharmacist, and are stored in containers other than the prescription bottles, such as medication minders. Medication minder containers must be clearly marked as to day and time of dosage, and must be kept in such a way as to prevent tampering. Medication reminding includes only inquiries as to whether medications were taken, verbal prompting to take medications, handing the appropriately marked medication minder container to the client, and opening the appropriately marked medication minder container for the client if the client is physically unable to open the container. Medication reminding does not include taking the medication out of the container. These limitations apply to all prescription and all over the counter medications, including pm medications. Any irregularities noted in the preselected medications, such as medications taken too often or not often enough, or not at the correct time as marked on the medication minder container, shall be immediately reported by the personal care staff to a supervisor. 2. EXCLUSIONS: Medication assistance is considered skilled care and consists of putting the medication in the client's hand when the client can self-direct in the taking of medications. P. RESPIRATORY CARE 1. INCLUSIONS: Respiratory care is not considered unskilled. However, personal care staff may clean or change the tubing for oxygen equipment, may fill the distilled water reservoir, and may temporarily remove and replace the cannula or mask from the client's face for purposes of shaving or washing the client's face. Adjustments of the oxygen flow are not allowed. 2. EXCLUSIONS: Respiratory care is skilled care, and includes postural drainage, cupping, adjusting oxygen flow within established parameters, and suctioning of mouth and nose.

	Q. ACCOMPANYING 1. INCLUSIONS: Accompanying the client to medical appointments, banking errands, basic household errands, clothes shopping, and grocery shopping to the extent necessary and as specified on the care plan is considered unskilled, when all the care that is provided by the personal care staff in relation to the trip is unskilled personal care, as described in these regulations. Accompanying the client to other services is also permissible as specified on the care plan, to the extent of time that the client would otherwise receive personal care services in the home. Personal care for the purpose of accompanying the client shall only be authorized when a personal care provider is needed during the trip to provide one or more other unskilled personal care services listed in this Section. Accompanying the client primarily to provide companionship is not a covered benefit. 2. EXCLUSIONS: Accompanying is considered skilled when any of the tasks performed in conjunction with the accompanying are skilled tasks. Accompanying does not include transporting the client. R. HOMEMAKING Homemaking, as described at Section 8.490, HOMEMAKER SERVICES, may be provided by personal care staff, if provided during the same visit as unskilled personal care, as described in these regulations. S. PROTECTIVE OVERSIGHT 1. INCLUSIONS: Protective oversight is considered unskilled when the client requires stand-by assistance with any of the unskilled personal care described in these regulations, or when the client must be supervised at all times to prevent wandering. 2. EXCLUSIONS: Protective oversight for standby assistance with personal care tasks is considered skilled if any of the tasks performed are skilled tasks. Protective oversight to prevent wandering is considered skilled if any skilled personal care tasks are performed while providing oversight. .32 Personal care services as described above may be used to provide respite care for primary care givers, provided that the respite care does not duplicate any care which the primary caregiver may be receiving payment to provide. 8.489.40 CERTIFICATION STANDARDS FOR PERSONAL CARE SERVICES .41 Personal care provider agencies shall conform to all general certification standards and procedures at Section 8.487, HCBS-EBD PROVIDER AGENCIES, and shall meet all the additional personal care certification requirements in this section. .42 Personal care provider agencies shall assure and document that all personal care staff have received at least twenty hours of training, or have passed a skills validation test, in the provision of unskilled personal care as described above. Training, or skills validation, shall include the areas of bathing, skin care, hair care, nail care, mouth care, shaving, dressing, feeding, assistance with ambulation, exercises and transfers, positioning, bladder care, bowel care, medication reminding, homemaking, and protective oversight. Training shall also include instruction in basic first aid, and training in infection control techniques, including universal precautions. Training or skills validation shall be completed prior to service delivery, except for components of training that may be provided in the client's home, in the presence of the supervisor.

	.43 All employees providing personal care shall be supervised by a person who, at a minimum, has received the training, or passed the skills validation test, required of personal care staff, as specified above. Supervision shall include, but not be limited to, the following activities: A. Orientation of staff to agency policies and procedures. B. Arrangement and documentation of training. C. Informing staff of policies concerning advance directives and emergency procedures. D. Oversight of scheduling, and notification to clients of changes; or close communication with scheduling staff. E. Written assignment of duties on a client-specific basis. F. Meetings and conferences with staff as necessary. G. Supervisory visits to client's homes at least every three months, or more often as necessary, for problem resolution, skills validation of staff, client-specific or procedure-specific training of staff, observation of client's condition and care, and assessment of client's satisfaction with services. At least one of the assigned personal care staff must be present at supervisory visits at least once every three months. H. Investigation of complaints and critical incidents. I. Counseling with staff on difficult cases, and potentially dangerous situations. J. Communication with the case managers, the physician, and other providers on the care plan, as necessary to assure appropriate and effective care. K. Oversight of record-keeping by staff. .44 A personal care agency may be denied or terminated from participation in Colorado Medicaid, according to procedures found at Section 8.050 through 8.051.44, based on good cause, as defined at 8.051.01. Good cause for denial or termination of a personal care agency shall include, but not be limited to, the following: A. Improper Billing Practices: Any personal care/homemaker agency that is found to have engaged in the following practices may be denied or terminated from participation in Colorado Medicaid: 1. Billing for visits without documentation to support the claims billed. Acceptable documentation for each visit billed shall include the nature and extent of services, the care provider's signature, the month, day, year, and the exact time in and time out of the client's home, as well as time of departure and time of arrival for all travel time billed. Providers shall submit or produce requested documentation in accordance with rules at 8.079.62. 2. Billing for excessive hours that are not justified by the documentation of services provided, or by the client's medical or functional condition. This includes billing all units prior authorized when the allowed and needed services do not require as such time as that authorized. 3. Billing for time spent by the personal care provider performing any tasks that are not allowed according to regulations in this SECTION 8.489. This includes but is not limited to companionship, financial management, transporting of clients, skilled personal care, or delegated nursing tasks. 4. Unbundling of home health aide and personal care or homemaker services, which is defined as any and all of the following practices by any personal care/homemaker agency that is also certified as a Medicaid Home Health Agency, for all time periods during which regulations were in effect that defined the unit for home health aide services as one visit up to a maximum of two and one-half hours: a. One employee makes one visit, and the agency bills Medicaid for one home health aide visit and bills all the hours as HCBS personal care or homemaker.

b. One employee makes one visit and the agency bills for one home health aide visit, and bills some of the hours as HCBS personal care or homemaker, when the total time spent on the visit does not equal at least 2 1/2 hours plus the number of hours billed for personal care and homemaker.

c. Two employees make contiguous visits, and the agency bills one visit as home health aide and the other as personal care or homemaker, when the time spent on the home health aide visit was less than 2 1/2 hours.

d. One or more employees make two or more visits at different times on the same day, and the agency bills one or more visits as home health aide and one or more visits as personal care or homemaker, when any of the aide visits were less than 2 1/2 hours and there is no reason related, to the client's medical condition or needs that required the home health aide and personal care or homemaker visits to be scheduled at different times of the day.

e. One or more employees make two or more visits on different days of the week, and the agency bills one or more visits as home health aide and one or more visits as personal care or homemaker, when any of the aide visits were less than 2 1/2 hours and there is no reason related to the client's medical condition or needs that required the home health aide and personal care or homemaker visits to be scheduled on different days of the week.

f. Any other practices that circumvent these rules and result in excess Medicaid payment through unbundling of home health aide and personal care or homemaker services.

5. For all time periods during which the unit of reimbursement for home health aide is defined as hour and/or half-hour increments, all the practices described in 4 above shall constitute unbundling if the home health aide does not stay for the maximum amount of time for each unit billed.

B. Refusal to Provide Necessary and Allowed Personal Care or Homemaker Services Without Also Receiving Payment For Home Health Services. A personal care/homemaker agency that is also certified as a Medicaid Home Health Agency may be terminated from Medicaid participation if the agency refuses to provide necessary and allowed HCBS personal care or homemaker services to clients who do not need Home Health services or who receive their Home Health services from a Home Health Agency not affiliated with the personal care/homemaker agency.

C. Prior Termination From Medicaid Participation. A personal care/homemaker agency shall be denied or terminated from Medicaid participation if the agency or its owner(s) have previously been involuntarily terminated from Medicaid participation as a personal care/homemaker agency or any other type of service provider.

D. Abrupt Prior Closure. A personal care/homemaker agency may be denied or terminated from Medicaid participation if the agency or its owner(s) have abruptly closed, as any type of Medicaid provider, without proper prior client notification.

.45 Any Medicaid overpayments to a provider for services that should not have been billed shall be subject to recovery. Overpayments that are made as a result of a provider's false representation shall be subject to recovery plus civil monetary penalties and interest. False representation means an inaccurate statement that is relevant to a claim which is made by a provider who has actual knowledge of the false nature of the statement, or who acts in deliberate ignorance or with reckless disregard for truth. A provider acts with reckless disregard for truth if the provider fails to maintain records required by the department or if the provider fails to become familiar with rules, manuals, and bulletins issued by the State, the Medical Services Board, or the State's fiscal agent.

.46 When a personal care agency voluntarily discloses improper billing, and makes restitution, the State shall consider deferment of interest and penalties in the context of the particular situation.

8.489.50 REIMBURSEMENT

.51 Payments for personal care services shall be the lower of the billed charges or the maximum rate of reimbursement. Reimbursement shall be per unit of one hour. The maximum unit rate shall be adjusted by the State as funding becomes available.

.52 Payment may include travel time to and from the client's residence, to be billed at the same unit rate as personal care services. The time billed for

	travel shall be listed separately from, but documented on the same form as, the time for service provision on each visit. Travel time must be summed over a period of at least a week and then rounded to the nearest hour for billing purposes. Travel time to one client's residence may not also be billed as travel time from another client's residence, as this would represent duplicate billing for the same time period. .53 When personal care services are used to provide respite for unpaid primary care givers, the exact services rendered must be specified in the documentation. .54 When an employee of a personal care agency provides services to a client who is a relative, the personal care agency shall bill under a special procedure code, in hourly units, using rates and hours which shall not exceed a total cost to Medicaid of more than $13.00 per day. When averaged out over the number of days in the plan period. .55 If a visit by a personal care staff includes some homemaker services, as defined at Section 8.490. HOMEMAKER SERVICES, the entire visit shall be billed as personal care services. If the visit includes only homemaker services, and no personal care is provided, the entire visit shall be billed as homemaker services. .56 If a visit by a Home Health Aide from a Home Health Agency includes unskilled personal care, as defined in this section, only the Home Health Aide visit shall be billed. .57 Effective 21/99, there shall be no reimbursement under this section for personal care services provided in uncertified congregate facilities. Case managers may submit a written request to the Department for a waiver not to exceed six months for clients receiving these services in uncertified congregate facilities prior to the effective date of this rule. After that time, services shall be discontinued. .58 Cost Reporting A. All personal care agencies shall report and submit to the Department cost report information on a Department prescribed form. B. By dates set forth by the Department, personal care providers shall submit an annual cost report for the provider agency's most recent complete fiscal year or the State fiscal year. C. Providers that do not comply with Section 8.489.58 shall have their Medicaid provider agreement terminated.
Targeted Population	Adults 18-64 with physical disabilities and seniors 65+ with functional deficits who require nursing facility level of care.
Waiver Manager Comment	In general, this is a good service that is working well. There is extensive utilization of this service.. This service would benefit from improved consistency across waivers and in different service delivery options.

Waiver	**HCBS-Persons Living with Aids (PERSONAL CARE)**
Waiver Service Definition	Same as EBD Waiver

Service Limitations	Personal Care providers may be members of the individual's family. The number of Medicaid personal care units for provided by any single member of the client's family shall not exceed the equivalent of 444 personal care units per annual certification of HCBS-PLWA. Payment will not be made for services furnished to an individual by an individual's spouse employed by a Personal Care agency.
Rule	Same as EBD Waiver
Targeted Population	Persons of any age with a diagnosis of HIV/AIDs who meet nursing facility or hospital level of care.
Waiver Manager Comment	In general, this is a good service that is working well. There is extensive utilization of this service. This service would benefit from improved consistency across waivers.

Waiver	**HCBS- Community Mental Health Supports Waiver (PERSONAL CARE)**
Waiver Service Definition	Same as EBD Waiver
Service Limitations	Relatives, other than a spouse, that are related to the individual receiving services by virtue of blood, marriage, adoption, or Colorado common law, may be employed by a personal care/homemaker or home health agency to provide personal care services. Relatives employed by an agency shall meet the same experience and qualification standards required of all agency employees. Per 25.5-6-310, C.R.S., the number of Medicaid personal care units provided by relatives shall not exceed the equivalent of 444 hours per annual certification. Personal care services are limited based on the client's assessed need for services and prior authorization by case managers up to the cost containment parameters. Clients that choose to have personal care services delivered by an agency shall have no duplication of these services by CDASS. There shall be no duplication of the light housekeeping chores that are incidental to personal care and the services are reimbursed under the homemaker benefit. This service can only be participant-directed if the client chooses to participate in Consumer Directed Attendant Support Service (CDASS).
Rule	Same as EBD Waiver**: 10 CCR 2505-10 8.489**
Targeted Population	Persons who are 18 years and older with a major mental illness who meet nursing facility level of care.
Waiver Manager Comment	The Personal Care service is 526 out of 2,803 for Non-Relative care and 255 for Relative Care, a total of 736 clients in this waiver utilize this service. As Personal Care is included in the ACF rate, clients are unable to use it while living in the facility. There are many different definitions of Personal Care and the rule would benefit from having one, consistent, definition of the service.

Waiver	**HCBS- for Persons with Brain Injury Waiver (PERSONAL CARE)**
Waiver Service Definition	Personal care includes providing assistance with eating, bathing, dressing, personal hygiene or other activities of daily living. Although these services may include assistance with meal preparation, this service will not include the cost of the meals themselves. When specified in the service plan, personal care may also include housekeeping chores such as bed making, dusting and vacuuming. Housekeeping assistance must be incidental to the care furnished or essential to the health and welfare of the individual rather than for the benefit of the individual's family. Payment will not be made for services furnished to a minor if services are provided by the child's parent (or step parent), or to an individual whose service is provided by a spouse.
Service Limitations	NA
Rule	Same as EBD Waiver: **10 CCR 2505-10 Section 8.489**
Targeted Population	Persons 16 years of age and older with a brain injury sustained before the age of 65 who meet the hospital, nursing facility or ICF/ID level of care.
Waiver Manager Comment	There are many different definitions of Personal Care and the rule would benefit from having one, consistent, definition of the service.

Waiver	**HCBS-for Persons with Spinal Cord Injury (PERSONAL CARE)**
Waiver Service Definition	Personal care includes assistance with eating, bathing, dressing, personal hygiene, and activities of daily living. When specified in the service plan, this service may also include only such light housekeeping chores as meal preparation, bed making, dusting, and vacuuming that are incidental to the care furnished. This service may include assistance with preparation of meals, but does not include the cost of the meals themselves.
Service Limitations	Relatives, other than a spouse, that are related to the individual receiving services by virtue of blood, marriage, adoption, or Colorado common law may be employed by a personal care/homemaker or home health agency to provide personal care services. Relatives employed by an agency shall meet the same experience and qualification standards required of all agency employees. Per 25.5-6-310, C.R.S., the number of Medicaid personal care units provided by relatives shall not exceed the equivalent of 444 hours per annual certification. Personal care services are limited based on the client's assessed need for services and prior authorization by case managers up to the cost containment parameters. Clients that choose to have personal care services delivered by an agency shall have no duplication of these services by an IHSS agency or by CDASS. There shall be no duplication of the light housekeeping chores that are incidental to personal care and the services reimbursed under the homemaker benefit.

Rule	Same as EBD Waiver **10 CCR 2505-10 Section 8.489**
Targeted Population	Persons 18 years and older with a spinal cord injury who meet nursing facility level of care.
Waiver Manager Comment	This waiver has just been implemented and there isn't adequate data to assess whether this service is utilized for this target population.

Waiver	**HCBS- Supported Living Services Waiver (PERSONAL CARE)**
Waiver Service Definition	A range of assistance to enable participants to accomplish tasks that they would normally do for themselves (i.e. hygiene, bathing, eating, dressing, grooming, bowel and bladder care, menstrual care, transferring, money management, grocery shopping), if they did not have a developmental disability. This assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing to prompt the participant to perform a task. Personal Care services may be provided on an episodic, emergency or on a continuing basis. When Personal Care and health-related services are needed, they may be covered to the extent the Medicaid State Plan, Third Party Resource or another waiver service is not responsible.
Service Limitations	NA
Rule	**10 CCR 2505-10 Section 8.500.95.A(10): PERSONAL CARE** Personal Care is assistance to enable a client to accomplish tasks that the client would complete without assistance if the client did not have a disability. This assistance may take the form of hands-on assistance by actually performing a task for the client or cueing to prompt the client to perform a task. Personal care services include: a. Assistance with basic self care including hygiene, bathing, eating, dressing, grooming, bowel, bladder and menstrual care. b. Assistance with money management, c. Assistance with menu planning and grocery shopping, and d. Assistance with health related services including first aide, medication administration, assistance scheduling or reminders to attend routine or as needed medical, dental and therapy appointments, support that may include accompanying clients to routine or as needed medical, dental, or therapy appointments to ensure understanding of instructions, doctor's orders, follow up, diagnoses or testing required, or skilled care that takes place out of the home. e. Personal care services may be provided on an episodic, emergency or on a continuing basis. When personal care service is required, it shall be covered to the extent the Medicaid state plan or third party resource does not cover the service. f. If the annual functional needs assessment identifies a possible need for skilled care then the client shall obtain a home health assessment.
Targeted Population	Per Persons with a developmental disability aged 18 or older who meet ICF/ID level of care
Waiver Manager	None- service works as described above.

Waiver	HCBS-Children's Extensive Support Waiver (PERSONAL CARE)
Waiver Service Definition	A range of assistance to enable participants to accomplish tasks that they would normally do for themselves (i.e. hygiene, bathing, eating, dressing, grooming, bowel and bladder care, menstrual care, transferring, money management, grocery shopping), if they did not have a developmental disability. This assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing to prompt the participant to perform a task. Personal Care services may be provided on an episodic, emergency or on a continuing basis. When Personal Care and health-related services are needed, they may be covered to the extent the Medicaid State Plan, Third Party Resource or another waiver service is not responsible.
Service Limitations	NA
Rule	8.503.40.A.8. Personal Care is assistance to enable a client to accomplish tasks that the client may complete without assistance if the client did not have a disability. This assistance may take the form of hands-on assistance by actually performing a task for the client or cueing to prompt the client to perform a task. a. Personal care services include assistance with basic self care tasks that include performing hygiene activities, bathing, eating, dressing, grooming, bowel, bladder and menstrual care. b. Personal care services may be provided on an episodic, emergency or on a continuing basis. When personal care service is required it shall be provided by the HCBS-CES waiver only to the extent the Medicaid State Plan or third party resource does not cover the service. c. If the annual Functional Needs Assessment identifies a possible need for skilled care then the client shall obtain a home health assessment.
Targeted Population	Clients ages birth up to 18th birthday Must have developmental delay (age 5 and under) or developmental disability. Have a behavior or medical condition so intense it requires near constant line of sight supervision.
Waiver Manager Comment	Low use: FY PD claims unduplicated client count 38; overall waiver unduplicated count 409 Most children who need assistance with ADL;s access through MSP. If a child demonstrates "Medical necessity" for assistance with Activities of Daily living then personal care should be covered through EPSDT under Medicaid state plan. Although low use, this service is needed for a while longer until we educate the system that children who cannot complete activities of daily living due to cognitive or developmental effects should receive assistance with ADL's through the Medicaid state plan. See EPSDT definition of Medical Necessity below. **8.280 EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT [Eff. 10/01/2007]** **8.280.1 DEFINITIONS** Early and Periodic Screening, Diagnosis and Treatment (EPSDT) means the child health component of Medicaid. Early and Periodic Screening, Diagnosis and Treatment Case Management means an activity that assists Medicaid clients in getting and/or coordinating services based on individual need. EPSDT Outreach means methods to inform recipients or potential recipients, such as those found to be presumptively eligible, to enter into care.

	EPSDT Outreach and Case Management Entity means an entity that has contracted with the Department to provide the activities specified in 8.280.3 below. Medical necessity means that a covered service shall be deemed a medical necessity or medically necessary if, in a manner consistent with accepted standards of medical practice, it: 1. Is found to be an equally effective treatment among other less conservative or more costly treatment options, and 2. Meets at least one of the following criteria: a. The service will, or is reasonably expected to prevent or diagnose the onset of an illness, condition, primary disability, or secondary disability. b. The service will, or is reasonably expected to cure, correct, reduce or ameliorate the physical, mental cognitive or developmental effects of an illness, injury or disability. c. The service will, or is reasonably expected to reduce or ameliorate the pain or suffering caused by an illness, injury or disability. d. The service will, or is reasonably expected to assist the individual to achieve or maintain maximum functional capacity in performing Activities of Daily Living. Medical necessity may also be a course of treatment that includes mere observation or no treatment at all.

ADULT DAY SERVICES

Waiver	**HCBS-Elderly, Blind and Disabled Waiver**
Waiver Service Definition	Services furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to assure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a full nutritional regimen (3 meals per day). Physical, occupational and speech therapies indicated in the individual's plan of care would be furnished as component parts of this service if such services are not being provided in the participant's home.
Service Limitations	Adult Day Health services offered in this waiver are limited based on the client's assessed need for services, physician's orders and prior authorization by case managers up to the cost containment parameters.
Rule	8.491 ADULT DAY SERVICES .10 Adult Day Services (ADS) means health and social services, individual therapeutic and psychological activities furnished on a regularly scheduled basis in an adult day services center, as an alternative to long-term nursing facility care. .12 Basic Adult Day Services (ADS) Center means a community-based entity that conforms to all state established requirements as described in Section 8.130 and Section 8.491.14. .13 Specialized Adult Day Services (SADS) Center means a community-based entity determined by the State to be providing intensive health supportive services for participants with a primary diagnosis of Alzheimer's and related disorders, Multiple Sclerosis, Brain Injury, Chronic Mental Illness, Developmental Disability or post-stroke participants who require extensive rehabilitative therapies. To be determined specialized, two-thirds of an ADS center's population must be participants whose physician has verified one of the above diagnoses and recommended the appropriate specialized services. In addition, verification and documentation of the participant's diagnosis and the recommended specialized services must be included in each participant's case record and must include the following: A. For Medicaid participants, the case manager must forward the most recent copy of page 1 of the participant's ULTC-100 to the ADS center as documentation of one of the above diagnoses. Documentation must be verified at the time of admission, reassessment or whenever then; is a significant change in the participant's condition. B. For participants from other payment sources, diagnosis and recommended specialized services must be documented in an individual care plan, or other admission form, and verified by the participant's physician. This documentation must be verified at the time of admission, or whenever mere is a significant change in the participant's condition. C. The Department or its designee will review an adult day services center's designation as a specialized facility (SADS) on an annual basis. .14 Only participants whose needs can be met by the Adult Day Services Center within its certification category and populations served shall be admitted

	to the Center. Adult day services shall include, but are not limited to, the following: A. Daily monitoring to assure that participants are maintaining activities prescribed; and assisting with activities of daily living (e.g., eating, dressing, bathing). B. Emergency services including written procedures to meet medical crises. C. Activities mat assist in the development of self-care capabilities, personal hygiene, and social support services. D. Nutrition services including therapeutic diets and snacks appropriate to the participant's care plan and hours in which the participant is served E. Daily services provided to monitor the participant's health status, supervise medications, and carry out physicians' orders in participant's care plan as needed. F. Social and recreational services as prescribed to meet the participant's needs and as documented in the participant's care plan. Participants have the right to choose not to participate in social and recreational activities. G. Adult day services centers certified on or after July 1, 1996, or upon change of ownership, shall provide basic personal care services including bathing in emergency situations. H. Any additional services such as physical therapy, occupational therapy and speech therapy, if such services are prescribed by the participant's physician, documented in the participant's care plan and if such services are not being provided in the participant's home. Such services must be included in the budget submitted to the State in accordance with the section on REIMBURSEMENT METHOD FOR ADULT DAY SERVICES, and determined by the State to be necessary for adult day services. 8.491.15 DEFINITIONS 1242749 A. Director means any person who owns and operates an ADS center, or is a managing employee with delegated authority by ownership to manage, control, or perform the day-to-day tasks of operating the facility as described in section 8.495.C.22. B. Participant means any individual found to be eligible for adult day services regardless of payment source. C. Restraint means any physical or chemical device, application of force, or medication which is designed or used for the purpose of modifying, altering, or controlling behavior for the convenience of the facility, excluding medication prescribed by a physician as part of an ongoing treatment plan or pursuant to a diagnosis. D. Staff means a paid or voluntary employee of the facility. E. Universal Precautions refers to a system of infection control which assumes that every direct contact with body fluids is potentially infectious. This includes any reasonably anticipated skin, eye, mucous membrane or contact with blood-tinged body fluids, or other potentially infectious material 8.491.20 CERTIFICATION STANDARDS All ADS centers shall conform to all of the following State established standards: A. General 1. Conforms to all established State standards in the section on general provider participation requirements, as defined in Section 8.130, has in effect all necessary licenses and insurance, and is in compliance with ADS regulations as determined by an annual on-site survey conducted by the Department of Health Care Policy and Financing or its designee.

	2. A completed Provider Agreement between the provider and the Department of Health Care Policy and Financing shall serve as proof of Medicaid certification. 3. Denial, termination, or non-renewal of the Provider Agreement shall be for "Good Cause" as provided in Section 8.050 of this staff manual. B. Environment 1. All providers of ADS shall operate in full compliance with all applicable federal, State and local fire, health, safety, sanitation and other standards prescribed in law or regulations. 2. The agency shall provide a clean environment, free of obstacles that could pose a hazard to participant health and safety. 3. Agencies shall provide lockers or a safe place for participants' personal items. 4. ADS centers shall provide recreational areas and activities appropriate to the number and needs of the participants. 5. Drinking facilities shall be located within easy access to participants. 6. ADS centers shall provide eating and resting areas consistent with the number and needs of me participants being served. Centers certified on or after July 1, 19%, shall provide a minimum of 40 sq. feet per participants 7. ADS centers shall provide easily accessible toilet facilities, land-washing facilities and paper towel dispensers. Centers certified on or after My 1, 1996 must provide a facility for bathing in emergency situations. 8. The center shall be accessible to participants with supportive devices for ambulation or in wheelchairs. 9. There shall be adequate means by which food shall be maintained at the Mowing temperatures: Hot 140° F, Cold: 45° F. 10. All medications shall be stored in a secured area. 11. Centers shall be heated to at least seventy (70) degrees during hours of operation and no more than 76 degrees in the summer months. 12. ADS centers must provide an environment free from restraints as defined at Section 8.491.15 C. of these rules. 13. ADS Centers, in accordance with 8.491.14 above, must provide a safe environment for all participants, including participants exhibiting behavioral problems, wandering behavior, or limitations in mental/cognitive functioning. C. Records and Information ADS providers shall keep such records and information necessary to document the services provided to participants receiving adult day services. Records shall include but not be limited to: a. Name, address, sex, and age of each participant b. Name, address and telephone number of responsible party, c. Name, address and telephone number of primary physician d. Documentation of the supervision and monitoring of the services provided, e. Documentation that all participants were oriented to the center, the policies, and procedures relevant to the facility and the services provided.

	f. A services agreement signed by the participant and/or his or her designated representative and appropriate center staff. g. A plan of care. Plans of care for participants from other payment sources, receiving supportive services in a specialized ADS center must include a primary diagnosis and a physician's signature. 2. Medical Information included in the plan of care: a. Medications the client participant is taking and whether they are being self-administered. b. Special dietary needs, if any. c. Any restrictions on social and/or recreational activities identified by physician in the care plan. d. Documentation of any nursing or medical interventions; physical, speech, and/or occupational therapy administered to participants whose physician has prescribed such services to be included in the participant's individual plan of care. e. Any other special health or behavioral management needs. 3. Documentation that the participant and/or other responsible party was provided with written information about his/her rights under state law regarding advance directives in accordance with regulations at 8.130.65. Documentation as to whether the participant has executed an advance directive shall be kept in his/her case record. 4. All entries into the record shall be legible, written in ink, dated, and signed with name and title designation. 5. Records shall be maintained in such a manner as to ensure safety and confidentiality D. Staffing Requirements 1. All ADS centers must maintain a staff o participant ratio of 1:8 or lower to provide for the needs of the population served, as described above at 8.491.12 and .13, and shall provide the following: a. Supervision of participants at all tunes during the operating hours of the program; b. Immediate response to emergency situations to assure the welfare of participants; c. Prescribed recreational and social activities; d. Nursing services for regular monitoring of the on-going medical needs of participants and the supervision of medications. These services must be available a minimum of two hours daily and must be provided by an RN or LPN. CNAs may provide these services under the direction of a RN or an LPN. Supervision of CNAs must include consultation and oversight on a weekly basis or more according to the participant's needs. e. Administrative, recreational, social and supportive functions of the ADS center. 2. In addition to the above services, specialized adult day care services (SADS) centers providing a restorative model of care shall have sufficient staff to provide the following: a. Nursing services during all hours of operation. Nursing services must be provided by a licensed RN or LPN or by a CNA under the supervision of an RN or LPN, as per 8.491.20 D.1.d, above. b. Therapies, if included in the center's budget and as prescribed by the participant's physician, to meet the restorative needs of the client participant

	E. Training Requirements 1. ADS centers providing medication administration as a service must have qualified persons on their staff who have been trained in accordance with State Law, Chapter XXIV, Section 25-1-107(1) (ee) (I) (A) Qualified Medication Administration Staff Members. 2. All staff must be trained in the use of universal precautions as defined at Section 8.491.15 E. Facilities certified prior to the effective date of these rules shall have sixty (60) days to satisfy this training requirement 3. The operator and staff must have training specific to the needs of the populations served, e.g., elderly, blind and disabled, and as defined in Section 8.491.13 of these rules. 4. All staff and volunteers must be trained in the handling of emergencies including written procedures to meet medical crises. 5. All required training must be documented in employees' personnel files. F. Written Policies The ADS center shall have a written policy relevant to its operation. Such policy shall include, but not be limited to, statements describing: 1. Admission criteria mat qualify participants to be appropriately served the center; 2. Interview procedure conducted for qualified participants and/or family member prior to admission to the center, 3. The meals and nourishments including special diets that will be provided; 4. The hours that the participants will be served in the center and days of the week services will be available; 5. Medication administration; 6. The personal items that the participants may bring with them to the center, and 7. A written, signed agreement drawn up between the participant or responsible party and the center outlining rules and responsibilities of the center and of the participant Each party to me agreement shall be provided a copy. 8.491.30 REIMBURSEMENT METHOD FOR ADULT DAY SERVICES .31 Reimbursement for ADS services shall be based upon a single all-inclusive payment rate per unit of service for each participating provider which shall be prospectively determined A unit is defined as: one (1) unit = a partial day = three (3) to five (5)hours of service two (2) units = a full day = more than five (5)hours of service 8.491.32 The ADS center's rate of reimbursement shall be the lower of: A. The maximum allowable applicable Medicaid rate for either 1. Basic ADS Centers-the maximum rate shall not exceed $18.00 per unit of service, as defined above, except that the Department may adjust the maximum rate based upon future appropriations; or 2. Specialized ADS Centers-the maximum rate shall not exceed $23.00 per unit, as defined above, except that the Department may adjust the maximum rate

	based upon future appropriations. B. The ADS center's private-pay charges to the general public for similar services. C. The projected cost of ADS, as determined by the Department of Health Care Policy and Financing, after review of a cost report/budget to be submitted by the ADS center annually by such date and in a format as prescribed by the Department, with copies of any and all audit reports prepared within the previous twelve-month period. Failure to timely submit the required cost report to the Department shall result in the Department assigning the center's costs have not changed and assigning a cost figure at 100% of the prior year's reported cost per unit Failure to submit the cost report a second consecutive year shall result in the Department assigning a cost figure at 00% of the most recently reported met information. Cost reports submitted late shall not be considered until me next year's review. Cost reports shall be reviewed by the Department for appropriateness, with consideration given to: changes in type and intensity of services being provided, the previous year's reported costs adjusted forward by increases in the annual Consumer Price Index (CPI-W as of the beginning of the State fiscal year), and costs of comparable ADS centers in the State. The Department shall notify the provider by September 1 of each year of any costs determined to be inappropriate. The provider must sub nit any additional documentation supporting the costs in question within thirty (30) days of notification Supporting documentation received after that thirty-day period will not be considered until the next rate-setting period. D. The amount billed. 8.491.33 Upon completion of its review, the Department of Health Care Policy and Financing shall notify each ADS center provider of its approved cost per unit and its rate to be effective October 1. Adjustments in the approved cost per unit shall not be made until the next year's cost reporting and rate-setting period. 8.491.34 For new ADS centers the Department shall determine a rate per unit, taking into consideration the following criteria: anticipated costs reported by the provider, costs and rates of comparable ADS centers, any prior owner's reported costs, and proposed private pay charges to the general public for similar services. The determined rate per unit shall remain in effect until the next year's cost reporting and rate-setting period. 8.491.35 EXCLUSIONS: A. Transportation to and from adult day services centers shall be reimbursed as non-medical transportation, and these costs shall not be included as part of the adult day services rate. Nothing in this rule shall be construed to prohibit an ADS center from being certified as a transportation provider as specified in the section on NON-MEDICAL TRANSPORTATION below, and receiving reimbursement for transportation of ADS participants. B. There shall be no reimbursement for ADS provided to any participant who is a resident of any residential care facility, except for services as defined at Section 8.491.14.H. C. There shall be no reimbursement for overnight services in an ADS.
Targeted Population	Adults 18-64 with physical disabilities and seniors 65+ with functional deficits who meet nursing facility level of care
Waiver Manager Comment	In general, this is a good service that is working well. There is basic day program and specialized day program. There may be access issues for certain areas or regions, as there are not day programs with specialized services available everywhere. ACF clients are supposed to receive day programming at their ACF facility, unless they have specialized day programming needs and attend a specialized day program.

Waiver	HCBS-Persons Living with Aids (ADULT DAY)
Waiver Service Definition	Same as EBD Waiver
Service Limitations	Same as EBD Waiver
Rule	Same as EBD Waiver: 10 CCR 2505-10 Section 8.491
Targeted Population	Persons of any age with a diagnosis of HIV/AIDs who meet nursing facility or hospital level of care.
Waiver Manager Comment	Same as EBD.

Waiver	HCBS- Community Mental Health Supports Waiver (ADULT DAY)
Waiver Service Definition	Same as EBD Waiver
Service Limitations	Same as EBD Waiver
Rule	Same as EBD Waiver: 10 CCR 2505-10 Section 8.491
Targeted Population	Persons 18 years and older with a diagnosis of a major mental illness and who meet nursing facility level of care.
Waiver Manager Comment	CMHS had 69 clients utilize this service out of 2,803 about 2.5%. There is basic day program and specialized day program. There may be access issues for certain areas or regions, as there are not day programs with specialized services available everywhere. ACF clients are supposed to receive day programming at their ACF facility, unless they have specialized day programming needs and attend a specialized day program.

Waiver	HCBS- for Persons with Brain Injury Waiver (ADULT DAY)
Waiver Service Definition	Services furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to assure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a "full

	nutritional regimen" (3 meals per day). Physical, occupational and speech therapies indicated in the individual's plan of care would be furnished as component parts of this service if such services are not being provided in the participant's home.
Service Limitations	Adult Day Health services offered in this waiver are limited based on the client's assessed need for services, physician's orders and prior authorization by case managers up to the cost containment parameters.
Rule	**10 CCR 2505-10 Section 8.515.70** (New Rule References Prior Authorization but included old rule for clarification) A. DEFINITIONS 1. Adult Day Services means both health and social services furnished on a regularly scheduled basis in an adult day services center two or more hours per day, one or more days per week to ensure the optimal functioning of the client Services are directed towards recreation and socialization as well as maintaining a safe and supportive environment. 2. Adult Day Services Center means a non-institutional entity that conforms to requirements for maintenance 3. Maintenance Model means services in health monitoring and individual and group therapeutic and psychological activities which serve as an alternative to long-term nursing home care. 4. Adult day services include: a. Daily monitoring to assure that clients are maintaining personal hygiene and participating in age appropriate social activities as prescribed; and assisting with activities prescribed; and assisting with activities of daily living (e.g., eating, dressing). b. Emergency services including whiten procedures to meet medical crises. c. Assistance in the development of self-care capabilities personal hygiene, and social support services. d. Provision of nutritional needs appropriate to the hours in which the client is served. e. Nursing services as necessary to supervise medication regimen of trained medication aides and carry out any of the services listed as SKILLED CARE in SECTION 8.489.30. f. Social and recreational services as prescribed to meet the client's needs. g. Any additional services if such services are included in the budget submitted to the Department in accordance with the section on REIMBURSEMENT METHOD FOR ADULT DAY CARE below, and determined by the Department to be necessary for adult day care. B. CERTIFICATION STANDARDS All adult day service centers shall conform to all of the following Departmental standards 1. All providers must conform to all established departmental standards in the general certification standards section. 2. All providers of adult service care shall operate in full compliance with all applicable federal, state and local fire, health, safety, sanitation and other standards prescribed in law or regulation. 3. The agency shall provide a clean environment, free of obstacle; that could pose a hazard to client health and safety. 4. Agencies shall provide lockers or a safe place for clients' personal items.

	5. Adult day service centers shall provide recreational areas and activities appropriate to the number and needs of the recipients. 6. Drinking facilities shall be located within easy access to residents. 7. Adult day service centers shall provide eating and resting areas consistent with the number and needs of the clients being served. 8. Adult day service centers shall provide easily accessible toilet facilities, hand washing facilities and paper towel dispensers. 9. The center shall be accessible to clients with supportive devices for ambulation or who an in wheelchairs. C. RECORDS AND INFORMATION Adult day service providers shall keep such records and information necessary to document the services provided to clients receiving adult day services. Medical Information Records shall include but not be limited to: 1. Medications the client is taking and whether they are being self-administered. 2. Special dietary needs, if any. 3. Restrictions on activities identified by physician in the case plan. D. STAFFING All adult day service centers shall have staff who have been trained in current cardiopulmonary resuscitation, seizure prophylaxis and control and brain injury. Adequate staff shall be on the premises at all times to ensure: 1. Supervision of clients at all times during the operating hours of the program. 2. Immediate response to emergency situations to assure the welfare of clients. 3. Provision of prescribed recreational and social activities. 4. Provision of administrative, recreational, social and supportive functions of the adult day services center. E. POLICIES The center shall have a written policy relevant to the operation of the adult day services center. Such policy shall include but not be limited to statements describing: 1. Admission criteria that qualify clients to be appropriately served in the center. 2. Interview procedures conducted for qualified clients and/or family members prior to admission to the center. 3. The meals and nourishments that will be provided, including special diets. 4. The hours that the clients will be served in the center and days of the week services will be available. 5. The personal items participants may bring with them to the center. 6. A written signed contract to be drawn up between the client or responsible party and the center outlining rules and responsibilities of the center and of the client Each parry of the contract will have a copy.

	7. A statement of the center's policy for providing drop in care or day respite. F. REIMBURSEMENT METHOD FOR ADULT DAY SERVICES 1. Reimbursement for adult day services shall be based upon a single a single all-inclusive payment rate per unit of service for each participating provider. 2. Each provider will be paid on a per diem statewide uniform rate. The rate of payment shall be subject to available appropriations and may be the lower of the billed amount or the Medicaid allowable rate which is determined by multiplying the number of units times a rate established by the Department
Targeted Population	Persons 16 years of age and older with a brain injury sustained before the age of 65 who meet the hospital, nursing facility or ICF/ID level of care.
Waiver Manager Comment	Stakeholder community has requested a "restrictive" or locked facility option.

Waiver	**HCBS-for Persons with Spinal Cord Injury (ADULT DAY)**
Waiver Service Definition	Same as EBD Waiver
Service Limitations	Same as EBD Waiver
Rule	Same as EBD Waiver: 10 CCR 2505-10 Section 8.491
Targeted Population	Persons 18 years or older who have a diagnosis of a spinal cord injury and who meet the nursing facility level of care.
Waiver Manager Comment	This waiver has just been implemented and there isn't adequate data to assess whether this service is utilized for this target population.

HABILITATION SERVICES

Waiver	HCBS- Children's Habilitation Residential Program Waiver
Waiver Service Definition	Habilitation services are provided to clients that require additional care for the client to remain safely in a home-like setting. The client must demonstrate the need for such services above and beyond those of a typical child of the same age in custody of child welfare. These services are designed to assist participants in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings. Habilitation services under the waiver differ in scope, nature, supervision arrangements, and/or provider type (including provider training and qualifications) from any other services in the State plan. Habilitation services are provided to individuals placed in out-of-home care through their respective County Department of Human/Social Services. Out-of-home care is provided in community settings such as foster homes, group homes, group centers, and residential child care facilities. The Service Plan must document an identified need demonstrating that the client needs are above and beyond what would normally be provided in a foster care setting of a child of the same age without disability. Habilitation services include twenty-four hour habilitation services including Personal Assistance, Self-Advocacy, Cognitive Services, Communication Services, Emergency Assistance, Community Connections, Travel Services, Supervision, and Behavioral Line Staff Services. Specialized Habilitative Group Centers shall provide safe, cost effective services in a home-like setting to the children demonstrating the highest level of need in the CHRP waiver. Highest level of need is demonstrated through the following characteristics: a. Determined to have a developmental disability b. Dually diagnosed with a Medicaid covered mental illness and receiving treatment for that diagnosis c. Exhausted all other possible child welfare placements Personal Assistance means a range of assistance to enable waiver participants to accomplish tasks for themselves. This assistance may take the form of hands-on assistance (actually performing the task for the person) or cueing to prompt the participant to perform a task. Personal Assistance services may be provided on an episodic or on a continuing basis and may include performance and/or guidance of assisted daily living skills such as toileting, bathing, dressing, transferring, and mobility. Personal Assistance also includes performance and/or guidance in the instrumental activities of daily living skills to include hygiene, medication management, transportation, money management, shopping, meal preparation, laundry, accessing resources (e.g. using the telephone, making appointments), and housework. Self-Advocacy Training and support includes assistance and teaching of appropriate and effective ways to make individual choices, accessing needed

	services, asking for help, recognizing abuse, neglect, mistreatment, and/or exploitation of self, responsibility for one's own actions, and participation in all meetings. Cognitive Services means working with the waiver participant to better understand and comprehend cause and effect and the correlation between behaviors and consequences. It may also take the form of repetitive directions, staying on task, levels of receptive language capabilities, and retention of information. Communication Services means assistance with additional concepts and materials to enhance communication. Emergency Assistance means safety planning, fire and disaster drills, and crisis intervention. Community connections support the abilities and skills necessary to enable the individual to access typical activities and functions of community life such as those chosen by the general population, including community education or training, and volunteer activities. Community Connections includes providing a wide variety of opportunities to develop socially appropriate behaviors, facilitate and build relationships and natural supports in the community while utilizing the community as a learning environment to provide services and supports as identified in the participant's service plan. These activities are conducted in a variety of settings in which participants interact with non-disabled individuals (other than those individuals who are providing services to the participant). These types of services may include socialization, adaptive skills, and personnel to accompany and support the individual in community settings, resources necessary for participation in activities and supplies related to skill acquisition, retention, or improvement. Travel Services means transportation to access waiver services. Supervision means the level of supervision necessary to keep the waiver participant safe in the home and in the community. Levels of supervision would include line-of-sight, one-on-one, room-to-room, and within sight distance (yard). Behavioral needs would include, but not limited to, the waiver participants physical and verbal aggressiveness, sexual inappropriateness, victimization, property destruction, self-harm, suicidal, stealing. Medically fragile waiver participants could require, in addition to the behavioral needs, monitoring of medical equipment, feeding tubes, seizures, and other life threatening medical issues if not being provided by the state plan. Behavioral Line Staff are qualified personnel who implement the behavioral plan and training for commonly used behavioral supports as developed and monitored by the Senior Therapist for a designated period of time. Children who are placed in a specialized habilitative group center shall have no duplication of these services through other waiver services including Behavioral Services, Respite, and Supported Community Connections. However, they may choose to access professional and case management services according to the need identified in the service plan.
Service Limitations	NA
Rule	**10 CCR 2505-10 Section 8.508.100** A. Self-advocacy training may include training in expressing personal preferences, self-representation, individual rights and making increasingly responsible choices. It may also include team building with volunteers, professionals, and/or family members to examine changing roles as service models

	shift from the traditional supervision/control model to a self-actualization model. B. Independent living training may include training in personal care, household services, child and infant care (for parents themselves who are developmentally disabled), and communication skills such as using the telephone, using sign language, facilitated communication, reading, and letter writing. C. Cognitive services may include training with money management and personal finances, planning and decision-making. D. Communication services may include professional training and assistance to maintain or improve communication skills. It may include a professional or individual who provides interpretation and facilitated communication services. F. Personal care services may include any personal care functions requiring training/assistance by an RN, LPN, or Certified Nurse Aide. It may also include operating, maintaining, and training in the use of medical equipment. G. Emergency assistance training includes developing responses in case of emergencies, prevention planning and training in the use of equipment or technologies used to access emergency response systems. H. Community connection services may explore community services available to the individual, and develop methods to access additional services/supports/activities desired by the individual. Community connection services can provide the individual with the resources to participate in the activities and functions of the community desired and chosen by the individual receiving the services. Typically, these will be the same type of activities available and desired by the general population. I. Travel services may include providing, arranging, transporting, or accompanying a person with developmental disabilities to services and supports identified in the IP. J. Supervision services may include a person safeguarding an individual with developmental disabilities and/or utilizing technology for the same purpose. L. Payments for residential habilitation are not made for room and board, the cost of facility maintenance, upkeep, and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of residents, or to meet the requirements of the applicable life safety code. M. Only those services not available under Medicaid EPSDT, Medicaid State plan benefits, third party liability coverage, or other state funded programs, services or supports are available through the Children's Habilitation Residential Program (CHRP) Waiver. Appropriate community services must be exhausted before requesting similar services from the waiver. The CHRP Waiver does not reimburse services that are the responsibility of the Colorado Department of Education.
Targeted Population	Children and youth who are developmentally disabled as defined in Section 27-10.5-102(11), C.S.R. Children under age 5 who are developmentally delayed are included only when developmental delay is accompanied by significant medical and/or behavioral needs.

	Children from birth to 21 years of age who are placed through a County Department of Social Services, have a developmental disability and extraordinary service needs, and for whom services cannot be provided at the county negotiated rate.
Waiver Manager Comment	Continue to provide this service.

RESIDENTIAL SERVICES

Waiver	HCBS-for Persons with Developmental Disabilities (RESIDENTIAL)
Waiver Service Definition	Residential Habilitation Services and Supports (RHSS) are designed to ensure the health, safety and welfare of the participant, and to assist in the acquisition, retention and/or improvement in skills necessary to support the participant to live and participate successfully in their community. These services are individually planned and coordinated through the participants Service Plan. The frequency, duration and scope of these services are determined by the participants needs identified in the Service Plan. These services may include a combination of lifelong - or extended duration - supervision, training and/or support (i.e. support is any task performed for the participant, where learning is secondary or incidental to the task itself, or an adaptation is provided) which are essential to daily community living, including assessment and evaluation and the cost of training materials, transportation, fees and supplies. Reimbursement for RHSS does not include the cost of normal facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of participants or to meet the requirements of the applicable life safety code. Under Residential Habilitation Services and Supports the responsibility for the living environment rests with the service agency and encompasses two types of living environments: Individual Residential Services and Supports (IRSS) in which three (3) or fewer participants receiving services may live in a single residential setting or in a host home setting. The living environment does not require state licensure. However, the Division for Developmental Disabilities (DDD) must approve the service agencies to provide such services. Monitoring of IRSS services to individuals is the responsibility of CCB Case Managers and the monitoring of IRSS provider agencies is a DHS/DDD responsibility. Specific requirements for Case Management monitoring of all providers is located at 2 CCR 503-1 16.460. DHS/DDD monitors IRSS providers on an ongoing basis and for the purpose of provider certification, as described in Appendix H of the application. Group Residential Services and Supports (GRSS) encompass group living environments of four (4) to eight (8) participants receiving services who may live in a single residential setting which is licensed by the State as a Residential Care Facility/Residential Community Home. All IRSS and GRSS settings are required to have staff available to meet the needs of the participant as defined in the Service Plan. Residential Habilitation Services and Supports are available to participants who live with and/or are provided services by members of their family, as defined in C.R.S. 27-10.5-102(15)(a) and (b). The cost of room and board is not included in the reimbursement for RHSS. When family members are paid to provide RHSS the following conditions apply: 1) The paid family member shall meet all requirements of a direct care staff member and be employed as a direct care staff member of a Program Approved Service Agency; 2) All of the participant's needs identified in the Service Plan to be met by RHSS shall be met either by the paid family member, other paid direct care or management staff of the service provider agency, or by other unpaid family members, friends or community members; 3) When RHSS services are provided in the family home it is the family's responsibility to ensure that the residence meets Housing and Urban Development standards and 4) When a family member is to be paid for providing services and supports the Service Plan must document that the IDT has determined that provision of services by a paid family member is in the best interest of the participant and the reasons for that determination.

	The following activities are preformed by RHSS staff and are designed to assist participants to reside as independently as possible in the community. 1. Self-advocacy training may include training to assist in expressing personal preferences, self-representation, self-protection from and reporting of abuse, neglect and exploitation, individual rights and to make increasingly responsible choices. 2. Independent living training may include personal care, household services, infant and childcare (for parents who have a developmental disability), and communication skills such as using the telephone. 3. Cognitive services may include training involving money management and personal finances, planning and decision making. 4. Implementation of recommended follow-up counseling, behavioral or other therapeutic interventions by residential staff, under the direction of a professional. Services are aimed at increasing the overall effective functioning of the participant. 5. Medical and health care services that are integral to meeting the daily needs of participants (e.g., routine administration of medications or tending to the needs of participants who are ill or require attention to their medical needs on an ongoing basis). 6. Emergency assistance training includes developing responses in case of emergencies; prevention planning and training in the use of equipment or technologies used to access emergency response systems. 7. Community access services that explore community services available to all people, natural supports available to the participant, and develop methods to access additional services/supports/activities needed by the participant. 8. Travel services may include providing, arranging, transporting, or accompanying the participant to services and supports identified in the Service Plan. 9. Supervision services which ensure the health and welfare of the participant and/or utilizing technology for the same purpose. All direct case staff not otherwise licensed to administer medications must complete a training class approved by the Colorado Department of Public Health and Environment, pass a written test and a practical/competency test. The CCB is expected to review the list of qualified provider service agencies in its designated service area to verify that each agency has maintained a current program approval certification issued by the DDD, and a current license from the Colorado Department of Public Health and Environment if licensed as a community group home for the developmental disabled. The DDD and CCBs provide ongoing monitoring of all residential habilitation providers and the DDD is responsible for monitoring all individual and group residential service providers for certification purposes every two-years. The Colorado Department of Public Health and Environment is responsible to monitor each individually licensed group home every two years offset from the DDD on-site surveys. There are no differences with these processes if the provider or group home is operated by the CCB or by some other agency.
Service Limitations	Department of Public Health and Environment if licensed as a community group home for the developmental disabled. The DDD and CCBs provide ongoing monitoring of all residential habilitation providers and the DDD is responsible for monitoring all individual and group residential service providers for certification purposes every two-years. The Colorado Department of Public Health and Environment is responsible to monitor each individually licensed group home every two years offset from the DDD on-site surveys. There are no differences with these processes if the provider or group home is operated by the CCB or by some other agency.
Rule	**10 CCR 2505-10 Section 8.500.5.A(5)** Residential Habilitation Services and Supports (RHSS) are delivered to ensure the health and safety of the client and to assist in the acquisition, retention or improvement in skills necessary to support the client to live and participate successfully in the community. a. Services may include a combination of lifelong, or extended duration supervision, training or support that is essential to daily community living, including assessment and evaluation, and includes training materials, transportation, fees and supplies. b. The living environment encompasses two (2) types that include individual Residential Services and Supports (IRSS) and Group Residential Services and Supports (GRSS). c. All RHSS environments shall provide sufficient staff to meet the needs of the client as defined in the service plan. d. The following RHSS activities assist clients to reside as independently as possible in the community: i) Self-advocacy training, which may include training to assist in expressing personal preferences, increasing self-representation, increasing self-protection

	from and reporting of abuse, neglect and exploitation, advocating for individual rights and making increasingly responsible choices, ii) Independent living training, which may include personal care, household services, infant and childcare when the client has a child, and communication skills, iii) Cognitive services, which may include training in money management and personal finances, planning and decision making, iv) Implementation of recommended follow-up counseling, behavioral, or other therapeutic interventions. Implementation of physical, occupational or speech therapies delivered under the direction of a licensed or certified professional in that discipline. v) Medical and health care services that are integral to meeting the daily needs of the client and include such tasks as routine administration of medications or tending to the needs of clients who are ill or require attention to their medical needs on an ongoing basis, vi) Emergency assistance training including developing responses in case of emergencies and prevention planning and training in the use of equipment or technologies used to access emergency response systems, vii) Community access services that explore community services available to all people, natural supports available to the client and develop methods to access additional services, supports, or activities needed by the client, viii) Travel services, which may include providing, arranging, transporting or accompanying the client to services and supports identified in the service plan, and ix) Supervision services which ensure the health and safety of the client or utilize technology for the same purpose. e. All direct care staff not otherwise licensed to administer medications must complete a training class approved by the Colorado Department of Public Health and Environment and successfully complete a written test and a practical and competency test. f. Reimbursement for RHSS does not include the cost of normal facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of clients or to meet the requirements of the applicable life safety code.
Targeted Population	Participants with developmental disabilities age 18 and older who meet the ICF/IID and require 24/7 access to supervision
Waiver Manager Comment	Keep as is

DAY HABILITATION

Waiver	HCBS- for Persons with Brain Injury Waiver (DAY TREATMENT)
Waiver Service Definition	Day Treatment is structured, nonresidential therapeutic treatment directed towards individuals who have a prognosis for continued functional improvement. Services are delivered according to a treatment plan coordinated by a comprehensive interdisciplinary team including the client and other appropriate collaterals to provide for consolidation of services in one location. Services include, but are not limited to: occupational therapy, physical therapy, speech therapy, nursing, recreational therapy, and neuropsychology. Additional services include other rehabilitative services such as sensory motor skill development, social skills training, behavioral programming and other supports that allow for reintegration into the community.
Service Limitations	Day Treatment is available only to clients determined eligible for hospital level of care by the SEP agency. Day Treatment is not available to individuals who require specialized nursing facility level of care and have maximized their rehabilitative potential.
Rule	**10 CCR 2505-10 Section 8.515.80** (New rule references Waiting List but included old rule for clarification) A. DEFINITION Day Treatment means intensive therapeutic services scheduled on a regular basis for two or more hours per day, one or more days per week directed at the ongoing development of community living skills. Services take place in a non-residential setting separate from the home in which the recipient lives. B. PROGRAM COMPONENTS, POLICIES AND PROCEDURES 1. Treatment plans are coordinated by a comprehensive interdisciplinary team which includes the recipient and his/her family and provides for consolidation of services in one location. 2. Professional services including occupational therapy, physical therapy, speech therapy, vocational counseling, nursing, social work, recreational therapy, case management, and neuropsychology should be directly available from the provider or available as contracted services when deemed medically necessary by the treatment plan. 3. Certified occupational therapy aides, physical therapy aides, and communication aides may be used in lieu of direct therapy with fully licensed therapists to the extent allowed in existing state statue. 4. The provider shall network with all allied medical professionals and other community based resource providers. 5. Services include social skills training, sensory motor development, reduction/elimination of maladaptive behavior and services aimed at preparing the individual for community reintegration (reaching concepts such as compliance, attending, task completion, problem solving, safety, money management). 6. Crisis situations with family, client or staff shall be addressed through counseling and referral to appropriate professionals.

	7. Behavioral programs shall contain specific guidelines on treatment parameters and methods. 8. There shall be regular contact and meetings with the clients and their families to discuss treatment plan progress and revision. 9. Discharge planning will include the development of a plan which considers safety, environmental modification to support individual function, education of the family and caregiver, recommendations for the future, and referral to additional community resources. 10. Each entity must have a process, verified in writing, by which a client is made aware of the process for filing a grievance. 11. Complaints by the client or family are handled within a 24 hour period from the time of complaint by at least telephone contact. 12. Transportation between therapeutic tasks in the community shall be included in the per diem cost of day treatment. 13. There shall be an inform and consent mechanism by which the client, family medical proxy or substitute decision maker is made aware of the inherent risks associated with community based rehabilitation programs. Examples of such risks might include a greater likelihood of falling accidents, traffic hazards and access to drugs or alcohol. C. HUMAN RIGHTS Every person receiving HCBS-BI services has the following rights: 1. Every person shall mutually develop and sign their treatment plan. 2. Every person has the right to enjoy freedom of thought, conscience, and religion. 3. Every person has the right to live in a clean, safe environment. 4. Every person has the right to have his or her opinions heard and be included, to the greatest extent possible when any decisions are being made affecting his her life. 5. Every person has the right to be free from physical abuse and inhumane treatment. 6. Every person has the right to be protected from all forms of sexual exploitation. 7. Every person has the right to access necessary medical care which is adequate and appropriate to their condition. 8. Every person has the right to communicate with significant others. 9. Every person has the right to reasonable enjoyment of privacy in personal conversations. 10. Every person has the right to have access to telephones, both to make and receive calls in privacy. 11. Every person has the right to have frequent and convenient opportunities to meet with visitors. 12. Every person has the right to the same consideration and treatment as anyone else regardless of face, color, national origin, religion, age, sex, political affiliation, sexual orientation, financial status, or disability. 13. Every person who acts as his own legal guardian has the right to accept treatment of his/her own free will. 14. Nothing in this pan shall be construed to prohibit necessary assistance as appropriate, to those individuals who may require such assistance to exercise their rights. 15. Every person has the right to be free of physical restraint unless physical intervention is necessary to prevent such body movement that is likely to

	result in imminent injury to self or others, and only if alternative techniques have failed. Mechanical restraints are not allowed. D. DOCUMENTATION 1. Intake information shall include a complete neuropsychological assessment and all pertinent medical documentation from inpatient and outpatient therapy and social history to identify key treatment components and communicate the functional implications of treatment goals. 2. Initial treatment plan development and evaluations will occur within a two week period following admission. 3. Treatment plan goals and objectives shall reference specific outcomes in the degree of personal and living independence, work productivity, and psychological and social adjustment, quality of life and degree of community participation. 4. Specific treatment modalities outlined in the treatment plan shall be systematically implemented with techniques that are consistent, functionally based, and active throughout the day. Treatment methods will be appropriate to the goals and treatment plans will be reviewed and modified as appropriate. 5. Progress notes will be kept to support specific treatment modalities rendered by date and signed by the therapist providing the service. E. CERTIFICATION STANDARDS 1. Directors of day treatment programs shall have professional licensure in a health related program in combination with at least 2 years of experience in head trauma rehabilitation programming. 2. All providers shall operate in full compliance with all applicable federal, state and local fire, health, safety, sanitation and other standards prescribed in law or regulation. 3. The agency shall provide a clean environment, free of obstacles that could pose a hazard to client health and safety. 4. Agencies shall provide lockers or a safe place for clients' personal items. 5. Day treatment centers shall provide age appropriate activities and provide eating and resting areas consistent with the number and needs of the clients being served. 6. The center shall be accessible according to guidelines established by the Americans with Disabilities Act. 7. Personnel shall have training appropriate to the medical needs of the clients served including seizure management training, CPR certification, non-violent crisis intervention, and personal care standards according to SECTION-PERSONAL CARE 8.489.40. F. REIMBURSEMENT Day treatment services will be paid on a per diem basis at a rate to be determined by the Department In order for a provider to be paid for a day of treatment, a client must have attended and received therapeutic intervention which is substantiated by case file notes signed by the rendering therapist
Targeted Population	Persons 16 years of age and older with a brain injury sustained before the age of 65 who meet the hospital, nursing facility or ICF/ID level of care.
Waiver Manager Comment	Prognosis for function improvement requirement should be reviewed for continued appropriateness

Waiver	HCBS-for Persons with Developmental Disabilities (DAY HABILITATION)
Waiver Service Definition	Day Habilitation includes assistance with acquisition, retention or improvement in self-help, socialization and adaptive skills that takes place in a non-residential setting, separate from the participant's private residence or other residential living arrangement, except for the occasion of extreme medical and/or safety needs. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. These services are individually coordinated through the person's Service Plan. Day Habilitation Services and Supports encompass two types of habilitative environments: Specialized Habilitation (SH) and Supported Community Connections (SCC). Specialized Habilitation (SH) services focus on enabling the individual to attain his or her maximum functional level or to be supported in such a manner to allow the person to gain an increased level of self-sufficiency. These services are generally provided in non-integrated settings where a majority of the persons have a disability, such as program sites. Such services include assistance with self-feeding, toileting, self-care, sensory stimulation and integration, self-sufficiency, maintenance skills, and supervision. Specialized habilitation services may serve to reinforce skills or lessons taught in school, therapy or other settings and, where appropriate, are coordinated with any physical, occupational, or speech therapies listed in the Service Plan. Day habilitation does not include sheltered workshop activities. Supported Community Connection (SCC) supports the abilities and skills necessary to enable the individual to access typical activities and functions of community life such as those chosen by the general population, including community education or training, retirement and volunteer activities. Supported Community Connection provides a wide variety of opportunities to facilitate and build relationships and natural supports in the community, while utilizing the community as a learning environment to provide services and supports as identified in a person's Service Plan. These activities are conducted in a variety of settings in which participants interact with non-disabled individuals (other than those individuals who are providing services to the participant). These types of services may include socialization, adaptive skills and personnel to accompany and support the individual in community settings, resources necessary for participation in activities and supplies related to skill acquisition, retention or improvement. Supported Community Connections may be provided in a group setting (or groups traveling together into the community) and/or may be provided on a one-to-one basis as a learning environment to provide instruction when identified in the Service Plan.
Service Limitations	The number of units available for Day Habilitation in combination with Prevocational Services is 4800 units. When used in combination with Supported Employment Services, the total number of units available for Day Habilitation Services in combination with Prevocational Services will remain at 4800 units and the cumulative total, including Supported Employment Services, may not exceed 7112 units. In the event the Day Habilitation Services and Supports (DHSS) and Prevocational Services limit of 4800 units per Service Plan year is insufficient to meet a participant's needs, the safety net of Residential Habilitation Services and Supports (RHSS) is available to participant's 24-hours a day, seven days a week.
Rule	**10 CCR 2505-10 SECTION 8.500.5.A(2) Day Habilitation Services** Day Habilitation Services and Supports include assistance with the acquisition, retention or improvement of self-help, socialization and adaptive skills that take place in a non-residential setting, separate from the client's private residence or other residential living arrangement, except when services are necessary in the residence due to medical or safety needs. a. Day habilitation activities and environments shall foster the acquisition of skills, appropriate behavior, greater independence and personal choice. b. Day Habilitation Services and Supports encompass three (3) types of habilitative environments: specialized habilitation services, supported community connections, and prevocational services. c. Specialized Habilitation (SH) services are provided to enable the client to attain the maximum functioning level or to be supported in such a manner

	that allows the client to gain an increased level of self-sufficiency. Specialized habilitation services: i) Are provided in a non-integrated setting where a majority of the clients have a disability, ii) Include assistance with self-feeding, toileting, self-care, sensory stimulation and integration, self-sufficiency and maintenance skills, and iii) May reinforce skills or lessons taught in school, therapy or other settings and are coordinated with any physical, occupational or speech therapies listed in the service plan. d. Supported Community Connections Services are provided to support the abilities and skills necessary to enable the client to access typical activities and functions of community life, such as those chosen by the general population, including community education or training, retirement and volunteer activities. Supported community connections services: i) Provide a wide variety of opportunities to facilitate and build relationships and natural supports in the community while utilizing the community as a learning environment to provide services and supports as identified in a client's service plan, ii) Are conducted in a variety of settings in which the client interacts with persons without disabilities other than those individuals who are providing services to the client. These types of services may include socialization, adaptive skills and personnel to accompany and support the client in community settings, iii) Provide resources necessary for participation in activities and supplies related to skill acquisition, retention or improvement and are provided by the service agency as part of the established reimbursement rate, and iv) May be provided in a group setting or may be provided to a single client in a learning environment to provide instruction when identified in the service plan. v) Activities provided exclusively for recreational purposes are not a benefit and shall not be reimbursed. e. Prevocational Services are provided to prepare a client for paid community employment. Services consist of teaching concepts including attendance, task completion, problem solving and safety, and are associated with performing compensated work. i) Prevocational Services are directed to habilitative rather than explicit employment objectives and are provided in a variety of locations separate from the participant's private residence or other residential living arrangement. ii) Goals for Prevocational Services are to increase general employment skills and are not primarily directed at teaching job specific skills. iii) Clients shall be compensated for work in accordance with applicable federal laws and regulations and at less than fifty (50) percent of the minimum wage. Providers that pay less than minimum wage shall ensure compliance with the Department of Labor Regulations. iv) Prevocational Services are provided to support the client to obtain paid community employment within five (5) years. Prevocational services may continue longer than five (5) years when documentation in the annual service plan demonstrates this need based on an annual assessment. v) A comprehensive assessment and review for each person receiving Prevocational Services shall occur at least once every five (5) years to determine whether or not the person has developed the skills necessary for paid community employment. vi) Documentation shall be maintained in the file of each client receiving this service that the service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (IDEA) (20 U.S.C. § 1401 et seq.). f. The number of units available for day habilitation services in combination with prevocational services is four thousand eight hundred (4,800). When used in combination with supported employment services, the total number of units available for day habilitation services in combination with

	prevocational services will remain at four thousand eight hundred (4,800) units and g. The cumulative total, including supported employment services, may not exceed seven thousand one hundred and twelve (7,112) units. One unit equals fifteen (15) minutes of service.
Targeted Population	Participants with developmental disabilities 18 and older who meet the ICF/IID Level of Care and who require access to 24/7 supervision
Waiver Manager Comment	Keep Specialized Habilitation and Prevocational Services as is, and consider revising the SCC service to be more meaningful for clients. Compare the service definitions of SCC with Respite to determine the best service to meet clients needs and possibly change the services altogether.

Waiver	**HCBS- Supported Living Services Waiver (DAY HABILITATION)**
Waiver Service Definition	Day Habilitation includes assistance with acquisition, retention or improvement in self-help, socialization and adaptive skills that takes place in a non-residential setting, separate from the participant's private residence or other residential living arrangement, except when due to medical and/or safety needs. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. These services are individually coordinated through the person's Service Plan. Day Habilitation Services and Supports encompass two types of habilitative environments: Specialized Habilitation (SH) and Supported Community Connections (SCC) Specialized habilitation (SH) services focus on enabling the participant to attain his or her maximum functional level, or to be supported in such a manner, which allows the person to gain an increased level of self-sufficiency. These services are generally provided in non-integrated settings where a majority of the persons have a disability, such as program sites. Such services include assistance with self-feeding, toileting, self-care, sensory stimulation and integration, self-sufficiency, maintenance skills, and supervision. Specialized habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings and, where appropriate, are coordinated with any physical, occupational, or speech therapies listed in the Service Plan. Supported Community Connection (SCC) supports the abilities and skills necessary to enable the participant to access typical activities and functions of community life such as those chosen by the general population, including community education or training, retirement and volunteer activities. Supported Community Connection provides a wide variety of opportunities to facilitate and build relationships and natural supports in the community, while utilizing the community as a learning environment to provide services and supports as identified in a participant's Service Plan. These activities are conducted in a variety of settings in which participants interact with non-disabled individuals (other than those individuals who are providing services to the participant). These types of services may include socialization, adaptive skills and personnel to accompany and support the participant in community settings, resources necessary for participation in activities and supplies related to skill acquisition, retention or improvement. Supported Community Connections may be provided in a group setting (or groups traveling together into the community) and/or may be provided on a one-to-one basis as a learning environment to provide instruction when identified in the Service Plan.
Service Limitations	The number of units available for Day Habilitation Services in combination with Prevocational Services and Supported Employment Services is 7112 units. The HCBS-SLS waiver is not targeted to participant's requiring care 24 hours a day, seven days a week. In the event the combined 7,112 unit limitation of Day Habilitation Services and Supports, Prevocational Services and Supported Employment is not sufficient to meet a participant's needs, the client will be referred to another waiver program such as the HCBS-DD waiver. This language regarding Prevocational Services has been added to the application.

Rule	**10 CCR 2505-10 Section 8.500.95.A(3) Day Habilitation Services** Day habilitation services and supports include assistance with the acquisition, retention or improvement of self-help, socialization and adaptive skills that take place in a non-residential setting, separate from the client's private residence or other residential living arrangement, except when services are necessary in the residence due to medical or safety needs. a. Day habilitation activities and environments shall foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. b. Day habilitation services and supports encompass three (3) types of habilitative environments ; specialized habilitation services, supported community connections, and prevocational services. c. Specialized habilitation (SH) services are provided to enable the client to attain the maximum functional level or to be supported in such a manner that allows the client to gain an increased level of self-sufficiency. Specialized habilitation services: i) Are provided in a non-integrated setting where a majority of the clients have a disability, ii) Include assistance with self-feeding, toileting, self-care, sensory stimulation and integration, self-sufficiency and maintenance skills, and iii) May reinforce skills or lessons taught in school, therapy or other settings and are coordinated with any physical, occupational or speech therapies listed in the service plan. d. Supported community connections services are provided to support the abilities and skills necessary to enable the client to access typical activities and functions of community life, such as those chosen by the general population, including community education or training, retirement and volunteer activities. Supported community connections services: i) Provide a wide variety of opportunities to facilitate and build relationships and natural supports in the community while utilizing the community as a learning environment to provide services and supports as identified in a client's service plan, ii) Are conducted in a variety of settings in which the client interacts with persons without disabilities other than those individuals who are providing services to the client. These types of services may include socialization, adaptive skills and personnel to accompany and support the client in community settings, iii) Provide resources necessary for participation in activities and supplies related to skill acquisition, retention or improvement and are provided by the service agency as part of the established reimbursement rate, and iv) May be provided in a group setting or may be provided to a single client in a learning environment to provide instruction when identified in the service plan. v) Activities provided exclusively for recreational purposes are not a benefit and shall not be reimbursed. e. Prevocational services are provided to prepare a client for paid community employment. Services include teaching concepts including attendance, task completion, problem solving and safety and are associated with performing compensated work. i) Prevocational services are directed to habilitative rather than explicit employment objectives and are provided in a variety of locations separate from the participant's private residence or other residential living arrangement. ii) Goals for prevocational services are to increase general employment skills and are not primarily directed at teaching job specific skills. iii) Clients shall be compensated for work in accordance with applicable federal laws and regulations and at less than 50 percent of the minimum wage.

	Providers that pay less than minimum wage shall ensure compliance with the Department of Labor regulations. iv) Prevocational services are provided to support the client to obtain paid community employment within five years. Prevocational services may continue longer than five years when documentation in the annual service plan demonstrates this need based on an annual assessment. v) A comprehensive assessment and review for each person receiving prevocational services shall occur at least once every five years to determine whether or not the person has developed the skills necessary for paid community employment. vi) Documentation shall be maintained in the file of each client receiving this service that the service is not available under a program funded under section 110 of the rehabilitation act of 1973 or the Individuals with Educational Disabilities Act (20 U.S.C. Section 1401 et seq). f. Day habilitation services are limited to seven thousand one hundred and twelve (7,112) units per service plan year. One (1) unit is equal to fifteen (15) minutes of service. g. The number of units available for day habilitation services in combination with prevocational services and supported employment shall not exceed seven thousand one hundred and twelve (7,112) units.
Targeted Population	Persons 18 and older with a developmental disability who meet ICF/ID level of care
Waiver Manager Comment	Keep Specialized Habilitation and Prevocational and consider revising the SCC service to be more meaningful for clients. Compare the service definitions of SCC with Respite to determine the best service to meet clients needs and possibly change the services altogether.

PREVOCATIONAL SERVICES

Waiver	HCBS-for Persons with Developmental Disabilities (PREVOCATIONAL SERVICES)
Waiver Service Definition	Prevocational Services prepare a participant for paid community employment. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety that are associated with performing compensated work. Services are identified in the participant's Service Plan and are directed to habilitative rather than explicit employment objectives. Services are provided in a variety of locations separate from the participant's private residence or other residential living arrangement. Participants are compensated in accordance with applicable federal laws and regulations. Prevocational services can be differentiated from supported employment services by using the following criteria: 1) Compensation is paid at less than 50 percent of the minimum wage (agencies that pay less than minimum wage shall ensure compliance with department of labor regulations); and, 2) Goals for prevocational services are general in nature and are not primarily directed at teaching job specific skills. The intended outcome of prevocational services is to obtain paid or unpaid community employment within five years. Prevocational services may continue longer than five years when documentation in the annual service plan demonstrates this need and the need is based on an annual assessment. A comprehensive assessment and review for each person enrolled in prevocational services shall occur at least once every five years. The purpose of this assessment and review is to determine whether or not the person has developed the skills necessary for paid or unpaid community employment. Individuals who receive prevocational services may also receive Supported Employment and/or Day Habilitation Services. A participant's Service Plan may include two or more types of day services (i.e. Day Habilitation Services and Supports, Supported Employment or Prevocational Services), however different types of day services may not be billed during the same period of the day. Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C 1401 et seq.).
Service Limitations	The number of units available for Day Habilitation Services in combination with Prevocational Services is 4800 units. When used in combination with Supported Employment Services, the total number of units available for Day Habilitation Services in combination with Prevocational Services will remain at 4800 units and the cumulative total, including Supported Employment Services, may not exceed 7112. In the event the Day Habilitation Services and Supports (DHSS) and Prevocational Services limit of 4800 units per Service Plan year is insufficient to meet a participant's needs, the safety net of Residential Habilitation Services and Supports (RHSS) is available to participants 24-hours a day, seven days a week.
Rule	**10 CCR 2505-10 Section 8.500.5.A(2)e** Prevocational Services are provided to prepare a client for paid community employment. Services consist of teaching concepts including attendance, task completion, problem solving and safety, and are associated with performing compensated work. i) Prevocational Services are directed to habilitative rather than explicit employment objectives and are provided in a variety of locations separate from the

	participant's private residence or other residential living arrangement. ii) Goals for Prevocational Services are to increase general employment skills and are not primarily directed at teaching job specific skills. iii) Clients shall be compensated for work in accordance with applicable federal laws and regulations and at less than fifty (50) percent of the minimum wage. Providers that pay less than minimum wage shall ensure compliance with the Department of Labor Regulations. iv) Prevocational Services are provided to support the client to obtain paid community employment within five (5) years. Prevocational services may continue longer than five (5) years when documentation in the annual service plan demonstrates this need based on an annual assessment. v) A comprehensive assessment and review for each person receiving Prevocational Services shall occur at least once every five (5) years to determine whether or not the person has developed the skills necessary for paid community employment. vi) Documentation shall be maintained in the file of each client receiving this service that the service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (IDEA) (20 U.S.C. § 1401 et seq.). f. The number of units available for day habilitation services in combination with prevocational services is four thousand eight hundred (4,800). When used in combination with supported employment services, the total number of units available for day habilitation services in combination with prevocational services will remain at four thousand eight hundred (4,800) units and g. The cumulative total, including supported employment services, may not exceed seven thousand one hundred and twelve (7,112) units. One unit equals fifteen (15) minutes of service.
Targeted Population	Participants with developmental disabilities who meet the ICF/IID Level of Care and who require 24/7 access to supervision
Waiver Manager Comment	Implemented 12/1/11-keep as is

Waiver	**HCBS- Supported Living Services Waiver (PREVOCATIONAL SERVICES)**
Waiver Service Definition	Prevocational Services prepare a participant for paid community employment. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety that are associated with performing compensated work. Services are identified in the participant's Service Plan and are directed to habilitative rather than explicit employment objectives. Services are provided in a variety of locations separate from the participant's private residence or other residential living arrangement. Participants are compensated in accordance with applicable federal laws and regulations. Prevocational services can be differentiated from supported employment services by using the following criteria: 1) Compensation is paid at less than 50 percent of the minimum wage (agencies that pay less than minimum wage shall ensure compliance with department of labor regulations); and, 2) Goals for prevocational services are general in nature and are not primarily directed at teaching job specific skills. The intended outcome of prevocational services is to obtain paid or unpaid community employment within five years. Prevocational services may continue longer than five years when documentation in the annual service plan demonstrates this need and the need is based on an annual assessment. A comprehensive assessment and review for each person enrolled in prevocational services shall occur at least once every five years. The purpose of this assessment and review is to determine whether or not the person has developed the skills necessary for paid or unpaid community employment. While Prevocational Services may continue longer than five years when appropriate documentation show this need, the intended outcome of the service is

	employment within five years. If at the time of the five year evaluation or any time during those previous five years it is determined the client is not demonstrating progress toward their goal of community employment, the interdisciplinary team shall review other day program options and the Prevocational Services shall be discontinued.
Service Limitations	The number of units available for Prevocational Services in combination with Day Habilitation Services and Supported Employment Services is 7112 units. The HCBS-SLS waiver is not targeted to participant's requiring care 24 hours a day, seven days a week. In the event the combined 7,112 unit limitation of Day Habilitation Services and Supports, Prevocational Services and Supported Employment is not sufficient to meet a participant's needs, the client will be referred to another waiver program such as the HCBS-DD waiver. This language regarding Prevocational Services has been added to the application
Rule	**10 CCR 2505-10 Section 8.500.94.A(3)e** Prevocational Services are provided to prepare a client for paid community employment. Services consist of teaching concepts including attendance, task completion, problem solving and safety, and are associated with performing compensated work. i) Prevocational Services are directed to habilitative rather than explicit employment objectives and are provided in a variety of locations separate from the participant's private residence or other residential living arrangement. ii) Goals for Prevocational Services are to increase general employment skills and are not primarily directed at teaching job specific skills. iii) Clients shall be compensated for work in accordance with applicable federal laws and regulations and at less than fifty (50) percent of the minimum wage. Providers that pay less than minimum wage shall ensure compliance with the Department of Labor Regulations. iv) Prevocational Services are provided to support the client to obtain paid community employment within five (5) years. Prevocational services may continue longer than five (5) years when documentation in the annual service plan demonstrates this need based on an annual assessment. v) A comprehensive assessment and review for each person receiving Prevocational Services shall occur at least once every five (5) years to determine whether or not the person has developed the skills necessary for paid community employment. vi) Documentation shall be maintained in the file of each client receiving this service that the service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (IDEA) (20 U.S.C. § 1401 et seq.). f. The number of units available for day habilitation services in combination with prevocational services is four thousand eight hundred (4,800). When used in combination with supported employment services, the total number of units available for day habilitation services in combination with prevocational services will remain at four thousand eight hundred (4,800) units and g. The cumulative total, including supported employment services, may not exceed seven thousand one hundred and twelve (7,112) units. One unit equals fifteen (15) minutes of service.
Targeted Population	Persons aged 18 and older with developmental disabilities who meet the ICF/ID level of care.
Waiver Manager Comment	Implemented 12/1/11-keep as is

SUPPORTED EMPLOYMENT

Waiver	HCBS-for Persons with Developmental Disabilities
Waiver Service Definition	Supported Employment services consists of intensive, ongoing supports that enable participants, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need supports, to perform in a regular work setting. Supported employment may include assessment and identification of vocational interests and capabilities in preparation for job development, assisting the participant to locate a job or job development on behalf of the participant. Supported employment is conducted in a variety of settings in which participants interact with non-disabled individuals (other than those individuals who are providing services to the participant) to the same extent that individuals employed in comparable positions would interact. Persons must be involved in work outside of a base site. Included are persons in community jobs, in enclaves, and on mobile crews. Group employment (e.g. mobile crews and enclaves) shall not exceed eight persons. Supported employment includes activities needed to sustain paid work by participants, including supervision and training. When supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required by participants receiving waiver services as a result of their disabilities. This does not include payment for the supervisory activities rendered as a normal part of the business setting. Participants are required to apply for services through the Division for Vocational Rehabilitation. Supported employment does not take the place of nor is it duplicative of services received through the Division for Vocational Rehabilitation. Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program; payments that are passed through to users of supported employment programs; or payments for training that are not directly related to an individual's supported employment program.
Service Limitations	The number of units available for Supported Employment is 7,112 units. The limits for combined Day Habilitation Services and Supports and Prevocational Services is 4800 and when these services are used in combination with Supported Employment, the cumulative total cannot exceed 7,112 units. This number of units is the equivalent of 1,778 hours of service per year or on average 7 hours a day for 254 service days.
Rule	**10 CCR 2505-10 Section 8.500.5.A(7)** Supported Employment includes intensive, ongoing supports that enable a client, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who because of the client's disabilities needs supports to perform in a regular work setting. a. Supported Employment may include assessment and identification of vocational interests and capabilities in preparation for job development, and assisting the client to locate a job or job development on behalf of the client. b. Supported Employment may be delivered in a variety of settings in which clients interact with individuals without disabilities, other than those

	individuals who are providing services to the client, to the same extent that individuals without disabilities employed in comparable positions would interact. c. Supported Employment is work outside of a facility-based site, which is owned or operated by an agency whose primary focus is service provision to persons with developmental disabilities. d. Supported Employment is provided in community jobs, enclaves or mobile crews. e. Group Employment including mobile crews or enclaves shall not exceed eight (8) clients. f. Supported Employment includes activities needed to sustain paid work by clients including supervision and training. g. When Supported Employment services are provided at a work site where individuals without disabilities are employed, service is available only for the adaptations, supervision and training required by a client as a result of the client's disabilities. h. Documentation of the client's application for services through the Colorado Department of Human Services Division of Vocational Rehabilitation shall be maintained in the file of each client receiving this service. Supported employment is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education CCT (20 U.S.C. § 1401 et seq). i. Supported Employment does not include reimbursement for the supervisory activities rendered as a normal part of the business setting. j. Supported Employment shall not take the place of nor shall it duplicate services received through the Division of Vocational Rehabilitation. k. The limitation for Supported Employment services is seven thousand one hundred and twelve (7,112) units per service plan year. One (1) unit equals fifteen (15) minutes of service. l. The following are not a benefit of Supported Employment and shall not be reimbursed: i) Incentive payments, subsidies or unrelated vocational training expenses, such as incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment, ii) Payments that are distributed to users of supported employment, and iii) Payments for training that are not directly related to a client's supported employment.
Targeted Population	Persons with developmental disabilities age 18 and older who meet the ICF/IID Level of Care and require 24/7 access to supervision
Waiver Manager Comment	Keep as is and consider addition of Career Planning and Discovery Services as discrete component services either in Supported Employment or Prevocational Services

Waiver	**HCBS- Supported Living Services Waiver (SUPPORTED EMPLOYMENT)**
Waiver Service Definition	Supported Employment services consists of intensive, ongoing supports that enable participants, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need supports, to perform in a regular work setting. Supported employment may include assessment and identification of vocational interests and capabilities in preparation for job development, assisting the

	participant to locate a job or job development on behalf of the participant. Supported employment is conducted in a variety of settings in which participants interact with non-disabled individuals (other than those individuals who are providing services to the participant) to the same extent that individuals employed in comparable positions would interact. Persons must be involved in work outside of a base site. Included are persons in community jobs, in enclaves, and on mobile crews. Group employment (e.g. mobile crews and enclaves) shall not exceed eight persons. Supported employment includes activities needed to sustain paid work by participants, including supervision and training. When supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required by participants receiving waiver services as a result of their disabilities. This does not include payment for the supervisory activities rendered as a normal part of the business setting. Participants are required to apply for services through the Division for Vocational Rehabilitation. Supported employment does not take the place of nor is it duplicative of services received through the Division for Vocational Rehabilitation. Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program; payments that are passed through to users of supported employment programs; or payments for training that are not directly related to an individual's supported employment program.
Service Limitations	The number of units available for Supported Employment Services in combination with Day Habilitation Services and Prevocational Services is 7,112 units. This number of units is the equivalent of 1,778 hours of service per year or on average 7 hours a day for 254 service days. The HCBS-SLS waiver is not targeted to participant's requiring care 24 hours a day, seven days a week. In the event the combined 7,112 unit limitation of Day Habilitation Services and Supports, Prevocational Services and Supported Employment is not sufficient to meet a participant's needs, the client will be referred to another waiver program such as the HCBS-DD waiver.
Rule	**10 CCR 2505-10 Section 8.500.94.A(14)** Supported Employment includes intensive, ongoing supports that enable a client, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who because of the client's disabilities needs supports to perform in a regular work setting. a. Supported Employment may include assessment and identification of vocational interests and capabilities in preparation for job development, and assisting the client to locate a job or job development on behalf of the client. b. Supported Employment may be delivered in a variety of settings in which clients interact with individuals without disabilities, other than those individuals who are providing services to the client, to the same extent that individuals without disabilities employed in comparable positions would interact. c. Supported Employment is work outside of a facility-based site, which is owned or operated by an agency whose primary focus is service provision to persons with developmental disabilities. d. Supported Employment is provided in community jobs, enclaves or mobile crews. e. Group Employment including mobile crews or enclaves shall not exceed eight (8) clients. f. Supported Employment includes activities needed to sustain paid work by clients including supervision and training. g. When Supported Employment services are provided at a work site where individuals without disabilities are employed, service is available only for the

	adaptations, supervision and training required by a client as a result of the client's disabilities. h. Documentation of the client's application for services through the Colorado Department of Human Services Division of Vocational Rehabilitation shall be maintained in the file of each client receiving this service. Supported employment is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education CCT (20 U.S.C. § 1401 et seq). i. Supported Employment does not include reimbursement for the supervisory activities rendered as a normal part of the business setting. j. Supported Employment shall not take the place of nor shall it duplicate services received through the Division of Vocational Rehabilitation. k. The limitation for Supported Employment services is seven thousand one hundred and twelve (7,112) units per service plan year. One (1) unit equals fifteen (15) minutes of service. l. The following are not a benefit of Supported Employment and shall not be reimbursed: i) Incentive payments, subsidies or unrelated vocational training expenses, such as incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment, ii) Payments that are distributed to users of supported employment, and iii) Payments for training that are not directly related to a client's supported employment.
Targeted Population	Persons aged 18 and older with a developmental disability who meet ICF/ID level of care
Waiver Manager Comment	Keep as is and consider addition of Career Planning and Discovery Services as discrete component services either in Supported Employment or Prevocational Services

RESPITE

Waiver	**HCBS-Elderly, Blind and Disabled Waiver**
Waiver Service Definition	Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.
Service Limitations	An individual client shall be authorized for no more than 30 days of respite care in each calendar year.
Rule	**10 CCR 2505-10 Section 8.492: RESPITE** 8.492.10 DEFINITIONS .11 Respite care means services provided to an eligible client on a short-term basis because of the absence or need for relief of those persons normally providing the care. .12 Respite care provider means a Class I nursing facility, an alternative care facility or an employee of a certified personal care agency which meets the certification standards for respite care specified below. 8.492.20 INCLUSIONS .21 A nursing facility shall provide all the skilled and maintenance services ordinarily provided by a nursing facility which are required by the individual respite client, as ordered by the physician. .22 An alternative care facility shall provide all the alternative care facility services as listed at Section 8.495, ALTERNATIVE CARE FACILITIES, which are required by the individual respite client. 8.492.30 RESTRICTIONS 1242845 .31 An individual client shall be authorized for no more than thirty (30) days of respite care in each calendar year. .32 Alternative care facilities shall not admit individuals for respite care who are not appropriate for alternative care facility placement, as specified at Section 8.495, ALTERNATIVE CARE FACILITIES. .33 Only those portions of the facility that are Medicaid certified for nursing facility or alternative care facility services may be utilized for respite clients. 8.492.40 CERTIFICATION STANDARDS AND PROCEDURES 41 Respite care standards and procedures for nursing facilities are as follows: A. The nursing facility must have a valid contract with the State as a Medicaid certified nursing facility. Such contract shall constitute automatic certification for respite care. A respite care provider billing number shall automatically be issued to all certified nursing facilities. B. The nursing facility does not have to maintain or hold open separately designated beds for respite clients, but may accept respite clients on a bed

available basis.

C. For each HCBS-EBD respite client, the nursing facility must provide an initial nursing assessment, which will serve as the plan of care, must obtain physician treatment orders and diet orders; and must have a chart for the client. The chart must identify the client as a respite client. If the respite stay is for fourteen (14) days or longer, the MDS must be completed.

D. An admission to a nursing facility under HCBS-EBD respite does not require a new ULTC-100.2, a PASARR review, an AP-5615 form, a physical, a dietitian assessment, a therapy assessment, or labwork as required on an ordinary nursing facility admission. The MDS does not have to be completed if the respite stay is shorter than fourteen (14) days.

E. The nursing facility shall have written policies and procedures available to staff regarding respite care clients. Such policies could include copies of these respite rules, the facility's policy regarding self administration of medication, and any other policies and procedures which may be useful to the staff in handling respite care clients.

F. The nursing facility should obtain a copy of the ULTC-100.2 and the approved Prior Authorization Request (PAR) form from the case manager prior to the respite client's entry into the facility.

.42 Respite care standards and procedures for alternative care facilities are as follows:

A. The alternative care facility shall have a valid contract with the Department as a Medicaid certified HCBS-EBD alternative care facility provider. Such contract shall constitute automatic certification for HCBS-EBD respite care.

B. For each respite care client, the alternative care facility shall follow normal procedures for care planning and documentation of services rendered.

.43 Individual respite care providers shall be employees of certified personal care agencies. Family members providing respite services shall meet the same competency standards as all other providers and be employed by the certified provider agency.

8.492.50 REIMBURSEMENT

.51 Respite care reimbursement to nursing facilities shall be as follows:

A. The nursing facility shall bill using the facility's assigned respite provider number, and on the HCBS-EBD claim form according to fiscal agent instructions.

B. The unit of reimbursement shall be a unit of one day. The day of admission and the day of discharge may both be reimbursed as full days, provided that there was at least one full twenty-four hour day of respite provided by the nursing facility between the date of admission and the date of discharge. There shall be no other payment for partial days.

C. Reimbursement shall be the lower of billed charges or the average weighted rate for administrative and health care for Class I nursing facilities in effect on July 1 of each year.

.52 Respite care reimbursement to alternative care facilities shall be as follows:

A. The alternative care facility shall bill using the alternative care facility provider number, on the HCBS-EBD claim form according to fiscal agent instructions.

B. The unit of reimbursement shall be a unit of one day. The day of admission and the day of discharge may both be reimbursed as full days, provided that there was at least one full twenty-four hour day of respite provided by the alternative care facility between the date of admission and the date of discharge. There shall be no other payment for partial days.

	C. Reimbursement shall be the lower of billed charges; or the maximum Medicaid rate for alternative care services, plus the standard alternative care facility room and board amount prorated for the number of days of respite. .53 Individual respite providers shall bill according to an hourly rate or daily institutional rate, whichever is less. .54 The respite care provider shall provide all the respite care that is needed, and other HCBS-EBD services shall not be reimbursed during the respite stay. .55 Effective 2/1/99, there shall be no reimbursement provided under this section for respite care in uncertified congregate facilities.
Targeted Population	Waiver participants who have primary caregivers (often family) who would benefit from a break in providing care. Adults 18-64 with physical disabilities and seniors 65+ with functional deficits, who meet nursing facility level of care
Waiver Manager Comment	In general, this is a beneficial service and it is underutilized, because of limitations in rule. SEP's and clients report that this is service that is desperately needed, although limitations to this service in rule do not allow for the use of respite in certain circumstances.

Waiver	**HCBS- Community Mental Health Supports Waiver (RESPITE CARE)**
Waiver Service Definition	Services provided to individuals unable to care for themselves, furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.
Service Limitations	An individual client shall be authorized for no more than 30 days of respite care in each calendar year
Rule	Same as EBD Waiver: **10 CCR 2505-10 Section 8.492**
Targeted Population	Persons 18 years and older with a major mental illness who meet nursing facility level of care
Waiver Manager Comment	This service has the potential to be beneficial for clients and families on this waiver but is incredibly underutilized with only 24 clients receiving it, 16 in an ACF and 8 in a nursing home for FY 2011. The main problem with the Respite service for this waiver is that it can only be provided in a nursing facility or an ACF, there is no "in-home" respite benefit. There have been discussions on changing the Respite service to mirror that of EBD so clients who have a major mental illness do not need to leave their home in order for the care giver to receive respite.

Waiver	**HCBS- for Persons with Brain Injury Waiver (RESPITE CARE)**
Waiver Service Definition	Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.
Service Limitations	An individual client shall be authorized for no more than 30 days of respite care in each calendar year.
Rule	Same as EBD Waiver: **10 CCR 2505-10 Section 8.492 (New Rule Change)**
Targeted Population	Persons 16 years of age and older with a brain injury sustained before the age of 65 who meet the hospital, nursing facility or ICF/ID level of care.
Waiver Manager Comment	There are many definitions for respite services; the state may consider revising/consolidating service definitions. The service needs to include both in home and out of home options.

Waiver	**HCBS-for Persons with Spinal Cord Injury (RESPITE CARE)**
Waiver Service Definition	Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care
Service Limitations	An individual client shall be authorized for no more than 30 days of respite care in each certification period. Relatives, other than a spouse, that are related to the individual receiving services by virtue of blood, marriage, adoption, or common law may be employed by a personal care/homemaker or home health agency to provide respite services. Relatives employed by an agency shall meet the same experience and qualification standards required of all agency employees. Relatives shall be employed by an agency and shall not be the same persons normally providing care. There shall be no duplication of this service and the personal care, homemaker, IHSS, and CDASS benefits.
Rule	Same as EBD Waiver **10 CCR 2505-10 Section 8.492**
Targeted Population	Persons 18 years and older with a spinal cord injury who meet nursing facility level of care.
Waiver Manager Comment	This waiver has just been implemented and there isn't adequate data to assess whether this service is utilized for this target population.

Waiver	HCBS- Supported Living Services Waiver (RESPITE CARE)
Waiver Service Definition	Respite services provided on a short-term basis, because of the absence or need for relief to those persons who normally provide care for the participant. Respite may be provided in the participant's home/private place of residence or the private residence of a respite care provider. Federal financial participation is not to available for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence. Respite services shall be billed according to a unit rate or daily rate whichever is less.
Service Limitations	A full day is 10 hours (15 minute units x 4 x 10) or greater within a twenty-four (24) service period.
Rule	**10 CCR 2505-10 Section 8.500.94.A(12): RESPITE CARE** Respite service is provided to clients on a short-term basis, because of the absence or need for relief of the primary caregivers of the client. a. Respite may be provided: i) In the client's home and private place of residence, ii) The private residence of a respite care provider, or iii) In the community. b. Respite shall be provided according to individual or group rates as defined below: i) Individual: the client receives respite in a one-on-one situation. There are no other clients in the setting also receiving respite services. Individual respite occurs for ten (10) hours or less in a twenty four (24)-hour period. ii) Individual Day: the client receives respite in a one-on-one situation for cumulatively more than 10 hours in a 24-hour period. A full day is 10 hours or greater within a 24- hour period. iii) Overnight Group: the client receives respite in a setting which is defined as a facility that offers 24 hour supervision through supervised overnight group accommodations. The total cost of overnight group within a 24-hour period shall not exceed the respite daily rate. iv) Group: the client receives care along with other individuals, who may or may not have a disability. The total cost of group within a 24-hour period shall not exceed the respite daily rate. c. The following limitations to respite services shall apply: i) Federal financial participation shall not be claimed for the cost of room and board except when provided, as part of respite care furnished in a facility approved pursuant to 2 CCR 503-1, Section 16.221. by the state that is not a private residence. ii) Overnight group respite may not substitute for other services provided by the provider such as personal care, behavioral services or services not covered by the HCBS-SLS Waiver. iii) Respite shall be reimbursed according to a unit rate or daily rate whichever is less. The daily overnight group respite rate shall not exceed the respite daily rate.

Targeted Population	Persons aged 18 and older with a developmental disability who meet ICF/ID level of care
Waiver Manager Comment	Respite is needed for clients who cannot be left unsupervised due to their disability. Most of the individual, group and day respite is utilized by working parents. I recommend we keep these categories of respite. Respite service description needs to be revamped to clearly define what respite is, and what it is not. Respite Camp is "Overnight group respite". I recommend respite Camp be removed. HCBS waivers are not intended to mitigate poverty. They are designed to support the individual in his or her (residential) community. Most Camps are out of the client's residential community and do not assist the client to integrate into his or her own community.

Waiver	**HCBS- Children's Habilitation Residential Program Waiver (RESPITE CARE)**
Waiver Service Definition	Respite services are provided to participants residing in a foster home and unable to care for themselves because of the absence or need for relief of those persons who normally provide care for the waiver participant. Respite services shall be provided in a certified foster home or licensed respite care facility outside of the participant's normal foster home. Federal financial participation is not to be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence
Service Limitations	Respite up to 28-30 days per year with at least 24 hours. If under 24 hours it is not considered respite. One day equals one unit.
Rule	Respite Services: Services that are provided to an eligible client on a short term basis because of the absence or need for relief of those persons normally providing the care. Respite services may be approved for up to 30 days a calendar year for each eligible client.
Targeted Population	Children and youth who are developmentally disabled as defined in Section 27-10.5-102(11), C.S.R. Children under age 5 who are developmentally delayed are included only when developmental delay is accompanied by significant medical and/or behavioral needs. Children from birth to 21 years of age, who are placed through a County Department of Social Services, have a developmental disability and extraordinary service needs, and for whom services cannot be provided at the county negotiated rate.
Waiver Manager Comment	Continue to Provide this service

Waiver	**HCBS- Children with Life Limiting Illness Waiver (RESPITE CARE)**
Waiver Service Definition	Respite Care means services provided to an eligible client who is unable to care for himself/herself on a short term basis because of the absence or need for relief of those persons normally providing care. Respite Care under this waiver is preferentially provided in the client's residence and may be provided by different levels of providers depending upon the needs of the client. In extraordinary circumstances, state approval may allow Respite care in an Inpatient Hospice facility. Care providers may be Home and Community Based Personal Care agency non-relative or relative personal care providers, home health agency or hospice agency registered nurses, licensed practical nurses, or certified nurse aides. In those extraordinary circumstances of approved facility based care, the provider must be an Inpatient Hospice located in a Skilled Nursing Facility. Depending upon the client's condition Respite Care provided may be any one of, or a combination of the following depending upon the need of the client: 1. Personal care services means services needed to meet a client's physical requirements and functional needs when such services are provided by a personal care attendant and do not require the supervision of a nurse or physician, such as assistance with activities of daily living. 2. Private Duty Nursing or Continuous nursing means line of sight, face-to-face skilled nursing that is more individualized and continuous, as opposed to visits or intermittent nursing care that is available under the State Plan home health benefit. 3. Home Health Aide services (certified nurse aide) defined in 42 CFR §440.70 that are provided when home health aide services furnished under the approved State plan limits are exhausted. Certified nurse aide services provided as part of a Respite Care plan of care, are furnished for extended periods and do not need to be intermittent or part time in nature, and may be greater than the maximum daily amount allowed under the State Plan. In addition, the aide may be left alone in the residence with a minor. 4. Skilled Nursing services listed in the care plan that are within the scope of the state's Nurse Practice Act are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the state. Services furnished as part of respite care are those that are provided when nursing services furnished under the approved State Plan limits are exhausted. The additional amount of services that may be provided through the waiver is as follows: The part-time or intermittent skilled nursing services may exceed the maximum daily amount as specified in the approved State Plan. 5. Facility based services for Respite Care in extra-ordinary circumstances after state approval based on the child's condition, family need and physician agreement. The Respite care will be limited to the 30 day per year benefit.
Service Limitations	Respite Care may be provided for up to a maximum of 30 days per year. Respite Care services and State Plan nursing, home health aide, or private duty nursing services shall not be duplicated on the same date of service. Claims system edits shall prevent reimbursement for both waiver services and State Plan benefits from occurring on the same date of service, or Palliative/Supportive Care services duplicative of Respite Care services. Respite Care does not diminish services a client is entitled to under Early Periodic Screening, Diagnosis and Treatment however; it will not duplicate those services.
Rule	**10 CCR 2505-10 Section 8.504.2.E: RESPITE CARE** Respite Care shall be provided in the home of an eligible client on a short term basis, not to exceed 30 days per every 365 days based on the date the client entered the program. Respite Care shall not be duplicated on the same date of service as state plan Home Health or Palliative/Supportive Care services. 1. Respite Care services include any of the following in any combination necessary according to the Service Plan. a. Skilled nursing.

	b. Home health aide c. Personal Care d. Private duty nursing
Targeted Population	The waiver is targeted to children who are considered medically fragile through the age of 18. The child must have a diagnosis of a life limiting illness and meet the hospital level care.
Waiver Manager Comment	Working to develop provider capacity for skilled respite, currently this service is poorly utilized.

Waiver	**HCBS-Children's Extensive Support Waiver (RESPITE CARE)**
Waiver Service Definition	Respite service may be provided to eligible participants, on a short-term basis, because of the absence or need for relief of the primary care-givers of the participant. Respite is to be provided in an age appropriate manner. The eligible participant older than 11 years of age may receive Respite during the time the care-giver works because same age typical peers do not need ongoing supervision at that age and the need for the respite is based on the child's disability. Children, 11 years of age and younger, will not receive respite during the time the parent works because this is a typical expense for all working parents. In the event the cost of care during the time the parents work is more for an eligible participant, 11 years of age or younger, than it is for same age typical peers, then Respite may be used to pay the additional cost. Respite may be provided for siblings of eligible participant who reside in the same home and who are 11 years of age or younger in the event supervision is needed so the primary caretaker(s) can take the recipient to a service covered by state plan benefits or the waiver. Sibling care is not allowable for care needed due to parent's work schedule or breaks. Federal financial participation is not available for the cost of room and board except when provided, as part of Respite care furnished in a facility approved by the State that is not a private residence. Respite shall be billed according to a unit rate or daily rate whichever is less.
Service Limitations	The total amount of respite provided in one plan year may not exceed 30 days and 1,880 additional units when the service period is less than a day. A full day is 10 hours (15 minute units x 4 x 10) or greater within a twenty-four (24) service period. DHS/DDD may approve a higher amount based on a documented increase in medical or behavioral needs as reflected in the behavior plan for behavioral needs or in the medical records for medical needs.
Rule	**10 CCR 2505-10 Section 9.503.40.A(10): RESPITE CARE** Respite is provided to clients on a short-term basis, because of the absence or need for relief of the primary caregivers of the client. a. Respite may be provided: i.) In the client's home, private residence, ii.) The private residence of a respite care provider, or iii.) In the community.

	b. Respite is to be provided in an age appropriate manner. i.) The eligible client age twelve (12) or older may receive respite during the time the care-giver works because same age typical peers do not need ongoing supervision at that age and the need for the respite is based on the client's disability. ii.) A client eleven (11) years of age and younger, will not receive respite during the time the parent works, pursues continuing education or volunteers, because this is a typical expense for all parents of young children. c. When the cost of care during the time the parents works is more for an eligible client, eleven (11) years of age or younger, than it is for same age peers, then respite may be used to pay the additional cost. Parents shall be responsible for the basic and typical cost of child care. d. Respite may be provided for siblings, age eleven (11) and younger, who reside in the same home of an eligible client when supervision is needed so the primary caretaker can take the client to receive a state plan benefit or a HCBS-CES waiver service. e. Respite shall be provided according to an individual or group rates as defined below: i) Individual: the client receives respite in a one-on-one situation. There are no other clients in the setting also receiving respite services. Individual respite occurs for ten (10) hours or less in a twenty four (24)-hour period. ii) Individual day: the client receives respite in a one-on-one situation for cumulatively more than ten (10) hours in a twenty four (24)-hour period. A full day is ten (10) hours or greater within a twenty four (24)- hour period. iii) Overnight group: the client receives respite in a setting which is defined as a facility that offers twenty four (24)-hour supervision through supervised overnight group accommodations. The total cost of overnight group within a twenty four (24)-hour period shall not exceed the respite daily rate. iv) Group: the client receives care along with other individuals, who may or may not have a disability. The total cost of group within a twenty four (24)-hour period shall not exceed the respite daily rate. The following limitations to respite service shall apply: 1) Sibling care is not allowed for care needed due to parent's work, volunteer, or education schedule or for parental relief from care of the sibling. f. Federal financial participation shall not to be claimed for the cost of room and board except when provided, as part of respite care furnished in a facility approved pursuant to 2 CCR 503-1 Section 16.221 by the state that is not a private residence. g. The total amount of respite provided in one service plan year may not exceed an amount equal to thirty (30) day units and one thousand eight hundred eighty (1,880) individual units. The Operating Agency may approve a higher amount based on a need due to the client's age, disability or unique family circumstances. h. Overnight group respite may not substitute for other services provided by the provider such as Personal Care, Behavioral Services or services not covered by the HCBS-CES waiver. i. Respite shall be reimbursed according to a unit rate or daily rate whichever is less. The daily overnight or group respite rate shall not exceed the respite daily rate. j. The purpose of respite is to provide the primary caregiver a break from the ongoing daily care of a client. Therefore, additional respite units beyond the service limit will not be approved for clients who receive skilled nursing, certified nurse aid services, or home care allowance from the primary caregiver.
Targeted Population	Clients ages birth up to 18th birthday Must have developmental delay (age 5 and under) or developmental disability

	Have a behavior or medical condition so intense it requires near constant line of sight supervision.
Waiver Manager Comment	High use: FY PD claims unduplicated client count Respite Individual (15 minute units) 317; Day and group 171 and Camp 40 overall waiver unduplicated count 409 Respite is needed for children who cannot be left unsupervised due to their disability. Most of the individual, group and day respite is utilized by working parents of children over the age of 12. I recommend we keep these categories of respite. Respite service description needs to be revamped to clearly define what respite is, and what it is not. CDHS recently lost an appeal where use of Respite to pay for Skiing (denied by CDHS) was overturned by ALJ. Respite Camp is "Overnight group respite". I recommend respite Camp be removed. Attending camp is an activity that children of all abilities engage in. The primary factor that determines if a typically developing child attends summer camp is not his or her disability, but the family's financial status. HCBS waivers are not intended to mitigate poverty. They are designed to support the individual in his or her (residential) community. Most Camps are out of the client's residential community and do not assist the client to integrate into his or her own community.

DAY TREATMENT

Waiver	HCBS- for Persons with Brain Injury Waiver
Waiver Service Definition	Day Treatment is structured, nonresidential therapeutic treatment directed towards individuals who have a prognosis for continued functional improvement. Services are delivered according to a treatment plan coordinated by a comprehensive interdisciplinary team including the client and other appropriate collaterals to provide for consolidation of services in one location. Services include, but are not limited to: occupational therapy, physical therapy, speech therapy, nursing, recreational therapy, and neuropsychology. Additional services include other rehabilitative services such as sensory motor skill development, social skills training, behavioral programming and other supports that allow for reintegration into the community.
Service Limitations	Day Treatment is available only to clients determined eligible for hospital level of care by the SEP agency. Day Treatment is not available to individuals who require specialized nursing facility level of care and have maximized their rehabilitative potential.
Rule	**10 CCR 2505-10 Section 8.515.80** (New rule references Waiting List but included old rule for clarification) A. DEFINITION Day Treatment means intensive therapeutic services scheduled on a regular basis for two or more hours per day, one or more days per week directed at the ongoing development of community living skills. Services take place in a non-residential setting separate from the home in which the recipient lives. B. PROGRAM COMPONENTS, POLICIES AND PROCEDURES 1. Treatment plans are coordinated by a comprehensive interdisciplinary team which includes the recipient and his/her family and provides for consolidation of services in one location. 2. Professional services including occupational therapy, physical therapy, speech therapy, vocational counseling, nursing, social work, recreational therapy, case management, and neuropsychology should be directly available from the provider or available as contracted services when deemed medically necessary by the treatment plan. 3. Certified occupational therapy aides, physical therapy aides, and communication aides may be used in lieu of direct therapy with fully licensed therapists to the extent allowed in existing state statue. 4. The provider shall network with all allied medical professionals and other community based resource providers. 5. Services include social skills training, sensory motor development, reduction/elimination of maladaptive behavior and services aimed at preparing the individual for community reintegration (reaching concepts such as compliance, attending, task completion, problem solving, safety, money management). 6. Crisis situations with family, client or staff shall be addressed through counseling and referral to appropriate professionals. 7. Behavioral programs shall contain specific guidelines on treatment parameters and methods.

	8. There shall be regular contact and meetings with the clients and their families to discuss treatment plan progress and revision. 9. Discharge planning will include the development of a plan which considers safety, environmental modification to support individual function, education of the family and caregiver, recommendations for the future, and referral to additional community resources. 10. Each entity must have a process, verified in writing, by which a client is made aware of the process for filing a grievance. 11. Complaints by the client or family are handled within a 24 hour period from the time of complaint by at least telephone contact. 12. Transportation between therapeutic tasks in the community shall be included in the per diem cost of day treatment. 13. There shall be an inform and consent mechanism by which the client, family medical proxy or substitute decision maker is made aware of the inherent risks associated with community based rehabilitation programs. Examples of such risks might include a greater likelihood of falling accidents, traffic hazards and access to drugs or alcohol. C. HUMAN RIGHTS Every person receiving HCBS-BI services has the following rights: 1. Every person shall mutually develop and sign their treatment plan. 2. Every person has the right to enjoy freedom of thought, conscience, and religion. 3. Every person has the right to live in a clean, safe environment. 4. Every person has the right to have his or her opinions heard and be included, to the greatest extent possible when any decisions are being made affecting his her life. 5. Every person has the right to be free from physical abuse and inhumane treatment. 6. Every person has the right to be protected from all forms of sexual exploitation. 7. Every person has the right to access necessary medical care which is adequate and appropriate to their condition. 8. Every person has the right to communicate with significant others. 9. Every person has the right to reasonable enjoyment of privacy in personal conversations. 10. Every person has the right to have access to telephones, both to make and receive calls in privacy. 11. Every person has the right to have frequent and convenient opportunities to meet with visitors. 12. Every person has the right to the same consideration and treatment as anyone else regardless of face, color, national origin, religion, age, sex, political affiliation, sexual orientation, financial status, or disability. 13. Every person who acts as his own legal guardian has the right to accept treatment of his/her own free will. 14. Nothing in this pan shall be construed to prohibit necessary assistance as appropriate, to those individuals who may require such assistance to exercise their rights. 15. Every person has the right to be free of physical restraint unless physical intervention is necessary to prevent such body movement that is likely to result in imminent injury to self or others, and only if alternative techniques have failed. Mechanical restraints are not allowed.

	D. DOCUMENTATION 1. Intake information shall include a complete neuropsychological assessment and all pertinent medical documentation from inpatient and outpatient therapy and social history to identify key treatment components and communicate the functional implications of treatment goals. 2. Initial treatment plan development and evaluations will occur within a two week period following admission. 3. Treatment plan goals and objectives shall reference specific outcomes in the degree of personal and living independence, work productivity, and psychological and social adjustment, quality of life and degree of community participation. 4. Specific treatment modalities outlined in the treatment plan shall be systematically implemented with techniques that are consistent, functionally based, and active throughout the day. Treatment methods will be appropriate to the goals and treatment plans will be reviewed and modified as appropriate. 5. Progress notes will be kept to support specific treatment modalities rendered by date and signed by the therapist providing the service. E. CERTIFICATION STANDARDS 1. Directors of day treatment programs shall have professional licensure in a health related program in combination with at least 2 years of experience in head trauma rehabilitation programming. 2. All providers shall operate in full compliance with all applicable federal, state and local fire, health, safety, sanitation and other standards prescribed in law or regulation. 3. The agency shall provide a clean environment, free of obstacles that could pose a hazard to client health and safety. 4. Agencies shall provide lockers or a safe place for clients' personal items. 5. Day treatment centers shall provide age appropriate activities and provide eating and resting areas consistent with the number and needs of the clients being served. 6. The center shall be accessible according to guidelines established by the Americans with Disabilities Act. 7. Personnel shall have training appropriate to the medical needs of the clients served including seizure management training, CPR certification, non-violent crisis intervention, and personal care standards according to SECTION-PERSONAL CARE 8.489.40. F. REIMBURSEMENT Day treatment services will be paid on a per diem basis at a rate to be determined by the Department In order for a provider to be paid for a day of treatment, a client must have attended and received therapeutic intervention which is substantiated by case file notes signed by the rendering therapist
Targeted Population	Persons 16 years of age and older with a brain injury sustained before the age of 65 who meet the hospital, nursing facility or ICF/ID level of care.
Waiver Manager Comment	No concerns with the service.

OTHER SERVICES

42 CFR §440.180(b)(9) permits a state to request the authority to offer "other" services that are not expressly authorized in the statute as long as it can be demonstrated that the service is necessary to assist a waiver participant to avoid institutionalization and function in the community. Other services are services that are not: (a) statutory services; (b) extended state plan services; or, (c) services in support of participant direction.

Colorado's Other Services include:

Home Modification
Vehicle Modification
Non-Medical Transportation
Specialized Medical Equipment Services
Assistive Technology
Mental Health Counseling
Parent Education
Personal Emergency Response System (PERS)
Community Transition Services
Adaptive Therapeutic Recreational Equipment and Fees
Alternative Care Facility
Independent Life Skills Training
Professional Services
Supported Living Program
Transitional Living Program
Mentorship
Expressive Therapy
Substance Abuse Counseling
Behavioral Services
Behavioral Assessments
Bereavement Counseling
Supported Community Connector
Alternative Therapies

HOME MODIFICATION

Waiver	HCBS-Elderly, Blind and Disabled Waiver
Waiver Service Definition	Those physical adaptations to the home, required by the individual's plan of care, which are necessary to assure the health, welfare, and safety of the individual, or which enable the individual to function with greater independence in the home, and without which the individual would require institutionalization. Such adaptations may include the installation of ramps and grab bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State and local building codes.
Service Limitations	Home modifications are limited based on the client's assessed need for services. There is a lifetime cap of $10,000 per home modification client. Home modifications shall not be made to provider-owned housing.
Rule	**10 CCR 2505-10 Section 8.493, HOME MODIFICATION** **8.493.1 DEFINTIONS** Eligible Client means a client who is enrolled in a Home and Community-Based Services (HCBS) waiver for Persons with Brain Injury, Persons with Major Mental Illness or Persons who are Elderly, Blind and Disabled. Home Modification means specific modifications, adaptations or improvements in an Eligible Client's existing home setting which, based on the client's medical condition: 1. Are necessary to ensure the health, welfare and safety of the client, and 2. Enable the client to function with greater independence in the home, and 3. Are required because of the client's illness, impairment or disability, as documented on the ULTC-100.2 form and the care plan; and 4. Prevents institutionalization of the client. Home Modification Provider means a provider agency that has met all the standards for Home Modification described in 10 C.C.R. 2505-10, Section 8.493.5.B and is an enrolled Medicaid provider.

	8.493.2 BENEFITS 8.493.2.A. Home Modifications, adaptations or improvements may include but are not limited to the following: 1. Installing or building ramps. 2. Installing grab-bars and installing other durable medical equipment as part of a larger Home Modification project. 3. Widening doorways. 4. Modifying bathrooms. 5. Modifying kitchen facilities. 6. Installing specialized electric and plumbing systems that are necessary to accommodate medically necessary equipment and supplies. **8.493.3 EXCEPTIONS AND RESTRICTIONS** 8.493.3.A. Modifications to an existing home that are not a direct medical or remedial benefit to the client are not a benefit. 8.493.3.B. Duplicate adaptations, modifications or improvements and modifications as a part of new construction costs are not a benefit. 8.493.3.C. The Department may deny requests for Home Modification projects that exceed usual and customary charges or do not meet industry standards. 8.493.3.D. Home Modification projects are not a benefit in any type of certified or non-certified congregate facility, as defined in 10 C.C.R. 2505-10, Sections 8.485.50 F. and G. 8.493.3.E. There shall be a lifetime cap of $10,000.00 per client. 8.493.3.F. Volunteer work on a Home Modification project approved by the Department shall be completed under the supervision of the Home Modification Provider as stated on the bid. 8.493.4 SINGLE ENTRY POINT AGENCY RESPONSIBILITIES 8.493.4.A. The SEP case manager shall consider alternative funding sources to complete the Home Modification. These alternatives shall be documented in the case record. 8.493.4.B. The SEP case manager shall obtain prior approval by submitting a Prior Authorization request form (PAR) to the Department for Home Modification projects estimated at between $1,000.00 and $10,000.00. 8.493.4.C. The SEP case manager may approve Home Modification projects estimated at less than $1,000.00 without prior authorization. 8.493.4.D. The Department may conduct on-site visits or any other investigations deemed necessary prior to approving or denying the Home Modification request. 8.493.4.E. Home Modifications estimated to cost $1,000.00 or more shall be evaluated according to the following procedures: 1. An occupational therapist shall assess the client's needs and the therapeutic value of the requested Home Modification. When an occupational therapist with experience in Home Modification is not available, a Department-approved physical therapist or other qualified individual may be substituted. A report specifying how the Home Modification would contribute to a client's ability to remain in or return to his/her home, and how the Home Modification would increase the individual's independence and decrease the need for other services, shall be completed before bids are solicited.

	This evaluation shall be submitted with the PAR. 2. The occupational therapist services may be provided by a home health agency and billed to Medicaid Home Health consistent with Home Health rules set forth in 10 C.C.R. 2505-10, Section 8.520, including physician orders and plans of care. 3. The SEP case manager and the occupational therapist shall consider less expensive alternative methods of addressing the client's needs. The case manager shall document these alternatives in the client's case file. 8.493.4.F. The SEP case manager shall follow a bid process according to the following procedures: 1. The SEP case manager shall solicit and receive bids from at least two Home Modification Providers. 2. The bids shall include a breakdown of the costs of the project including: a. Description of the work to be completed. b. Estimate of the materials and labor needed to complete the project. c. Estimate for building permits, if needed. d. Estimated timeline for completing the project. e. Name, address and telephone number of the Home Modification Provider. f. Signature of the Home Modification Provider. 3. Home Modification Providers have a maximum of 30 days to submit a bid for the Home Modification project after the SEP case manager has solicited the bid. 4. The SEP case manager shall submit copies of the bids and occupational therapists evaluation with the PAR to the Department. The Department shall authorize payment to the lowest bidder. 5. The SEP case manager may request approval of bid that is not the lowest by submitting a written justification or explanation to the Department with the PAR. 6. If the SEP case manager has made three attempts to obtain a written bid from Home Modification Providers and the Home Modification Providers have not responded within 30 calendar days, the case manager may accept one bid. Documentation of the contacts and an explanation of these attempts shall be attached to the PAR. 7. A revised PAR and bid request shall be submitted according to the procedures outlined in this Section for any changes from the original approved PAR. 8. Home Modification projects shall be initiated within 60 days of signed approval from the Department. 8.493.4.G. If a property to be modified is not owned by the client or the client's family, the SEP case manager shall obtain a letter from the owner of the property authorizing modifications to the property prior to initiation of the project and allowing the client to leave the modification in place if the property is vacated by the client. 8.493.5 PROVIDER RESPONSIBILITIES 8.493.5.A. Home Modification Providers shall conform to all general certification standards and procedures set forth in 10 C.C.R. 2505-10, Section

	8.487.11. 8.493.5.B. Home Modification Providers shall be licensed in the city or county in which they propose to provide Home Modification services to perform the work proposed, if required by that city or county. 8.493.5.C. The Home Modification Provider shall provide a one-year written warranty on materials and labor from date of final inspection on all completed work. 8.493.5.D. The Home Modification Provider shall assure that the project complies with local and/or state building codes. In areas where there is no building authority, the Home Modification Provider shall assure that the project complies with the appropriate provisions of the 2003 edition of the International Residential Code and the accessibility provisions contained within the 2003 edition of the International Building Code. The Home Modification project shall also comply with the Colorado Plumbing Code as adopted by the Colorado Examining Board of Plumbers and the National Electrical Code as adopted by the Colorado Electrical Board, effective July 1, 2005. No amendments or later editions are incorporated. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library. Copies of the 2003 International Building Code and copies of the rules and regulations of the State Electrical Board and State Examining Board of Plumbers are available for inspection from: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado, 80203-1714. 8.493.5.E. All Home Modification projects shall be inspected and approved by a state, local or county building inspector or a licensed engineer, architect, contractor or any other person as designated by the Department. 8.493.5.F. Copies of building permits and inspection reports shall be submitted to the SEP case manager and all problems noted on inspections shall be corrected before the Home Modification Provider submits a final invoice for the payment. In the event that a permit is not required, the Home Modification Provider shall submit to the SEP case manager a signed statement indicating that a permit is not required. **8.493.6 REIMBURSEMENT** 8.493.7 Payment for Home Modification services shall be the lower of the billed charges or the prior authorized amount. Reimbursement shall be made in two payments per Home Modification. 8.493.7.A. The Home Modification Provider may submit a claim for an initial payment of no more than fifty percent of the project cost for materials, permits and initial labor costs. 8.493.7.B. Final payment shall be made when the Home Modification project has been completed and the SEP agency has in the client's file copies of: 1. Signed lien waivers for all labor and materials, including lien waivers from sub-contractors. 2. Required permits. 3. One year written warranty on parts and labor. 4. Final inspection documentation verified by the SEP case manager and documented in the client's file that the Home Modification has been completed through: a. Contact with the building inspector or other inspector as referenced at 10 C.C.R. 2505-10, Section 8.493.5.E, or b. Contact with the client , or c. Contact with the family member or responsible party, or

	d. By conducting an on-site visit. 8.493.7.C. The Home Modification Provider shall only be reimbursed for materials and labor for work that has been completed satisfactorily. If another Home Modification Provider is required to complete the work, the original Home Modification Provider shall be paid only the difference between the amount paid originally to the Home Modification Provider and the amount needed to complete the Home Modification paid to the second Home Modification Provider, up to the $10,000.00 maximum lifetime cap. 8.493.7.D. The Home Modification Provider shall not be reimbursed for durable medical equipment available as a Medicaid state plan benefit unless the purchase and installation of the equipment is part of a larger Home Modification project.
Targeted Population	Persons with physical disabilities and elderly persons with a functional deficit who require modifications of their home for access and safety. Adults 18-64 with physical disabilities and seniors 65+ with functional deficits, who meet nursing facility level of care
Waiver Manager Comment	In general, this is a good service that is working well. Because this is a service that has complicated requirements, (PT/OT recommendations, building estimates, building contractors) complications can arise.

Waiver	**HCBS- Community Mental Health Supports Waiver (HOME MODIFICATION)**
Waiver Service Definition	Same as EBD Waiver
Service Limitations	Same as EBD Waiver
Rule	Same as EBD Waiver: **10 CCR 2505-10 Section 8.493**
Targeted Population	Persons 18 years and older with a major mental illness that meet nursing facility level of care.
Waiver Manager Comment	This is one of the services that I question its validity in the CMHS waiver. Only 8 clients used this service in FY 2011. There have not appeared to be large problems for this waiver and the Home Modification service.

Waiver	HCBS- for Persons with Brain Injury Waiver (ENVIRONMENTAL MODIFICATION)
Waiver Service Definition	Same as EBD Waiver: **ENVIRONMENTAL MODIFICATION**
Service Limitations	Same as EBD Waiver
Rule	Same as EBD Waiver; **10 CCR 2505-10, Section 8.493**
Targeted Population	Persons 16 years of age and older with a brain injury sustained before the age of 65 who meet the hospital, nursing facility or ICF/ID level of care.
Waiver Manager Comment	No concerns with this service

Waiver	HCBS-for Persons with Spinal Cord Injury (HOME MODIFICATIONS)
Waiver Service Definition	Same as EBD Waiver
Service Limitations	Same as EBD Waiver
Rule	Same as EBD Waiver; **10 CCR 2505-10, Section 8.493**
Targeted Population	Persons 18 years and older with a spinal cord injury who meet nursing facility level of care.
Waiver Manager Comment	As this waiver has just been implemented, there is not adequate data to determine the effectiveness and utilization of this service. It seems that this is a necessary service for this waiver, as individuals with a spinal cord injury may require modification of their home in order to remain in the community.

Waiver	HCBS- Supported Living Services Waiver (HOME ACCESSIBILITY ADAPTATIONS)
Waiver Service Definition	Those physical adaptations to the primary residence of the participant's family, required by the participant's Service Plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home. All adaptations shall be the most cost effective means to meet the identified need. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant. Excluded are those adaptations or improvements to the home that are of

	general utility (e.g., carpeting, roof repair, central air conditioning, etc.) and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). Prior authorization is required for any adaptation adding square footage to a home.. All devices and adaptations shall be provided in accordance with applicable State or local building codes and/or applicable standards of manufacturing, design and installation. Medicaid State Plan or third party resources shall be utilized prior to accessing waiver funds
Service Limitations	The total cost of home accessibility adaptations, vehicle modifications, and assistive technology may not exceed $10,000 over the life of the waiver except that on a case by case basis the DHS/DDD may approve a higher amount, to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home, or if it decreases the need for paid assistance in another waiver service on a long-term basis. Any request to add square footage to the home shall be prior authorized.
Rule	**10 CCR 2505-10 Section 8.500.94.A(5) HOME ACCESSIBILITY ADAPTATIONS** Home Accessibility Adaptations are physical adaptations to the primary residence of the client, that are necessary to ensure the health, and safety of the client or that enable the client to function with greater independence in the home. All adaptations shall be the most cost effective means to meet the identified need. Such adaptations include: a. The installation of ramps, b. Widening or modification of doorways, c. Modification of bathroom facilities to allow accessibility and assist with needs in activities of daily living, d. The installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment supplies that are necessary for the welfare of the client, and e. Safety enhancing supports such as basic fences, door and window alarms. f. The following items are specifically excluded from home accessibility adaptations and shall not be reimbursed: i) Adaptations or improvements to the home that are considered to be on-going homeowner maintenance and are not related to the client's disability, ii) Carpeting, iii) Roof repair, iv). Central air conditioning, v) Air duct cleaning, vi) Whole house humidifiers, vii) Whole house air purifiers, viii) Installation or repair of driveways and sidewalks, ix) Monthly or ongoing home security monitoring fees, x) Home furnishings of any type, and

	xii) Luxury upgrades. g. When the HCBS-SLS waiver has provided modifications to the client's home and the client moves to another home, those modifications shall not be duplicated in the new residence unless prior authorized in accordance with Operating Agency procedures. Adaptation to rental units, when the adaptation is not portable and cannot move with the client shall not be covered unless prior authorized in accordance with Operating Agency procedures. h. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation to: i. improve entrance or egress to a residence; or, ii. configure a bathroom to accommodate a wheelchair. i. Any request to add square footage to the home shall be prior authorized in accordance with Operating Agency procedures. j. All devices and adaptations shall be provided in accordance with applicable state or local building codes or applicable standards of manufacturing, design and installation. Medicaid state plan, EPSDT or third party resources shall be utilized prior to authorization of waiver services. k. The total cost of home accessibility adaptations, vehicle modifications, and assistive technology shall not exceed $10,000 over the five-year life of the waiver without an exception granted by the Operating Agency. Costs that exceed this limitation may be approved by the Operating Agency for devices to ensure the health, and safety of the client or that enable the client to function with greater independence in the home, or if it decreases the need for paid assistance in another waiver service on a long-term basis. Requests to exceed the limit shall be prior authorized in accordance with Operating Agency procedure.
Targeted Population	Persons aged 18 and older who have a developmental disability and who meet ICF/ID level of care
Waiver Manager Comment	**Recommendation: Keep this service** 1. Highly needed service; increases independence; addresses health and safety; reduces ongoing costs to the waiver; prevents out of home placement; No changes recommended

Waiver	**HCBS-Children's Extensive Support Waiver (HOME ACCESSIBILITY ADAPTATIONS)**
Waiver Service Definition	Those physical adaptations to the primary residence of the participant's family, required by the participant's service plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home. All adaptations shall be the most cost effective means to meet the identified need. Such adaptations include the installation of fencing, ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant. Excluded are those adaptations or improvements to the home that are of general utility (e.g., carpeting, roof repair, central air conditioning, etc.) and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve

	entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). Any request to add square footage to the home shall be prior authorized. All devices and adaptations shall be provided in accordance with applicable State or local building codes and/or applicable standards of manufacturing, design and installation. Medicaid State Plan, EPSDT or third party resources shall be utilized prior to accessing waiver funds.
Service Limitations	The total cost of home accessibility adaptations, vehicle modifications, and assistive technology shall not exceed $10,000 over the life of the waiver except that, on a case by case basis, the DHS/DDD may approve a higher amount, to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home, or if it decreases the need for paid assistance in another waiver service on a long-term basis.
Rule	**10 CCR 2505-10 Section 8.503.40.A(5) HOME ACCESSIBILITY ADAPTATIONS** Home Accessibility Adaptations are physical adaptations to the primary residence of the client, that are necessary to ensure the health and safety of the client or that enable the client to function with greater independence in the home. All adaptations shall be the most cost effective means to meet the identified need. Such adaptations include: a. The installation of ramps, b. Widening or modification of doorways, c. Modification of bathroom facilities to allow accessibility, and assist with needs in activities of daily living. d. The installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment or supplies that are necessary for the health and safety of the client, and e. Safety enhancing supports such as basic fences or basic door and window alarms; f. The following items are specifically excluded from Home Accessibility Adaptations and shall not be reimbursed: i. Adaptations or improvements to the home that are considered to be on-going homeowner maintenance and are not related to the client's disability, ii.) Carpeting, iii.) Roof repair, iv.) Central air conditioning, v.) Air duct cleaning, vi.) Whole house humidifiers, vii.) Whole house air purifiers, viii.) Installation and repair of driveways and sidewalks, viii.) Monthly or ongoing home security monitoring fees, ix.) Home furnishings of any type, x.) Adaptations to rental units when the adaptation is not portable and cannot move with the renter, and xi.) Luxury upgrades.

	g. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation to: i. Improve entrance or egress to a residence; or, ii. Configure a bathroom to accommodate a wheelchair. h. Any request to add square footage to the home shall be prior authorized in accordance with Operating Agency procedures. i. All devices and adaptations shall be provided in accordance with applicable state or local building codes and applicable standards of manufacturing, design and installation. Medicaid State Plan, EPSDT or third party resources shall be utilized prior to authorization of HCBS-CES waiver services. j. The total cost of Home Accessibility Adaptations, Vehicle Modifications, and Assistive Technology shall not exceed ten thousand (10,000) dollars over the five (5) year life of the HCBS-CES waiver without an exception granted by the Operating Agency. Costs that exceed this limitation may be approved for services, items or devices to ensure the health and safety of the client, enable the client to function with greater independence in the home, or decrease the need for paid assistance in another HCBS-CES waiver service on a long-term basis. Requests to exceed the limit shall be prior authorized in accordance with Operating Agency procedure
Targeted Population	Clients ages birth up to 18th birthday Must have developmental delay (age 5 and under) or developmental disability Have a behavior or medical condition so intense it requires near constant line of sight supervision.
Waiver Manager Comment	Low use: FY PD claims unduplicated client count 34; overall waiver unduplicated count 409 **Recommendation: Keep this service** 2. Highly needed service; increases independence; addresses health and safety; reduces ongoing costs to the waiver; prevents out of home placement; 3. No changes recommended

VEHICLE MODIFICATION

Waiver	HCBS- Supported Living Services Waiver
Waiver Service Definition	Adaptations or alterations to an automobile or van that is the participant's primary means of transportation in order to accommodate the special needs of the participant. Vehicle adaptations are specified by the Service Plan as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant. The following are specifically excluded: (1) Adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the participant; (2) Purchase or lease of a vehicle; and (3) Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.
Service Limitations	The total cost of home accessibility adaptations, vehicle modifications, and assistive technology may not exceed $10,000 over the life of the waiver except that on a case by case basis the DHS/DDD may approve a higher amount, to ensure the health, welfare and safety of the participant or if it decreases the need for paid assistance in another waiver service on a long-term basis.
Rule	**10 CCR 2505-10 Section 8.500.94.A(15)** Vehicle modifications are adaptations or alterations to an automobile or van that is the client's primary means of transportation; to accommodate the special needs of the client; are necessary to enable the client to integrate more fully into the community; and to ensure the health and safety of the client a. Upkeep and maintenance of the modifications are allowable services. b. Items and services specifically excluded from reimbursement under the HCBS Waiver include: i) Adaptations or improvements to the vehicle that are not of direct medical or remedial benefit to the client, ii) Purchase or lease of a vehicle, and iii) Typical and regularly scheduled upkeep and maintenance of a vehicle. c. The total cost of home accessibility adaptations, vehicle modifications, and assistive technology shall not exceed $10,000 over the five (5) year life of the HCBS Waiver except that on a case by case basis the Operating Agency may approve a higher amount. Such requests shall ensure the health and safety of the client, enable the client to function with greater independence in the home, or decrease the need for paid assistance in another HCBS-SLS Waiver service on a long-term basis. Approval for a higher amount will include a thorough review of the current request as well as past expenditures to ensure

	cost-efficiency, prudent purchases and no duplication.
Targeted Population	Persons aged 18 and older with a developmental disability who meet the ICF/ID level of care
Waiver Manager Comment	S **Recommendation: Keep service, no changes recommended.** High impact services. Increases independence; addresses health and safety; reduces ongoing costs to the waiver and prevents out of home placement.

Waiver	**HCBS-Children's Extensive Support Waiver (VEHICLE MODIFICATION)**
Waiver Service Definition	Adaptations or alterations to an automobile or van that is the participant's primary means of transportation in order to accommodate the special needs of the participant. Vehicle adaptations are specified by the service plan as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant. The following are specifically excluded: (1) Adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the participant; (2) Purchase or lease of a vehicle; and (3) Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.
Service Limitations	The total cost of home accessibility adaptations, vehicle modifications and assistive technology may not exceed $10,000 over the life of the waiver except that on a case by case basis the DHS/DDD may approve a higher amount, to ensure the health, welfare and safety of the participant or if it decreases the need for paid assistance in another waiver service on a long-term basis
Rule	**10 CCR 2505-10 Section 8.503.40.A(12)** Vehicle Modifications are adaptations or alterations to an automobile or van that is the client's primary means of transportation, to accommodate the special needs of the client, are necessary to enable the client to integrate more fully into the community and to ensure the health, and safety of the client. a. Upkeep and maintenance of the modifications are allowable services. b. Items and services specifically excluded from reimbursement under the HCBS-CES waiver include: i) Adaptations or improvements to the vehicle that are not of direct medical or remedial benefit to the client, ii) Purchase or lease of a vehicle, and iii) Typical and regularly scheduled upkeep and maintenance of a vehicle c. The total cost of Home Accessibility Adaptations, Vehicle Modifications, and Assistive Technology shall not exceed ten thousand (10,000) dollars over the five (5) year life of the HCBS-CES waiver without an exception granted by the Operating Agency. Costs that exceed this limitation may be approved for services, items or devices to ensure the health and safety of the client, enable the client to function with greater independence in the home, or decrease the need for paid assistance in another HCBS-CES waiver service on a long-term basis. Approval for a higher amount will include a thorough review of the current request as well as past expenditures to ensure cost-efficiency, prudent purchases and no unnecessary duplication.

Targeted Population	Clients ages birth up to 18th birthday Must have developmental delay (age 5 and under) or developmental disability Have a behavior or medical condition so intense it requires near constant line of sight supervision.
Waiver Manager Comment	Low use: FY PD claims unduplicated client count 14 with overall waiver unduplicated count 409 **Recommendation: Keep service, no changes recommended.** 1. High impact services. Increases independence; addresses health and safety; reduces ongoing costs to the waiver and prevents out of home placement.

NON-MEDICAL TRANSPORTATION

Waiver	HCBS-Elderly, Blind and Disabled Waiver
Waiver Service Definition	Service offered in order to enable individuals served on the waiver to gain access to waiver and other community services, activities and resources, specified by the service plan. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State Plan, defined at 42 CFR 440.170 (a) (if applicable), and shall not replace them. Transportation services under the waiver shall be offered in accordance with the individual's service plan. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge will be utilized.
Service Limitations	Effective, 05/17/2010, excluding transportation to Adult Day facilities, a client may not receive more than the equivalent of four (4) one-way trip services per week, or 104 round trip (two (2) one-way trips) per annual certification period, unless otherwise authorized by the Department. Non-medical transportation services offered in this waiver are limited based on the client's assessed need for services, physician's orders and prior authorization by case managers up to the cost containment parameters.
Rule	**10 CCR 2505-10 Section 8.494** NON-MEDICAL TRANSPORTATION 8.494.10 DEFINITIONS .11 Non-medical transportation services means transportation which enable eligible clients to gain personal physical access to non-medical community services and resources, as required by the care plan to prevent institutionalization. .12 Non-medical transportation provider means a provider agency as defined at Section 8.484.50, P, GENERAL DEFINITIONS, which has met all the certification standards for transportation providers listed below. 8.494.20 INCLUSIONS .21 Non-medical transportation services shall include, but not be limited to, transportation between the client's home and non-medical services or resources such as adult day services, shopping, therapeutic swimming, dentist appointments, counseling sessions, and other services as required by the care plan to prevent institutionalization. 8.494.30 EXCLUSIONS .31 Non-medical transportation services shall not be used to substitute for medical transportation, which is subject to reimbursement under Section 8.680 through 8.691, OTHER HEALTH SERVICES - TRANSPORTATION. .32 Non-medical transportation services shall only be used after the case manager has determined that free transportation is not available to the client. 8.494.40 CERTIFICATION STANDARDS FOR TRANSPORTATION SERVICES .41 Transportation providers shall conform to all general certification standards and procedures at Section 8.487, HCBS-EBD PROVIDER AGENCIES.

	.42 Transportation providers shall assure that: A. All drivers shall possess a valid Colorado drivers license, shall be free of physical or mental impairment that would adversely affect driving performance, and have not had two or more convictions or chargeable accidents within the past two years. B. All vehicles and related auxiliary equipment shall meet all applicable federal, state and local safety inspection and maintenance requirements, and shall be in compliance with state automobile insurance requirements. 8.494.50 LIMITATIONS AND REIMBURSEMENT .51 Reimbursement for non-medical transportation shall be the lower of billed charges or the prior authorized unit cost at a rate not to exceed the cost of providing medical transportation services. .52 A provider's submitted charges shall not exceed those normally charged to 'the general public, other public or private organizations, or non-subsidized rates negotiated with other governmental entities. .53 No payment shall be made for charges when the recipient is not actually in the vehicle. .54 Effective 2/1/99, there shall be no reimbursement under this section for non-medical transportation services provided to clients residing in uncertified congregate facilities. Case managers may submit a written request to the Department for a waiver not to exceed six months for clients receiving services in uncertified congregate facilities prior to the effective date of this rule. After that time, services shall be discontinued. .55 Effective 12/01/2009, excluding transportation to HCBS Adult Day facilities, a client may not receive more than the equivalent of two (2) round trip services per week, or 104 round trip services per annual certification period utilizing NMT, unless otherwise authorized by the Department.
Targeted Population	Waiver clients needing transportation to attend day program, go to doctor's appointments, and access their community, when they do not have other access to transportation. Adults 18-64 with physical disabilities and seniors 65+ with functional deficits, who meet nursing facility level of care
Waiver Manager Comment	This service is undergoing significant change across HCPF operated adult waivers. This service has been recently changed to include mileage band billing, to help rural providers afford the cost of transporting client longer distances. This recent change has also included important clarification of the use of different provider types. However, SEPs and providers report that lower mileage rates need to increase. Reports are that if rates don't increase for the lower mileage there could be a significant drop-off in the number of companies able to provide transportation in the metro area. This would require clients to use a more expensive taxi option if a provider is not available.

Waiver	**HCBS-Persons Living with Aids**

Waiver Service Definition	Same as EBD Waiver
Service Limitations	Same as EBD Waiver
Rule	**10 CCR 2505-10 Section 8.494** NON-MEDICAL TRANSPORTATION 8.494.10 DEFINITIONS .11 Non-medical transportation services means transportation which enable eligible clients to gain personal physical access to non-medical community services and resources, as required by the care plan to prevent institutionalization. .12 Non-medical transportation provider means a provider agency as defined at Section 8.484.50, P, GENERAL DEFINITIONS, which has met all the certification standards for transportation providers listed below. 8.494.20 INCLUSIONS .21 Non-medical transportation services shall include, but not be limited to, transportation between the client's home and non-medical services or resources such such as adult day services, shopping, therapeutic swimming, dentist appointments, counseling sessions, and other services as required by the care plan to prevent institutionalization. 8.494.30 EXCLUSIONS .31 Non-medical transportation services shall not be used to substitute for medical transportation, which is subject to reimbursement under Section 8.680 through 8.691, OTHER HEALTH SERVICES - TRANSPORTATION. .32 Non-medical transportation services shall only be used after the case manager has determined that free transportation is not available to the client. 8.494.40 CERTIFICATION STANDARDS FOR TRANSPORTATION SERVICES .41 Transportation providers shall conform to all general certification standards and procedures at Section 8.487, HCBS-EBD PROVIDER AGENCIES. .42 Transportation providers shall assure that: A. All drivers shall possess a valid Colorado drivers license, shall be free of physical or mental impairment that would adversely affect driving performance, and have not had two or more convictions or chargeable accidents within the past two years. B. All vehicles and related auxiliary equipment shall meet all applicable federal, state and local safety inspection and maintenance requirements, and shall be in compliance with state automobile insurance requirements. 8.494.50 LIMITATIONS AND REIMBURSEMENT .51 Reimbursement for non-medical transportation shall be the lower of billed charges or the prior authorized unit cost at a rate not to exceed the cost of providing medical transportation services. .52 A provider's submitted charges shall not exceed those normally charged to 'the general public, other public or private organizations, or non-subsidized rates negotiated with other governmental entities.

	.53 No payment shall be made for charges when the recipient is not actually in the vehicle. .54 Effective 2/1/99, there shall be no reimbursement under this section for non-medical transportation services provided to clients residing in uncertified congregate facilities. Case managers may submit a written request to the Department for a waiver not to exceed six months for clients receiving services in uncertified congregate facilities prior to the effective date of this rule. After that time, services shall be discontinued. .55 Effective 12/01/2009, excluding transportation to HCBS Adult Day facilities, a client may not receive more than the equivalent of two (2) round trip services per week, or 104 round trip services per annual certification period utilizing NMT, unless otherwise authorized by the Department.
Targeted Population	Persons of any age with a diagnosis of HIV/AIDs who require a nursing facility or hospital level of care.
Waiver Manager Comment	Same as EBD

Waiver	**HCBS- Community Mental Health Supports Waiver (NMT)**
Waiver Service Definition	Same as EBD Waiver
Service Limitations	Excluding transportation to Adult Day facilities, a client may not receive more than the equivalent of four one-way trip services per week, or 104 round trip (two, one-way trips) per annual certification period, unless otherwise authorized by the Department. Non-medical transportation services offered in this waiver are limited based on the client's assessed need for services, physician's orders and prior authorization by case managers up to the cost containment parameters.
Rule	Same as EBD Waiver: **10 CCR 2505-10 Section 8.494**
Targeted Population	Persons 18 years and older who have a major mental illness and meet nursing facility level of care.
Waiver Manager Comment	Same comments as EBD. Over 600 clients on this waiver utilize this service.

Waiver	**HCBS- for Persons with Brain Injury Waiver (NMT)**
Waiver Service Definition	Same as EBD Waiver
Service Limitations	Non-medical transportation services offered in this waiver are limited based on the client's assessed need for services, physician's orders and prior

	authorization by case managers up to the cost containment parameters.
Rule	Same as EBD Waiver: **10 CCR 2505-10 Section 8.494**
Targeted Population	Persons 16 years of age and older with a brain injury sustained before the age of 65 who meet the hospital, nursing facility or ICF/ID level of care.
Waiver Manager Comment	Same as EBD

Waiver	**HCBS-for Persons with Spinal Cord Injury (NMT)**
Waiver Service Definition	Same as EBD Waiver
Service Limitations	Excluding transportation to Adult Day facilities, a client may not receive more than the equivalent of four one-way trip services per week, or 104 round trip (two, one-way trips) per annual certification period, unless otherwise authorized by the Department. Non-medical transportation services offered in this waiver are limited based on the client's assessed need for services, physician's orders and prior authorization by case managers up to the cost containment parameters.
Rule	Same as EBD Waiver; **10 CCR 2505-10 Section 8.494**
Targeted Population	Persons 18 years and older with a spinal cord injury who meet nursing facility level of care
Waiver Manager Comment	Non-medical transportation is going to be necessary for clients to have access to for the new alternative the new alternative therapy services as they are only provided at two locations in the Denver Metro Area. As this waiver has just been implemented, we are unable to determine the utilization of this service at this point in time.
Waiver	**HCBS-for Persons with Developmental Disabilities (NMT)**
Waiver Service Definition	Service offered in order to enable waiver participants to gain access to day habilitation and supported employment services as specified by the Service Plan that are not related to medical interventions as covered in the State Plan. Transportation to and from work is a benefit in conjunction with Supported Employment service except when the Supported Employment service occurs at a frequency less than the number of days worked. In that case, transportation to and from the place of employment is a benefit when the participant does not have resources available, including personal funds, natural supports and/or third party resources. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State plan, defined at 42 CFR §440.170(a) (if applicable), and does not replace them. Transportation services under the waiver are offered in accordance with the participant's Service Plan. Whenever possible, family, neighbors, friends, or community agencies that can provide this

	service without charge are utilized.
Service Limitations	Transportation to and from day program shall be reimbursed based on the applicable transportation band. The number of units available for Transportation Services is 508 units per Service Plan year or approximately 42 trips per month. A unit is a per-trip charge for to and from Day Habilitation and Supported Employment programs.
Rule	**10 CCR 2505-10 Section 8.500.5.A(4)** Non-Medical Transportation enables clients to gain access to Day Habilitation Services and Supports, Prevocational Services and Supported Employment services. A bus pass or other public conveyance may be used only when it is more cost effective than or equivalent to the applicable mileage band. a. Whenever possible, family, neighbors, friends or community agencies that can provide this service without charge must be utilized and documented in the Service Plan. b. Non-Medical Transportation to and from day program shall be reimbursed based on the applicable mileage band. Non-Medical Transportation services to and from day program are limited to five hundred and eight (508) units per service plan year. A unit is a per-trip accessed each way to and from day habilitation and supported employment services. c. Non-Medical Transportation does not replace medical transportation required under 42 C.F.R. § 431.53 or transportation services under the Medicaid State Plan, defined at 42 C.F.R. § 440.170(A).
Targeted Population	Persons with developmental disabilities who meet the ICF/IID Level of Care and who require 24/7 access to supervision
Waiver Manager Comment	Keep as is-no changes recommended

Waiver	**HCBS- Supported Living Services Waiver (NON-MEDICAL TRANSPORTATION)**
Waiver Service Definition	Service provided in order to enable waiver participants to gain access to waiver and other community services, activities and resources, as specified by the Service Plan. Transportation to and from work is a benefit in conjunction with Supported Employment service except when the Supported Employment service occurs at a frequency less than the number of days worked. In that case, transportation to and from the place of employment is a benefit when the participant does not have resources available, including personal funds, natural supports and/or third party resources. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State plan, defined at 42 CFR §440.170(a) (if applicable), and does not replace them. Transportation services under the waiver are offered in accordance with the participant's Service Plan. Whenever possible, family, neighbors, friends, or community agencies, which can provide this service without charge, are utilized.
Service Limitations	Transportation to and from day program shall be reimbursed based on the applicable transportation band. The number of units available for Transportation Services is 508 units per Service Plan year or approximately 42 trips per month. A unit is a per-trip charge for to and from Day Habilitation and Supported Employment services. Transportation in addition to Day Habilitation and Supported Employment is limited to 4 trips per week reimbursed at transportation band one.

Rule	Same as DD Waiver; **10 CCR 2505-10 Section 8.500.94.A(8)**
Targeted Population	Persons aged 18 and older with a developmental disability who meet ICF/ID level of care
Waiver Manager Comment	Keep as is-no changes recommended

SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES

Waiver	**HCBS-Elderly, Blind and Disabled Waiver**
Waiver Service Definition	(The service title approved in the current waiver has been changed from "Specialized Medical Equipment and Supplies Provider" to Medication Reminders) The devices, controls, or appliances which enable an individual at high risk of institutionalization to increase their abilities to perform activities of daily living, such as medication administration. Medication Reminders shall include devices or items that remind or signal the client to take prescribed medications or other devices necessary for the proper functioning of such items, and durable and non-durable medical equipment not available as a State plan benefit. Medication Reminders shall be considered a benefit only when reasonable and necessary for the treatment of an individual's illness, impairment, or disability as documented on the ULTC 100.2 and service plan.
Service Limitations	Items reimbursed as Medication Reminder shall be in addition to any medical equipment and supplies furnished under the Medicaid State plan. Medication Reminder shall be authorized only for individuals who have the physical and mental capacity to utilize the particular system requested for that client. Medications Reminder shall be authorized only if they are in accordance with current accepted standards of medical practice in the treatment of the client's condition without excess or extreme function or expense beyond which is necessary.
Rule	**10 CCR 2505-10 Section 8.488 (Electronic Monitoring)** 8.488.10 DEFINITIONS .11 Electronic monitoring services means the installation purchase or rental of electronic monitoring devices which: A. enable the individual to secure help in the event of an emergency; B. may be used to provide reminders to the individual of medical appointments, treatments, or medication schedules; C. are required because of the individual's illness, impairment or disability, as documented on the ULTC-100 form and the care plan form; and D. are essential to prevent institutionalization of the individual. .12 Electronic monitoring provider means a provider agency as defined at Section 8.484.50,Q, GENERAL DEFINITIONS, which has met all the certification standards for electronic monitoring services specified below. 8.488.20 INCLUSIONS .21 Electronic monitoring services shall include personal emergency response systems, medication reminders, or other devices which comply with the definition above and are not included in the non-benefit items below at 8.488.31. 8.488.30 EXCLUSIONS, RESTRICTIONS AND NON-BENEFIT ITEMS .31 Electronic monitoring services shall be authorized only for individuals who live alone, or who are alone for significant parts of the day, or whose

	only companion for significant parts of the day is too impaired to assist in an emergency, and who would otherwise require extensive supervision. .32 Electronic monitoring services shall be authorized only for individuals who have the physical and mental capacity to utilize the particular system requested for that individual. .33 Electronic monitoring services shall not be authorized under HCBS if the service or device is available as a regular Medicaid benefit .34 The following are not benefits of electronic monitoring services: A. Augmentative communication devices and communication boards; B. Hearing aids and accessories; C. Phonic ears; D. Environmental control units, unless required for me medical safety of a client living alone unatended; E. Computers and computer software; F. Wheelchair lifts for automobiles or vans; G. Exercise equipment, such as exercise cycles; H. Hot tubs, Jacuzzis, or similar items. CERTIFICATION STANDARDS FOR ELECTRONIC MONITORING SERVICES .41 Electronic monitoring providers shall conform to all general certification standards and procedures at Section 8.487, HCBS-EBD PROVIDER AGENCIES. .42 In addition, electronic monitoring providers shall conform to the following standards for electronic monitoring services: A. All equipment, materials or appliances used as part of the electronic monitoring service shall carry a UL (Underwriter's Laboratory) number or an equivalent standard. All telecommunications equipment shall be FCC registered B. All equipment, materials or appliances shall be installed by properly trained individuals, and the installer shall train the client in the use of the device. C. All equipment, materials or appliances shall be tested for proper for functioning at the time of installation and at periodic intervals thereafter. Any malfunction shall be promptly repaired and equipment shall be replaced when necessary, including buttons and batteries. D. All telephone calls generated by electronic monitoring equipment shall be toll-free and all clients shall be allowed to run unrestricted tests on their equipment E. Electronic monitoring providers shall send written information to each client's case manager about the system, how it works, and how it will be maintained 8.488.50 REIMBURSEMENT METHOD FOR ELECTRONIC MONITORING .51 Payment for electronic monitoring services shall be the lower of the billed charges or the prior authorized amount The unit of reimbursement shall be one unit per service for non-recurring services, or one unit per month for services recurring monthly. .52 Effective 2/1/99, there shall be no reimbursement under this section for electronic monitoring services provided in uncertified congregate facilities
Targeted Population	Waiver clients who would benefit from special medical equipment to increase safety and independence in their home and community. Adults 18-64 with physical disabilities and seniors 65+ with functional deficits, that meets nursing facility level of care
Waiver Manager Comment	In general, this is a good service that is well-used.

Waiver	HCBS-Persons Living with Aids (SPECIALIZED MEDICAL EQUIPMENT)
Waiver Service Definition	Same as EBD Waiver
Service Limitations	Same as EBD Waiver
Rule	**Same as EBD Waiver: 10 CCR 2505-10 Section 8.488 (Electronic Monitoring)**
Targeted Population	Waiver clients who would benefit from special medical equipment to increase safety and independence in their home and community.
Waiver Manager Comment	In general, this is a good service that is well-used.

Waiver	HCBS- Community Mental Health Supports Waiver (SPECIALIZED MEDICAL EQUIPMENT)
Waiver Service Definition	The devices, controls, or appliances which enable an individual at high risk of institutionalization to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. Specialized Medical Equipment and Supplies shall include items necessary for life support, ancillary supplies, and equipment or other devices necessary for the proper functioning of such items, and durable and non-durable medical equipment not available as a State plan benefit. Specialized Medical Equipment and Supplies shall be considered a benefit only when reasonable and necessary for the treatment of an individual's illness, impairment, or disability as documented on the ULTC 100.2 and service plan.
Service Limitations	Items reimbursed as specialized medical equipment and supplies shall be in addition to any medical equipment and supplies furnished under the Medicaid State plan. Specialized Medical Equipment and Supplies shall be limited to medication minders and shall only be authorized for individuals who have the physical and mental capacity to utilize the particular system requested for that client. Specialized Medical Equipment and Supplies shall be authorized only if they are in accordance with current accepted standards of medical practice in the treatment of the client's condition without excess or extreme function or expense beyond which is necessary.
Rule	**Same as EBD Waiver: 10 CCR 2505-10 Section 8.488 (Electronic Monitoring)**
Targeted Population	Persons 18 years and older with a major mental illness who meet nursing facility level of care.
Waiver Manager	This service appears to be working well. We need to have a set fee for installation and purchase of this service as it depends on who the case manager uses

Comment	in each county. 139 clients in FY 2011 used this service for the Installation and 521 have a monthly service set up. This service includes Medication Reminders which can be essential for individuals who require daily medication and may forget to take this medication without a prompt.

Waiver	**HCBS- for Persons with Brain Injury Waiver (SPECIALIZED MEDICAL EQUIPMENT)**
Waiver Service Definition	Specialized medical equipment and supplies includes devices, controls or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items and durable/non-durable medical equipment not available under the Medicaid State Plan.
Service Limitations	Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State Plan and shall exclude items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.
Rule	Same as EBD Waiver
Targeted Population	Persons 16 years of age and older with a brain injury sustained before the age of 65 who meet the hospital, nursing facility or ICF/ID level of care.
Waiver Manager Comment	There have been no complaints about this service from clients, providers or CDPHE.

Waiver	**HCBS-for Persons with Spinal Cord Injury (SPECIALIZED MEDICAL EQUIPMENT)**
Waiver Service Definition	(The service title approved in the current waiver is Medication Reminders) The devices, controls, or appliances which enable an individual at high risk of institutionalization to increase their abilities to perform activities of daily living, such as medication administration. Medication Reminders shall include devices or items that remind or signal the client to take prescribed medications or other devices necessary for the proper functioning of such items, and durable and non-durable medical equipment not available as a State plan benefit. Medication Reminders shall be considered a benefit only when reasonable and necessary for the treatment of an individual's illness, impairment, or disability as documented on the ULTC 100.2 and service plan.
Service Limitations	Items reimbursed as Medication Reminder shall be in addition to any medical equipment and supplies furnished under the Medicaid State plan. Medication Reminder shall be authorized only for individuals who have the physical and mental capacity to utilize the particular system requested for that client. Medication Reminder shall be authorized only if they are in accordance with current accepted standards of medical practice in the treatment of the client's condition without excess or extreme function or expense beyond which is necessary.
Rule	**Same as EBD Waiver: 10 CCR 2505-10 Section 8.488 (Electronic Monitoring)**

Targeted Population	Persons 18 years and older with a spinal cord injury who meet nursing facility level of care.
Waiver Manager Comment	This waiver has just been implemented and there isn't adequate data to assess whether this service is utilized for this target population.

Waiver	**HCBS-for Persons with Developmental Disabilities (SPECIALIZED MEDICAL EQUIPMENT)**
Waiver Service Definition	Specialized Medical Equipment and supplies include: 1. Devices, controls, or appliances that enable participants to increase their ability to perform activities of daily living 2. Devices, controls, or appliances that enable the participant to perceive, control or communicate with the environment in which they live 3. Items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items 4. Such other durable and non-durable medical equipment not available under the State plan that is necessary to address participant functional limitations; and, 5. Necessary medical supplies in excess of state plan limitation or not available under the State plan. Specialized Medical Equipment and Supplies are in addition to any medical equipment and supplies furnished under the State plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation.
Service Limitations	NA
Rule	**10 CCR 2505-10 Section 8.500.5.A(6)** Specialized Medical Equipment and Supplies include: a. Devices, controls or appliances that enable the client to increase the client's ability to perform activities of daily living, b. Devices, controls or appliances that enable the client to perceive, control or communicate within the client's environment, c. Items necessary to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items, d. Durable and non-durable medical equipment not available under the Medicaid State Plan that is necessary to address client functional limitations, or e. Necessary medical supplies in excess of Medicaid State Plan limitations or not available under the Medicaid State Plan. f. All items shall meet applicable standards of manufacture, design and installation. g. Specialized medical equipment and supplies exclude those items that are not of direct medical or remedial benefit to the client.

Targeted Population	Participants with developmental disabilities age 18 and older who meet the ICF/IID Level of Care and who require 24/7 access to supervision
Waiver Manager Comment	Compare this SMES to the State Plan and consider moving any non State Plan covered items into the State Plan and eliminate this service (currently only incontinence wipes, hearing aids and batteries are utilized in this SMES in the DD Waiver)

Waiver	**HCBS- Supported Living Services Waiver (SPECIALIZED MEDICAL EQUIPMENT)**
Waiver Service Definition	Specialized Medical Equipment and supplies include: 1. Devices, controls, or appliances, specified in the Service Plan, that enable participant to increase their ability to perform activities of daily living; 2. Kitchen equipment required for the preparation of special diets if this results in a cost saving over prepared foods. 3. General care items such as distilled water for saline solutions, supplies such as specialized eating utensils, etc., required by a participant with a developmental disability and related to the disability. 4. Specially designed clothing (e.g. Velcro) for participant if the cost is over and above the costs generally incurred for a participant's clothing. 5. Maintenance and upkeep of the equipment Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation.
Service Limitations	NA
Rule	**10 CCR 2505-10 Section 8.500.94.A(13)** Specialized Medical Equipment and Supplies include: devices, controls, or appliances that are required due to the client's disability and that enable the client to increase the client's ability to perform activities of daily living or to safely remain in the home and community. Specialized medical equipment and supplies include: a. kitchen equipment required for the preparation of special diets if this results in a cost savings over prepared foods; b. specially designed clothing for a client if the cost is over and above the costs generally incurred for a client's clothing; c. maintenance and upkeep of specialized medical equipment purchased through the HCBS-SLS waiver. d. The following items are specifically excluded under the HCBS-SLS waiver and not eligible for reimbursement: i) Items that are not of direct medical or remedial benefit to the client are specifically excluded under the HCBS-SLS waiver and not eligible for reimbursement. These include but are not limited to; vitamins, food supplements, any food items, prescription or over the counter medications, topical ointments, exercise equipment, hot tubs, water walkers, resistance water therapy pools, experimental items or wipes for any purpose other incontinence.

Targeted Population	Persons aged 18 and older with a developmental disability who meet ICF/ID level of care
Waiver Manager Comment	**Recommendation: Changes to this service category.** 1. Change service name or delete service and move some necessary items into another service category: Name is inappropriate for the items in this category and very confusing. 2. Keep Kitchen equipment, specially designed clothing. 3. Remove all specialized medical equipment and supplies (as well as the name of the service category) as these items are related to medical condition and are available through the State Plan. 4. Incontinent wipes are the most common supply purchased through this category. Most of the supports and services in this category (not incontinent wipes) would be available to a client if the items are Medically necessary. Compare this service to the Assistive Technology Service in the SLS waiver and the equipment and supplies available in the State Plan to determine if this is a necessary service to continue.

Waiver	**HCBS-Children's Extensive Support Waiver (SPECIALIZED MEDICAL EQUIPMENT)**
Waiver Service Definition	Specialized Medical Equipment and supplies include: 1. Devices, controls, or appliances, specified in the service plan, that enable participant to increase their ability to perform activities of daily living; 2. Kitchen equipment required for the preparation of special diets if this results in a cost saving over prepared foods. 3. General care items such as distilled water for saline solutions, supplies such as specialized eating utensils, etc., required by a child with a developmental disability and related to the disability. 4. Specially designed clothing (e.g. Velcro) for participant if the cost is over and above the costs generally incurred for a participant's clothing. 5. Maintenance and upkeep of the equipment Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State plan, EPSDT and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation
Service Limitations	NA
Rule	**10 CCR 2505-10 Section 8.503.40.A(11)** Specialized Medical Equipment and Supplies include: devices, controls, or appliances that are required due to the client's disability and that enable the client to increase the client's ability to perform activities of daily living or to safely remain in the home and community. Specialized Medical Equipment and Supplies include:

	a. Kitchen equipment required for the preparation of special diets if this results in a cost savings over prepared foods; b. Specially designed clothing for a client if the cost is over and above the costs generally incurred for a client's clothing; c. Maintenance and upkeep of specialized medical equipment purchased through the HCBS-CES waiver. d. The following items are specifically excluded under the HCBS-CES waiver and not eligible for reimbursement: i) Items that are not of direct medical or remedial benefit to the client vitamins, food supplements, any food items, prescription or over the counter medications, topical ointments, exercise equipment, hot tubs, water walkers, resistance water therapy pools, experimental items or wipes for any purpose other incontinence.
Targeted Population	Clients ages birth up to 18th birthday Must have developmental delay (age 5 and under) or developmental disability Have a behavior or medical condition so intense it requires near constant line of sight supervision.
Waiver Manager Comment	Low to moderate use: FY PD claims unduplicated client count SME Equipment 22; SME supplies 139 with overall waiver unduplicated count 409 **Recommendation: Changes to this service category.** 5. Change service name or delete service and move some necessary items into another service category: Name is inappropriate for the items in this category and very confusing. 6. Keep Kitchen equipment, specially designed clothing. 7. Remove all specialized medical equipment and supplies (as well as the name of the service category) as these items are related to medical condition and are available through EPSDT portion of the state plan. 8. Incontinent wipes are the most common supply purchased through this category. Most of the supports and services in this category (not incontinent wipes) would be available to a child if the items are Medically necessary. See EPSDT definition of Medical Necessity below. (Waiver coordinator's emphasis in bold). 8.280 EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT [Eff. 10/01/2007] 8.280.1 DEFINITIONS Early and Periodic Screening, Diagnosis and Treatment (EPSDT) means the child health component of Medicaid. Early and Periodic Screening, Diagnosis and Treatment Case Management means an activity that assists Medicaid clients in getting and/or coordinating services based on individual need. EPSDT Outreach means methods to inform recipients or potential recipients, such as those found to be presumptively eligible, to enter into care. EPSDT Outreach and Case Management Entity means an entity that has contracted with the Department to provide the activities specified in 8.280.3 below.

	Medical necessity means that a covered service shall be deemed a medical necessity or medically necessary if, in a manner consistent with accepted standards of medical practice, it: 1. Is found to be an equally effective treatment among other less conservative or more costly treatment options, and 2. Meets at least one of the following criteria: a. The service will, or is reasonably expected to prevent or diagnose the onset of an illness, condition, primary disability, or secondary disability. b. The service will, or is **reasonably expected to** cure, correct, reduce or **ameliorate** the physical, mental **cognitive or developmental effects of** an illness, injury or **disability.** c. The service will, or is reasonably expected to reduce or ameliorate the pain or suffering caused by an illness, injury or disability. d. The service will, or is **reasonably expected** to assist the individual to **achieve or maintain** maximum functional capacity in **performing Activities of Daily Living.** Medical necessity may also be a course of treatment that includes mere observation or no treatment at all.

ASSISTIVE TECHNOLOGY SERVICE

Waiver	HCBS- Supported Living Services Waiver
Waiver Service Definition	Assistive technology device means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants. Assistive technology service means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device. Assistive technology includes: 1. The evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant; 2. Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices; 3. Training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and 4. Devices that help the participant to communicate such as electronic communication devices (excluding cell phones, pagers, and internet access unless prior authorized by the state); skill acquisition devices which are proven to be a cost effective and efficient means to meet the need and which make learning easier, such as adaptations to computers, or computer software related to the person's disability. Assistive technology devices and services are only available when the cost is above and beyond that of typical expenses and are not available through the Medicaid State Plan or third party resource.
Service Limitations	The total cost of home accessibility adaptations, vehicle modifications, and assistive technology may not exceed $10,000 over the life of the waiver except that on a case by case basis the DHS/DDD may approve a higher amount, to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home, or if it decreases the need for paid assistance in another waiver service on a long-term basis.
Rule	**10 CCR 2505-10 Section 8.500.94.A(1) Assisted Technology Service** 1. Assistive technology includes services, supports or devices that assist a client to increase maintain or improve functional capabilities. This may include assisting the client in the selection, acquisition, or use of an assistive technology device and includes: a. The evaluation of the assistive technology needs of a client, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the client in the customary environment of the client, b. Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices, c. Training or technical assistance for the client, or where appropriate, the family members, guardians, caregivers, advocates, or authorized representatives

	of the client, d. Warranties, repairs or maintenance on assistive technology devices purchased through the HCBS-SLS Waiver, and e. Adaptations to computers, or computer software related to the client's disability. This specifically excludes cell phones, pagers, and internet access unless prior authorized in accordance with the Operating Agency procedure. f. Assistive technology devices and services are only available when the cost is higher than typical expenses, and are limited to the most cost effective and efficient means to meet the need and are not available through the Medicaid state plan or third party resource. g. Assistive technology recommendations shall be based on an assessment provided by a qualified provider within the provider's scope of practice. h. When the expected cost is to exceed $2,500 per device three estimates shall be obtained and maintained in the case record. i. Training and technical assistance shall be time limited, goal specific and outcome focused. j. The following items and services are specifically excluded under HCBS-SLS waiver and not eligible for reimbursement: i) Purchase, training or maintenance of service animals, ii) Computers, iii) Items or devices that are generally considered to be entertainment in nature including but not limited to CDs, DVDs, iTunes®, any type of game, iv) Training or adaptation directly related to a school or home educational goal or curriculum. k. The total cost of home accessibility adaptations, vehicle modifications, and assistive technology shall not exceed $10,000 over the five year life of the waiver unless an exception is applied for and approved. Costs that exceed this limitation may be approved by the Operating Agency for devices to ensure the health and safety of the client or that enable the client to function with greater independence in the home, or if it decreases the need for paid assistance in another waiver service on a long-term basis. Requests for an exception shall be prior authorized in accordance with the Operating Agency's procedures within thirty (30) days of the request.
Targeted Population	Persons aged 18 and older with a developmental disability who meet ICF/ID level of care
Waiver Manager Comment	**Recommended changes:** 1. Remove "Devices that help the participant to communicate such as electronic communication devices" from waiver definition because communication devices are available through Medicaid state plan for children. Items in this category would be available to a client if the items are Medically necessary

Waiver	HCBS-Children's Extensive Support Waiver (ASSISTIVE TECHNOLOGY)
Waiver Service Definition	Assistive technology device means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants. Assistive technology service means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device. Assistive technology includes: 1. The evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant; 2. Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices; 3. Training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and 4. Devices that help the participant to communicate such as electronic communication devices (excluding cell phones, pagers, and internet access unless prior authorized by the state); skill acquisition devices which are proven to be a cost effective and efficient means to meet the need and which make learning easier, such as adaptations to computers, or computer software related to the person's disability. Assistive technology devices and services are only available when the cost is above and beyond that of typical expenses and are not available through the Medicaid State Plan or third party resource.
Service Limitations	The total cost of home accessibility adaptations, vehicle modifications, and assistive technology may not exceed $10,000 over the life of the waiver except that on a case by case basis the DHS/DDD may approve a higher amount, to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home, or if it decreases the need for paid assistance in another waiver service on a long-term basis.
Rule	**10 CCR 2505-10 Section 8.503.40 A(2) Assistive Technology** Assistive Technology includes services, supports or devices that assist a client to increase maintain or improve functional capabilities. This may include assisting the client in the selection, acquisition, or use of an assistive technology device and includes: a. The evaluation of the assistive technology needs of a client, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the client in the customary environment of the client, b Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices, c. Training or technical assistance for the client, or where appropriate, the family members, guardians, care-givers, advocates, or authorized representatives of the client, d. Warranties, repairs or maintenance on assistive technology devices purchased through the HCBS-CES waiver, and e. Adaptations to computers, or computer software related to the client's disability. This specifically excludes cell phones, pagers, and internet access unless prior authorized in accordance with the Operating Agency's procedures. f Assistive Technology devices and services are only available when the cost is higher than typical expenses, and are limited to the most cost effective and efficient means to meet the need and are not available through the Medicaid State Plan or third party resource.

	g Assistive Technology recommendations shall be based on an assessment provided by a qualified provider within the provider's scope of practice. h When the expected cost is to exceed two thousand five hundred (2,500) dollars per device three estimates shall be obtained and maintained in the case record. i. Training and technical assistance shall be time limited, goal specific and outcome focused. j The following items and services are specifically excluded under HCBS-CES waiver and not eligible for reimbursement: i. Purchase, training or maintenance of service animals, ii. Computers, iii. In home installed video monitoring equipment, iv. Medication reminders, v. Hearing aids, vi Items or devices that are generally considered to be entertainment in nature including but not limited to CDs, DVDs, iTunes®, any type of games , vii. training, or adaptation directly related to a school or home educational goal or curriculum; or viii. items considered as typical toys for children. k. The total cost of Home Accessibility Adaptations, Vehicle Modifications, and Assistive Technology shall not exceed ten thousand (10,000) dollars over the five (5) year life of the HCBS-CES waiver without an exception granted by the Operating Agency. Costs that exceed this limitation may be approved for services, items or devices to ensure the health and safety of the client or that enable the client to function with greater independence in the home, or decrease the need for paid assistance in another HCBS-CES waiver service on a long-term basis. Requests for an exception shall be prior authorized in accordance with the Operating Agency's procedures. : i. The Operating Agency shall respond to exception requests within thirty (30) days of receipt.
Targeted Population	Clients ages birth up to 18th birthday Must have developmental delay (age 5 and under) or developmental disability Have a behavior or medical condition so intense it requires near constant line of sight supervision.
Waiver Manager Comment	Relatively low utilization (FY 12 PD claims 48 unduplicated consumers) because most items in this category are available through Medicaid state plan. **Recommendation: Changes needed to this service category** 1. Issues with this service category are similar to issues identified in Personal Care and Specialized Medical Equipment and Supplies; services are redundant with Medicaid State Plan. 2. Service assist the client with maintaining technological devices. For example: even though the waiver does not pay for a computer, it does pay for software and applications. This service assists the client to understand how to load and maintain the software needed to operate a communication software or application.

Recommended changes:

2. Remove "Devices that help the participant to communicate such as electronic communication devices" from waiver definition because communication devices are available through Medicaid state plan for children.
3. Remove or modify language "Assistive Technology devices and services are only available when the cost is higher than typical expenses", after all, what is typical about assistive technology?

Items in this category would be available to a child if the items are Medically necessary. See EPSDT definition of Medical Necessity below. (Waiver coordinator's emphasis in bold).

8.280 EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT [Eff. 10/01/2007]

8.280.1 DEFINITIONS

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) means the child health component of Medicaid.

Early and Periodic Screening, Diagnosis and Treatment Case Management means an activity that assists Medicaid clients in getting and/or coordinating services based on individual need.

EPSDT Outreach means methods to inform recipients or potential recipients, such as those found to be presumptively eligible, to enter into care.

EPSDT Outreach and Case Management Entity means an entity that has contracted with the Department to provide the activities specified in 8.280.3 below.

Medical necessity means that a covered service shall be deemed a medical necessity or medically necessary if, in a manner consistent with accepted standards of medical practice, it:

1. Is found to be an equally effective treatment among other less conservative or more costly treatment options, and
2. Meets at least one of the following criteria:
   a. The service will, or is reasonably expected to prevent or diagnose the onset of an illness, condition, primary disability, or secondary disability.
   b. The service will, or is **reasonably expected to** cure, correct, reduce or **ameliorate** the physical, mental **cognitive or developmental effects of** an illness, injury or **disability.**
   c. The service will, or is reasonably expected to reduce or ameliorate the pain or suffering caused by an illness, injury or disability.
   d. The service will, or is **reasonably expected** to assist the individual to **achieve or maintain** maximum functional capacity in **performing Activities of Daily Living.**

Medical necessity may also be a course of treatment that includes mere observation or no treatment at all.

MENTAL HEALTH COUNSELING SERVICES

Waiver	**HCBS- for Persons with Brain Injury Waiver**
Waiver Service Definition	Mental Health Counseling services are designed to assist the client in managing and overcoming as effectively as possible the difficulties and stresses confronted after brain injury. As a benefit of the HCBS-BI Waiver, Mental Health Counseling expands mental health services offered under the Medicaid State Plan by serving a population that is not limited to the diagnosis or treatment of a covered mental health disorder and by allowing more than 35 visits per state fiscal year. Whenever possible, the client will first access Mental Health Counseling services under the Medicaid State Plan. Counseling includes services for families of individuals served by this waiver. For purposes of this service "family" is defined as persons who live with or provide care to a recipient of waiver services, and may include a parent, spouse, child, relative, foster family or in-laws. "Family" does not include individuals who are employed to care for recipient except where a family member may be providing personal care and receiving compensation. All individual, group and family counseling shall be included in the individual's written plan of care.
Service Limitations	NA
Rule	**10 CCR 2505-10 Section 8.516.50** COUNSELING A. DEFINITIONS Counseling services mean individualized services designed to assist the participants and their support systems to more effectively manage and overcome the difficulties and stresses confronted by people with brain injuries. B. INCLUSIONS 1. Counseling is available to the program participant's family in conjunction with the client if they: a) have a significant role in supporting the client or b) live with or provide care to the client. "Family" includes a parent, spouse, child, relative, foster family, in-laws or other person who may have significant ongoing interaction with the waiver participant. 2. Services may be provided in the waiver participant's residence, in community settings, or in the provider's office. 3. Intervention may be provided in either a group or individual setting: however, charges for group and individual therapy shall reflect differences. 4. All counseling services must be documented in the plan of care and must be provided by individuals or agencies approved as providers of waiver services by the Department of Health Care Policy and Financing as directed by certification standards listed below. 5. Family training is considered an integral part of the continuity of care in transition to home and community environments. Services are directed towards instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates as may be necessary to safely maintain the individual at home. 6. Prior authorization is required after thirty visits of individual, group, family or combination of modalities have been provided. Re-authorization is

	submitted to the State Brain Injury Program Coordinator. C. EXCLUSIONS 1. Family training is not available to individuals who are employed to care for the recipient. 2. Family training/counseling must be carried out in the presence of and for the direct benefit of the client of the HCBS-BI program. D. CERTIFICATION STANDARDS 1. Professionals providing counseling services must hold the appropriate license or certification for their discipline according to stale law or federal regulations and represent one of the following professional categories: Licensed Clinical Social Worker. Certified Rehabilitation Counselor. Licensed Professional Counselor, or Licensed Clinical Psychologist. 2. All professionals applying as providers of counseling services must demonstrate or document a minimum of two years experience in providing counseling to individuals with brain injury and their families. 3. Master's or doctoral level counselors who meet experiential and educational requirements but lack certification or credentialing as stated above, may submit their professional qualifications via curriculum vitae or resume for consideration. E. REIMBURSEMENT Reimbursement will be on an hourly basis per modality as established by the Department. There are three separate modalities allowable under HCBS-BI counseling services including Family Counseling (if the individual is present) Individual Counseling, and Group Counseling.
Targeted Population	Persons 16 years of age and older with a brain injury sustained before the age of 65 who meet the hospital, nursing facility or ICF/ID level of care.
Waiver Manager Comment	Service is not always implemented as outlined above. May consider offering it as an extended state plan benefit in an effort to streamline services offered through the local mental health centers and the waiver.

PARENT EDUCATION

Waiver	HCBS-Children's Extensive Support Waiver
Waiver Service Definition	Consultation and direct service costs for training parents and other care providers in techniques to assist in caring for the participant's needs, including sign language training. Acquisition of information, specific to the participant's disability, for family members from support organizations and special resource materials, cost of registration for parents/caregivers to attend conferences/educational workshops that are specific to the participant's disability, cost of membership to parent support/information organizations and publications designed for parents of children with disabilities.
Service Limitations	The maximum annual allowance for Parent Education is $1,000.00 per year
Rule	**10 CCR 2505-10 Section 8.503.40.A(7)** Parent Education provides unique opportunities for parents or other care givers to learn how to support the child's strengths within the context of the child's disability and enhances the parent's ability to meet the special needs of the child. Parent Education includes: a. Consultation and direct service costs for training parents and other care givers in techniques to assist in caring for the client's needs, including sign language training, b. Special resource materials, c. Cost of registration for parents or caregivers to attend conferences or educational workshops that are specific to the client's disability, d. Cost of membership to parent support or information organizations and publications designed for parents of children with disabilities. e. The maximum service limit for parent education is one thousand (1,000) units per service plan year. f. The following items are specifically excluded under the HCBS-CES waiver and not eligible for reimbursement: i) Transportation, ii) Lodging, iii). Food, or iv). Membership to any political organizations or any organization involved in lobby activities.
Targeted Population	Clients ages birth up to 18th birthday

	Must have developmental delay (age 5 and under) or developmental disability Have a behavior or medical condition so intense it requires near constant line of sight supervision.
Waiver Manager Comment	Low use: FY PD claims unduplicated client count 24; overall waiver unduplicated count 409 **Recommendation: Remove this service due to:** 1. Service it is outdated. This service was developed prior to the internet. With the internet families can now access information about their child's specific diagnosis. 2. Most conferences offer scholarships for parents who cannot afford the registration fee.

PERSONALIZED EMERGENCY RESPONSE SYSTEM (PERS)

Waiver	**HCBS-Elderly, Blind and Disabled Waiver**
Waiver Service Definition	PERS is an electronic device, which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. Monitoring of the device is included in the PERS service. The response center is staffed by trained professionals.
Service Limitations	PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time and who would otherwise require routine supervision.
Rule	**10 CCR 2505-10 Section 8.488** ELECTRONIC MONITORING 8.488.10 DEFINITIONS .11 Electronic monitoring services means the installation purchase or rental of electronic monitoring devices which: A. enable the individual to secure help in the event of an emergency; B. may be used to provide reminders to the individual of medical appointments, treatments, or medication schedules; C. are required because of the individual's illness, impairment or disability, as documented on the ULTC-100 form and the care plan form; and D. are essential to prevent institutionalization of the individual. .12 Electronic monitoring provider means a provider agency as defined at Section 8.484.50,Q, GENERAL DEFINITIONS, which has met all the certification standards for electronic monitoring services specified below. 8.488.20 INCLUSIONS .21 Electronic monitoring services shall include personal emergency response systems, medication reminders, or other devices which comply with the definition above and are not included in the non-benefit items below at 8.488.31. 8.488.30 EXCLUSIONS, RESTRICTIONS AND NON-BENEFIT ITEMS .31 Electronic monitoring services shall be authorized only for individuals who live alone, or who are alone for significant parts of the day, or whose only companion for significant parts of the day is too impaired to assist in an emergency, and who would otherwise require extensive supervision. .32 Electronic monitoring services shall be authorized only for individuals who have the physical and mental capacity to utilize the particular system requested for that individual. .33 Electronic monitoring services shall not be authorized under HCBS if the service or device is available as a regular Medicaid benefit .34 The following are not benefits of electronic monitoring services:

	A. Augmentative communication devices and communication boards; B. Hearing aids and accessories; C. Phonic ears; D. Environmental control units, unless required for me medical safety of a client living alone unatended; E. Computers and computer software; F. Wheelchair lifts for automobiles or vans; G. Exercise equipment, such as exercise cycles; H. Hot tubs, Jacuzzis, or similar items. CERTIFICATION STANDARDS FOR ELECTRONIC MONITORING SERVICES .41 Electronic monitoring providers shall conform to all general certification standards and procedures at Section 8.487, HCBS-EBD PROVIDER AGENCIES. .42 In addition, electronic monitoring providers shall conform to the following standards for electronic monitoring services: A. All equipment, materials or appliances used as part of the electronic monitoring service shall carry a UL (Underwriter's Laboratory) number or an equivalent standard. All telecommunications equipment shall be FCC registered B. All equipment, materials or appliances shall be installed by properly trained individuals, and the installer shall train the client in the use of the device. C. All equipment, materials or appliances shall be tested for proper for functioning at the time of installation and at periodic intervals thereafter. Any malfunction shall be promptly repaired and equipment shall be replaced when necessary, including buttons and batteries. D. All telephone calls generated by electronic monitoring equipment shall be toll-free and all clients shall be allowed to run unrestricted tests on their equipment E. Electronic monitoring providers shall send written information to each client's case manager about the system, how it works, and how it will be maintained 8.488.50 REIMBURSEMENT METHOD FOR ELECTRONIC MONITORING .51 Payment for electronic monitoring services shall be the lower of the billed charges or the prior authorized amount The unit of reimbursement shall be one unit per service for non-recurring services, or one unit per month for services recurring monthly. .52 Effective 2/1/99, there shall be no reimbursement under this section for electronic monitoring services provided in uncertified congregate facilities
Targeted Population	To allow increased independence and safety for elderly persons or persons with disabilities, to ensure they have access to assistance and emergency services if needed. Adults 18-64 with physical disabilities and seniors 65+ with functional deficits, who meet nursing facility level of care
Waiver Manager Comment	This is a good service that is working well. This is a very popular service.

Waiver	HCBS-Persons Living with Aids (PERS)
Waiver Service Definition	Same as EBD Waiver
Service Limitations	Same as EBD Waiver
Rule	Same as EBD Waiver; **10 CCR 2505-10 Section 8.488** ELECTRONIC MONITORING
Targeted Population	Persons of any age with a diagnosis of HIV/AIDs who require a nursing facility or hospital level of care.
Waiver Manager Comment	This is a good service that is working well. This is a very popular service.

Waiver	HCBS- Community Mental Health Supports Waiver (PERS)
Waiver Service Definition	Same as EBD Waiver
Service Limitations	Same as EBD Waiver
Rule	Same as EBD Waiver; **10 CCR 2505-10 Section 8.488** ELECTRONIC MONITORING
Targeted Population	Persons 18 years and older with a major mental illness who meet nursing facility level of care
Waiver Manager Comment	This service has a moderate utilization with a total of 451 people receiving this service. Generally, this service appears to be working well and there have been no visible complaints surrounding it for the clients on the CMHS waiver.

Waiver	HCBS- for Persons with Brain Injury Waiver (PERS)
Waiver Service	Same as EBD Waiver

Definition	
Service Limitations	Same as EBD Waiver
Rule	Same as EBD Waiver; **10 CCR 2505-10 Section 8.488** ELECTRONIC MONITORING
Targeted Population	Persons 16 years of age and older with a brain injury sustained before the age of 65 who meet the hospital, nursing facility or ICF/ID level of care.
Waiver Manager Comment	There have been no complaints regarding this service and generally it seems to be implemented in accordance with rule.

Waiver	**HCBS-for Persons with Spinal Cord Injury (PERS)**
Waiver Service Definition	Same as EBD Waiver
Service Limitations	Same as EBD Waiver
Rule	Same as EBD Waiver; **10 CCR 2505-10 Section 8.488** ELECTRONIC MONITORING
Targeted Population	Persons 18 years and older with a spinal cord injury who meet nursing facility level of care.
Waiver Manager Comment	This waiver has just been implemented and there isn't adequate data to assess whether this service is utilized for this target population.

Waiver	**HCBS- Supported Living Services Waiver (PERS)**
Waiver Service Definition	PERS is an electronic device that enables waiver participants to secure help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is connected to the participant's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. The participant and their case manager develop a protocol for identifying who is to be contacted if/when the system is activated.
Service Limitations	NA
Rule	**10 CCR 2505-10 Section 8.500.94.A(9)**

	Personal Emergency Response System (PERS) is an electronic device that enables clients to secure help in an emergency. The client may also wear a portable "help" button to allow for mobility. The system is connected to the client's phone and programmed to a signal a response center once a "help" button is activated. The response center is staffed by trained professionals. a. The client and the client's case manager shall develop a protocol for identifying who should to be contacted if the system is activated.
Targeted Population	Persons aged 18 and older with a developmental disability who meet ICF/ID level of care
Waiver Manager Comment	Continue to provide this service as is currently in the SLS waiver

COMMUNITY TRANSITIONAL SERVICES

Waiver	**HCBS-Elderly, Blind and Disabled Waiver**
Waiver Service Definition	Services that are provided by a Transition Coordination Agency and include items essential to move a client from a nursing facility and establish community-based residence. Community transition services include the cost of navigation, security and utility deposits, moving expenses, one-time pest eradication, one-time cleaning expenses, and essential household furnishings such as beds, linens, utensils, pots and pans, and dishes. Items for entertainment and convenience are not included.
Service Limitations	CTS shall not exceed $2,000.00 per eligible client, unless otherwise authorized by the Department.
Rule	**10 CCR 2505-10 Section 8.553** COMMUNITY TRANSITION SERVICES 8.553.1 DEFINITIONS Authorization Request means a request submitted by the Transition Coordination Agency to the Single Entry Point agency to authorize payment for delivery of Community Transition Services. Community Transition Services (CTS) means activities essential to move a client from a skilled nursing facility and establish a community-based residence. Independent Living Core Services means information and referral services; independent living skills training; peer counseling, including cross-disability peer counseling; and individual and systems advocacy. Transition Coordinator means a person employed by a Transition Coordination Agency to provide Transitional Case Management. Transition Coordination Agency (TCA) means an agency that is certified by the Department to provide CTS and provides at least two Independent Living Core Services. Transitional Case Management means case management exclusively supporting a client's transition from a skilled nursing facility to a community-based residence. 8.553.2 BENEFITS 8.553.2.A. CTS shall only be available to clients currently residing in a skilled nursing facility who are eligible for the Home and Community Based Services for the Elderly, Blind and Disabled (HCBS-EBD) waiver. 8.553.2.B. CTS shall only be for the benefit of the client and may include the following: 1. Transitional Case Management. 2. Payment made for the following: a. Security deposits that are required to obtain a lease on a residence.

	b. Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water. c. Essential household items and furnishings such as a bed, linens, seating, lighting, dishes, utensils and food preparation items. d. Moving expenses required to occupy a community-based residence. e. Health and safety assurances including a one-time pest eradication and a one-time cleaning prior to occupancy. f. A one-time purchase of food not to exceed $100. 8.553.2.C. The cost of CTS shall not exceed $2,000 per client unless otherwise authorized by the Department. 8.553.2.D. Items purchased through CTS shall be the property of the client. The client may take the property with him or her in the event of a move to another residence. 8.553.3 NON-BENEFITS 8.553.3.A. CTS shall not include the following: 1. Monthly rental expenses or other ongoing periodic residential expenses. 2. Recreation, entertainment or convenience items. 3. Items as described in 8.553.2.B.2 when already provided through other means. 4. Items as described in 8.553.2.B.2 when provided for the benefit of persons other than the client. 8.553.4 TCA QUALIFICATIONS 8.553.4.A. A TCA shall conform to all certification standards and procedures described in 10 C.C.R. 2505-10, Section 8.487, HCBS-EBD Provider Agencies. 8.553.4.B. A TCA shall meet all requirements as set forth in 8.553.5. 8.553.5 TCA RESPONSIBILITIES 8.553.5.A. TCAs shall administer the CTS benefit. 8.553.5.B. The TCA shall perform administrative functions, including ensuring timely reporting, on-site visits to clients, community coordination and outreach and client monitoring. 8.553.5.C. Staffing Requirements 1. The TCA shall document that each Transition Coordinator has received 20 hours of training or passed a Department-approved skills validation test in transition coordination knowledge and skills. The Transition Coordinator training or skills validation test shall include, but not be limited to: a. Knowledge of populations served by the TCA and the target population served by the HCBS-EBD waiver. b. Client interviewing and assessment skills. c. Intervention and interpersonal communication skills.

	d. Knowledge of available community resources and public assistance programs. e. Transition plan development. 2. The TCA supervisor(s), at a minimum, shall meet all qualifications for a Transition Coordinator. Supervision shall include, but not be limited to, the following activities: a. Arrangement and documentation of training or skills validation testing. b. Assessment of client's satisfaction with services. c. Investigation of complaints. d. Counseling with staff on difficult cases. e. Oversight of record keeping by staff. 3. Training and skills validation shall be completed prior to the delivery of CTS. 8.553.5.D. The Transition Coordinator shall administer a Department-approved assessment to determine the client's needs for housing, services and items necessary to establish a community-based residence. 8.553.5.E. The Transition Coordinator shall work with the client to create and implement a transition plan agreed upon by the Transition Coordinator and the client. The Transition Coordinator and the client shall sign the transition plan to signify agreement. 1. The Transition Coordinator shall submit the signed transition plan to the client's Single Entry Point (SEP) case manager for approval prior to plan implementation. 2. The plan shall include the items needed for the client to transition to a community-based residence. If after the plan has been approved the Transition Coordinator determines additional purchases are required, the Transition Coordinator shall submit a plan revision for approval prior to the purchases. 8.553.5.F. The Transition Coordinator shall work with the client to obtain a residence and any items necessary to establish a community-based residence. 8.553.5.G. The Transition Coordinator shall conduct a minimum of four on-site visits of the residence to ensure all essential furnishings, utilities, community resources and services are in place. If the Transition Coordinator finds any of the supports to be insufficient for the client to successfully live in the community, the Transition Coordinator shall correct the deficiencies. The on-site visits shall occur at the following intervals: 1. Prior to the client's discharge from the skilled nursing facility. a. If possible, the client shall accompany the Transition Coordinator during the on-site visit prior to discharge. If the client is unable to participate in the on-site visit, the Transition Coordinator shall document the reason in the client's file. 2. The day of the move. 3. One week after the transition to ensure the client has the proper supports to continue successfully living in the community. 4. One month after the transition to ensure the client has the proper supports to continue successfully living in the community. 8.553.6 SINGLE ENTRY POINT AGENCY RESPONSIBILITIES

	8.553.6.A. The SEP case manager shall perform a review to assure all items in the transition plan meet the criteria of the benefit described in 8.553.2. 1. The SEP case manager shall complete a review of the transition plan and shall notify the TCA of approval or denial of the plan within ten business days of receipt. 8.553.7 AUTHORIZATION REQUESTS 8.553.7.A. The TCA shall submit the Department prescribed Authorization Request (AR) form to the SEP case manager to authorize payment for CTS. 1. The TCA shall only submit the AR to authorize payment for any purchases or deposits after the client transitions to the community. The AR shall include a Department-approved cost report including copies of cancelled checks and copies of receipts detailing the items purchased and the cost. a. Any expenses submitted on the cost report for items that are not included in the approved transition plan shall be considered non-allowable expenses and shall not be reimbursed. b. The SEP case manager shall complete a review of the AR and the cost report and shall notify the TCA of approval or denial of the AR and if applicable, any non-allowable expenses on the cost report within ten business days of receipt. 2. The TCA shall only submit the AR for Transitional Case Management once the Transition Coordinator has conducted the on-site visit one month after the client's transition. a. The SEP case manager shall approve the AR only after verifying that the client is established in a community-based residence. b. The SEP case manager shall complete a review of the AR and shall notify the TCA of approval or denial within ten business days of receipt. 8.553.7.B. The SEP case manager shall complete a review of the AR and the cost report within ten business days of receipt. The SEP case manager shall notify the TCA of approval of the AR and if applicable, any non-allowable expenses on the cost report. 1. Approval of the AR by the SEP case manager shall authorize the TCA to submit claims to the Department's fiscal agent for authorized CTS provided during the authorized period. Payment of claims is conditional upon the client's financial eligibility on the dates of service and the TCA's use of correct billing procedures. 8.553.7.C. Incomplete ARs shall be returned to the TCA for correction within ten business days of receipt by the SEP agency. 8.553.8 REIMBURSEMENT 8.553.8.A. The TCA shall conform to all reimbursement procedures described in 10 C.C.R. 2505-10, Section 8.487.200 Provider Reimbursement. 8.553.8.B. Payment for CTS shall be the lower of the billed charges or the maximum rate of reimbursement. 8.553.8.C. The cost of Transitional Case Management shall be reimbursed by one unit of service completed when the client is established in a community-based residence as verified by the SEP case manager. 8.553.8.D. Reimbursement shall be made only for items listed on the transition plan with an accompanying receipt.
Waiver Manager Comment	Generally, service appears to be rendered in accordance with rule.

ADAPTED THERAPEUTIC RECREATIONAL EQUIPMENT AND FEES

Waiver	HCBS-Children's Extensive Support Waiver
Waiver Service Definition	Recreational equipment that is adapted specific to the participant's disability and not those items that a typical age peer would commonly need as a recreation item, the cost of recreation shall be above and beyond what is typically expected for recreation and recommended by a doctor or therapist; adaptive bicycle, adaptive stroller, adaptive toys, floatation collar for swimming, various types of balls with internal auditory devices and other types of adapted equipment appropriate for the recreational needs of a child with a developmental disability. Recreational activities including passes to community recreation centers when used to access professional services. Water Safety Training is allowed. Recreational passes shall be purchased in the most cost effective manner(i.e. day passes or monthly passes.) Specifically excluded are tickets for zoos, museums, butterfly pavilion, movie, theater, concerts, professional and minor league sporting events and indoor/outdoor play structures.
Service Limitations	The maximum annual allowance for recreational items/services is $1,000.00 per plan year.
Rule	**10 CCR 2505-10 Section 8.503.40 A(1) Adaptive Therapeutic Recreational Equipment and Fees** Adaptive Therapeutic Recreational Equipment and Fees are services which assist a client to recreate within the client's community. These services include recreational equipment that is adapted specific to the client's disability and not those items that a typical age peer would commonly need as a recreation item. a. The cost of item shall be above and beyond what is typically expected for recreation and recommended by a doctor or therapist. b. Adaptive recreational equipment may include adaptive bicycle, adaptive stroller, adaptive toys, floatation collar for swimming, various types of balls with internal auditory devices and other types of equipment appropriate for the recreational needs of a client with a developmental disability. c. A pass for admission to recreation centers for the client only when the pass is needed to access a professional service or to achieve or maintain a specific therapy goal as recommended and supervised by a doctor or therapist. Recreation passes shall be purchased as day passes or monthly passes, whichever is the most cost effective. d. Adaptive therapeutic recreation fees include those for water safety training. e The following items are specifically excluded under HCBS-CES waiver and not eligible for reimbursement:

	i. Entrance fees for zoos, i.) Museums, ii.) Butterfly pavilion, iii.) Movie, theater, concerts, iv.) Professional and minor league sporting events, v.) Outdoors play structures, vi. Batteries for recreational items; and, vii. Passes for family admission to recreation centers. f. The maximum annual allowance for adaptive therapeutic recreational equipment and fees is one thousand (1,000.00) dollars per service plan year.
Targeted Population	Clients ages birth up to 18th birthday Must have developmental delay (age 5 and under) or developmental disability Have a behavior or medical condition so intense it requires near constant line of sight supervision.
Waiver Manager Comment	Low use: FY PD claims unduplicated client count Equipment 23 and Fees 27 with overall waiver unduplicated count 409 This service is available for three reasons: 1. To purchase recreation equipment that is adapted specific to the child's disability. 2. To pay fees to a recreations center if the child needs admission to access a therapy (Watsu, PT, OT, etc.) 3. Water safety training. Utilization is relative low in both categories (FY 12 PD claims: Equipment 23 clients accessed: Fees 27 clients accessed) **Recommendation: Remove service category due to:** 1. Low utilization. 2. Typically used for "adapted" equipment related to a bicycle. 3. Fees are typically used for Water Safety Training i.e. swim lessons.

ALTERNATIVE CARE FACILITY

Waiver	HCBS-Elderly, Blind and Disabled Waiver
Waiver Service Definition	Alternative care facilities (ACF) shall provide safe, cost effective services in a home like setting. ACF services include twenty-four hour residential care support services, adequate sleeping and living areas, adequate recreational areas and opportunities, assistance with the arrangement of transportation when needed, protective oversight and social recreational services. Alternative care services means personal care such as assistance with eating, bathing, dressing, personal hygiene, activities of daily living, and homemaker services consisting of general household activities. Protective oversight means guidance of a resident who may travel independently in the community; monitoring the activities of the resident while on the premises to assure the health, safety, and well being of the residents including monitoring of prescribed medications, reminding the resident to carry out activities of daily living, and reminding the resident to carry out any important activities, including appointments. Room and Board is not part of the service package and must be paid by residents from their own funds.
Service Limitations	Alternative care facilities offered in this waiver are limited based on the client's assessed need for services, and prior authorization by case managers up to the cost containment parameters. Clients choosing to live in an alternative care facility shall have no duplication of these services by a Personal Care agency, Homemaker agency, IHSS agency or by CDASS.
Rule	**10 CCR 2505-10 Section 8.495** ALTERNATIVE CARE FACILITIES [Eff. 03/30/2009] 8.495.1 DEFINITIONS Alternative Care Facility (ACF) as defined in 25.5-6-303 (3) C.R.S. (2008) means an Assisted Living Residence as defined at 6 C.C.R. 1011-1, Chapter VII, Section 1.102, licensed by the Colorado Department of Public Health and Environment, pursuant to certification by the Department to provide Alternative Care Services and Protective Oversight to Medicaid clients. Alternative Care Services as defined in 25.5-6-303 (4) C.R.S. (2008) means, but is not limited to, a package of personal care and homemaker services provided in a state-certified alternative care facility including: assistance with bathing, skin, hair, nail and mouth care, shaving, dressing, feeding, ambulation, transfers, and positioning, bladder & bowel care, medication reminding, accompanying, routine housecleaning, meal preparation, bed making, laundry and shopping. Life Skills Training means services designed and directed at the development and maintenance of the resident's ability to independently sustain himself/herself physically, emotionally, and economically in the community. Medication Administration as defined in 25-1.5-301 C.R.S. (2008) means assisting a person in the ingestion, application, inhalation, or, using universal precautions, rectal or vaginal insertion of medication, including prescription drugs, according to the legibly written or printed directions of the attending physician or other authorized practitioner or as written on the prescription label and making a written record thereof with regard to each medication administered, including the time and the amount taken, but "administration" does not include judgment, evaluation, or assessments or the injections of medication, the monitoring of medication, or the self-administration of medication, including prescription drugs and including the self-injection of medication by the resident. Non-Medical Leave Days mean days of leave from the ACF by the client for non-medical reasons such as family visits or field trips. Programmatic Leave Days mean days of leave prescribed for a Medicaid client by a physician for therapeutic and/or rehabilitative purposes.

	Protective Oversight means guidance to a resident as defined at 6 C.C.R. 1011-1, Chapter VII, Section 1.102.(32) It is the monitoring and guidance of a resident to assure his/her health, safety, and well being. Protective oversight includes, but is not limited to: monitoring the resident while on the premises, monitoring ingestion and reactions to prescribed medications, if appropriate, reminding the resident to carry out activities of daily living, and facilitating medical and other health appointments. Protective oversight includes the resident choice and ability to travel and engage independently in the wider community, and guidance on safe behavior while outside the ACF. Provider means the entity that holds the Assisted Living Residence / Facility license and that shall be responsible or delegate responsibility to appropriate staff for the delivery of Alternative Care Services. Secured Environment means an ACF that operates as defined in 6 C.C.R. 1011-1, Chapter VII, Section 1.108. 8.495.2 CLIENT ELIGIBILITY 8.495.2. A. Clients who are participating in the Home and Community Based Services (HCBS) Elderly Blind and Disabled waiver pursuant to 10 C.C.R. 2505-10, Section 8.485 or the HCBS Mental Illness waiver pursuant to 10 C.C.R. 2505-10, Section 8.509 are eligible to receive Alternative Care Services. 8.495.2. B. Potential clients shall be assessed by a team which includes the client and his/her family and/or guardian, the ACF administrator or appointed representative, Single Entry Point (SEP) case manager, as appropriate case managers and other care givers, to determine that the ACF is an appropriate community setting that will meet the individual's choice and need for independence and community integration. 1. The assessment will be conducted prior to admission, annually and whenever there is a significant change in physical, medical or mental condition or behavior. The assessment will document that the facility is able to support the client and their needs. 2. The assessment will document physical, cognitive, behavioral and social care needs. 8.495.3 CLIENT BENEFITS 8.495.3. A. Alternative Care Services which include, but are not limited to, personal care and homemaker services pursuant to 10 C.C.R. 2505-10, Sections 8.489 and 8.490, are benefits to clients residing in an ACF. 1. Medication Administration is an Alternative Care Service included in the reimbursement rate for Alternative Care Services and shall not be additionally reimbursed or billed in any other manner. 8.495.3. B. Room and board shall not be a benefit of ACF services. Clients shall be responsible for room and board in an amount not to exceed the Department annually established rate. 8.495.4 CLIENT RIGHTS 8.495.4. A. An ACF shall foster the independence of the client while promoting each client's individuality, choice of care and lifestyle. 1. The client's choice to live in an ACF shall afford the client the opportunity to responsibly contribute to the home in meaningful ways and shall avoid reducing personal choice and initiative. The client's individual behaviors shall not negatively impact the harmony of the ACF. 8.495.4. B. Clients shall be informed of their rights. Pursuant to 6 C.C.R. 1011-1, Chapter VII, Section 104 (5) (e) (ii), the policy on resident rights shall be posted in a conspicuous place. 8.495.4. C. Clients shall be informed of all ACF rules and/or policies. Rules and/or policies shall apply consistently to the administrator, staff, volunteers, and as appropriate, to clients residing in the facility and their family or friends who visit.

	8.495.4. D. Clients shall be informed of the facility's policy regarding the implementation of an individual's advance directives, should the need arise. 8.495.4. E. Clients shall be allowed to decorate and use personal furnishings in their bedrooms in accordance with house rules while maintaining a safe and sanitary environment at all times. 1. If requested by the client, the ACF shall provide bedroom furnishings, including but not limited to a bed, bed and bath linens, a lamp, chair and dresser and a way to secure personal articles. 8.495.4. F. As documented in the admission assessment (8.495.2.B), the provider will accommodate roommate choices within reason. 8.495.4. G. Clients and their roommates determined capable to control access to private personal quarters, shall be allowed to lock their doors and control access to their quarters. 8.495.4. H. Clients shall have unscheduled access to food and food preparation areas if determined capable to appropriately handle cooking activities. 8.495.4. I. Providers shall not require a Medicaid client to participate in performing household or other tasks unless such tasks have been outlined in the client's individual care plan as necessary Life Skills Training. 8.495.4. J. Clients shall have the right to possess and self-administer medications with a physician's written order, as appropriate. 8.495.5 PROVIDER ELIGIBILITY 8.495.5. A. The Provider shall be licensed in accordance with 6 C.C.R. 1011-1, Chapter VII. 8.495.5. B. Certification Standards for ACFs 1. The Provider shall be Medicaid certified by the Department as an ACF in accordance with 10 C.C.R., Volume 8. 2. Administrators as defined at 6 C.C.R. 1011-1, Chapter VII, Section 1.102 shall satisfactorily complete the Department authorized training on ACF rules and regulations prior to Medicaid certification. 3. ACF Providers shall maintain any license, permit, certification, insurance or bond as required by state or local authority. 4. Provisional certification may be granted at the discretion of the Department for up to 60 days. 5. Certification shall be denied when a Provider is unable to meet, or adequately correct licensure and/or certification standards as defined at 6 C.C.R. 1011-1, Chapter VII, Section 1.102 and detailed at 6 C.C.R. 1011-1, Chapter VII, Section 1.103.; 10 C.C.R. 2505-10, Section 8.495. 8.495.5. C. The Provider shall enter into a Provider Agreement with the Department. 8.495.5. D. Notification to the Department of Significant ACF Change 1. Suspension, Revocation or Termination a. ACF Providers shall notify the Department within five working days when any required license, permit, certification, insurance or bond has a change in status, including any suspension, revocation or termination. 2. Change of Ownership. a. Providers shall provide written notice to the Department of intent to change ownership no later than 30 days before the sale of the facility.

	i) The new owner shall meet all licensing, certification or approval processes and shall not automatically become a Medicaid Provider. 3. The Department may terminate or not renew the Provider Agreement if a Provider is in violation of any applicable standards or regulations. 8.495.6 PROVIDER RESPONSIBILITIES 8.495.6. A. All documentation, including but not limited to individual resident agreements and care plans, employee files, activity schedules, licenses, insurance policies, claim submission documents and program and financial records, shall be maintained according to 10 C.C.R. 2505-10, Section 8.130 and provided to supervisor(s), program monitor(s) and auditors(s) upon request. 8.495.6.B Using the State approved Critical Incident Reporting Form, Providers shall notify the client's Single Entry Point (SEP) case manager within 24 hours of any incident or situation that would be communicated to other interested parties. 8.495.6. C. Providers shall notify the client's SEP case manager of any client planned or unplanned non-medical and/or programmatic leave for greater than 24 hours. 1. The therapeutic and/or rehabilitative purpose of leave shall be documented as part of the client's care plan. 8.495.6. D. Any additional monies assessed the client or his/her family and/or guardian 1. Shall not be for Medicaid services. 2. Shall be clearly delineated in the client agreement. 3. Shall be fully refunded or withholdings clearly defined on the day of discharge. 8.495.6. E. Environmental Standards 1. Alternative Care Facilities are responsible and shall maintain a home-like quality and feel for all residents at all times. 2. Facilities shall provide an accessible private telephone with toll free local calls. 3. Facilities shall provide a private area where clients in shared bedrooms may have visitors. 4. Facilities shall provide access to common areas that is not through another resident's bedroom. 5. Facilities shall be heated to at least 70 degrees during the day and 65 degrees at night. Bedroom temperatures shall not exceed 85 degrees. During the summer months the facility shall provide at least one common area that can accommodate all residents where the temperature is no more than 76 degrees. 6. Facilities shall have a battery or generator-powered alternative lighting system available in the event of power failure. 7. The monthly schedule of daily recreational and social activities shall be posted in a conspicuous place at all times and developed in accordance with 6 C.C.R. 1011-1, Chapter VII, Section 1.107.2 Social and Recreation Activities. a. The daily schedule of recreational and social activities shall be implemented by staff and offered to all clients. 8. Appropriate reading material that reflects the residents' interests and hobbies shall be made available in the common area(s). 9. Facilities shall provide nutritious food and beverage that clients have access to at all times. Access to food and cooking of food shall be in accordance with 6 C.C.R. 1011-1, Chapter VII, Section 1.105(4) House Rules and Section 1.111 (1) Interior Environment. The access to food shall be provided in at

	least one of the following ways: a. Access to the ACF kitchen. b. Access to an area separate from the ACF kitchen stocked with nutritious food and beverage. c. A kitchenette with a refrigerator, sink, and stove or microwave, separate from the client's bedroom. d. A safe, sanitary way to store food in the client's room. 10. The cooking capacity of residents shall be assessed in the original pre-admission team evaluation and on-going care plans. a. Cooking may be limited to supervised access, if necessary for the client's safety and well-being. 8.495.6. F. Service Standards 1. The facility shall provide Protective Oversight to clients every day of the year, 24 hours per day. 2. Alternative Care Service Providers shall maintain and follow written policies and procedures for the administration of medication in accordance with 6 C.C.R. 1011-1, Chapter VII and XXIV, Medication Administration Regulations, if the facility administers medication to clients. 3. Providers shall not discontinue nor refuse services to a client unless documented efforts have been ineffective to resolve the conflict leading to the discontinuance or refusal of services. 4. Providers shall have written policies and procedures for employment practices. 5. Providers shall maintain the following records/files: a. Personnel files for all staff and volunteers shall include: i) Name, home address, phone number and date of hire. ii) The job description, chain of supervision and performance evaluation(s). iii) For staff with direct resident contact, including food handlers, evidence of pre-hire and annual tuberculin (TB) testing or chest x-ray, where appropriate. b. Client files shall include: i) The team assessment outlined in 10 C.C.R. 2505-10, Section 8.495.2. B. and care plan per 6 C.C.R. 1011-1, Chapter VII, 1.107(3). 6. The facility shall ensure that its staff has a clear understanding of all regulations pertaining to the facility's licensure and certification by the State of Colorado. 7. The facility shall encourage and assist client's participation in activities within the ACF community and the wider community, when appropriate. 8.495.6. G. Staffing Standards 1. Each facility will divide and document the 24-hour day into two 12 hour blocks which will be considered daytime and nighttime. The designation of daytime and nighttime hours shall be permanently documented in facility policy and disclosed in the written resident agreements. The facility shall comply with the following staffing standards:

	a. A minimum of 1 staff to 10 residents during the daytime. b. A minimum of 1 staff to 16 residents during the nighttime. c. A minimum of 1 staff to 6 residents in a Secured Environment at all times. i) There shall be a minimum of one awake staff that is on duty during all hours of operation in a Secured Environment. 2. Prior to receiving consideration for a staffing waiver, the facility shall be free of deficiencies for both fire safety and patient care issues in Life Safety and Health surveys. 3. Subject to Departmental approval, the Department may grant staffing waivers for nighttime hours only except in a Secured Environment. a. The Provider shall adequately document that a staffing waiver would not jeopardize the health, safety or quality of life of the residents. b. Any existing staffing waiver may be subject to revocation if a facility is cited with fire safety or patient care deficiencies or substantiated patient care complaints. c. In the event of a staffing waiver denial or revocation, a facility may reapply for a staffing waiver only after the facility receives an annual survey with no deficiencies in either fire safety or patient care. d. Existing staffing waivers shall be null and void upon a change in the total number of licensed beds or a change of ownership in a facility. 8.495.6. H. Standards for Secured Environment ACFs 1. Facilities providing a secured environment may be licensed for a maximum of 30 secured beds. a. A waiver may be granted by the Department when adequate documentation of the need for additional beds has been proven and the number of beds would not jeopardize the health, safety and quality of care of residents. 2. The facilities shall establish an environment that promotes independence and minimizes agitation through the use of visual cues and signs. 3. Doors to bedrooms shall not be locked unless the resident is able to manage the key independently. 4. Provide a secured outdoor area accessible without staff assistance, which shall be level, well maintained and appropriately equipped for the population served. 8.495.6.I. Appropriateness of Medicaid Client Placement 1. An ACF shall not admit, or shall discharge within 30 days, any client, who: a. Needs skilled services on more than an intermittent basis. Skilled services shall only be provided on an intermittent basis by and certified home health provider. b. Is incapable of self-administration of medication, and the facility does not administer medications. c. Is consistently unwilling to take medication prescribed by a physician. d. Is diagnosed with substance abuse issue and refuses treatment by the appropriate mental health/medical professionals. e. Has an acute physical illness which cannot be managed through medications or prescribed therapy.

	f. Has a seizure disorder which is not adequately controlled. g. Exhibits behavior that: i) Disrupts the safety, health and social needs of the home. ii) Poses a physical threat to self or others, including but not limited to, violent and disruptive behavior and/or any behavior which involves physical, sexual, or psychological force or intimidation and fails to respond to interventions, as outlined in the client's care plan. iii) Indicates an unwillingness or inability to maintain appropriate personal hygiene under supervision or with assistance. iv) Is consistently disorientated to time, person and place to such a degree he/she poses a danger to self or others and the ACF does not provide a Secured Environment. h. Has physical limitations that: i) Limit ambulation, unless compensated for by assistive device(s) or with assistance from staff. ii) Require tray food services on a continuous basis. 2. Clients admitted for respite care to the ACF must meet the same criteria as other clients for appropriate placement. 8.495.7 REIMBURSEMENT 8.495.7. A. Effective January 1 of each year, the Department shall establish a uniform room and board payment for all Medicaid clients in ACFs. The standard room and board payment shall be permitted to rise in a dollar-for-dollar relationship to any increase in the Supplemental Security Income grant standard if the Colorado Department of Human Services also raises its grant amounts. 8.495.7. B. Facilities shall bill for reimbursement according to 10 C.C.R. 2505-10, Section 8.040. 1. Reimbursement shall be per unit, with one unit equaling one day of care, as estimated on the Prior Authorization (PAR) form. 2. When a client is determined eligible for HCBS services under the 300% income standard pursuant to 10 C.C.R. 2505-10, Section 8.100, Medicaid reimbursement shall be determined for Alternative Care Services according to 10 C.C.R. 2505-10, Section 8.486.60. 8.495.7. C. Reimbursement shall be the lower of: 1. The Medicaid unit rate; or 2. The rate the ACF charges its private-pay residents for similar services. 8.495.7. D. Non-Medical/Programmatic Leave Reimbursement 1. The ACF may receive reimbursement for a maximum of 42 days in a calendar year for Non-Medical/Programmatic Leave Days combined.
Targeted Population	Adults 18-64 with physical disabilities and seniors 65+ with functional deficits , who meet nursing facility level of care
Waiver Manager Comment	There has been a lot of discussion surrounding ACFs within the Department and with our stakeholder community. During a CMS audit in 2011, Colorado's ACFs received a lot of comments about needing to be more "home-like." There has been a lot of uncertainty about what this means in terms of the new CMS rules around what it means to be Home-Like and what our ACFs need to do before these rules are finalized

Waiver	**HCBS- Community Mental Health Supports Waiver (ACF)**
Waiver Service Definition	Alternative care facilities shall provide safe, cost effective services including twenty-four hour residential care support services, adequate sleeping and living areas, adequate recreational areas and opportunities, assistance with the arrangement of transportation when needed, protective oversight and social recreational services. Alternative care services means personal care such as assistance with eating, bathing, dressing, personal hygiene, activities of daily living, and homemaker services consisting of general household activities. Protective oversight means guidance of a resident who may travel independently in the community; monitoring the activities of the resident while on the premises to assure the health, safety, and well being of the residents including monitoring of prescribed medications, reminding the resident to carry out activities of daily living, and reminding the resident to carry out any important activities, including appointments. Room and board is not part of the service package and must be paid by residents from their own funds.
Service Limitations	Alternative care facilities offered in this waiver are limited based on the client's assessed need for services, physician's orders and prior authorization by case managers up to the cost containment parameters as defined in 10 CCR 2505-10, Section 8.485.50 (J). Clients choosing to live in an alternative care facility shall have no duplication of these services by a personal care agency, homemaker agency, or by CDASS.
Rule	Same as EBD Waiver; **10 CCR 2505-10 Section 8.495**
Targeted Population	Persons 18 years and older with a major mental illness who meet nursing facility level of care.
Waiver Manager Comment	There has been a lot of discussion surrounding ACFs within the Department and with our stakeholder community. During a CMS audit in 2011, Colorado's ACFs received a lot of comments about needing to be more "home-like." There has been a lot of uncertainty about what this means in terms of the new CMS rules around what it means to be Home-Like and what our ACFs need to do before these rules are finalized. With 1.286 out of 2,803 clients living in an ACF, it is one of the CMHS waiver's most utilized services at around 45%.

INDEPENDENT LIVING SKILLS TRAINING

Waiver	HCBS- for Persons with Brain Injury Waiver
Waiver Service Definition	Independent Living Skills Training is designed and directed at the development and maintenance of the waiver participant's ability to be self-sustaining physically, emotionally and economically in the community. Skills training may include assessment, training and supervision or assistance to an individual with self-care and the activities of daily living as well as medication supervision, task completion, communication skill building, interpersonal skill development, socialization training, community mobility training, reduction or elimination of maladaptive behaviors, problem solving, benefits coordination, resource coordination, financial managment and household management. Independent Living Skills Training shall be delivered according to client's service plan and need for rehabilitation maintenance.
Service Limitations	Intensive Independent Living Skills Training delivered for rehabilitation shall be no more than 40 hours per week and shall not exceed five years in duration. This intensive support is available only to clients determined eligible for hospital level of care by the SEP agency. After five years, Independent Living Skills Training shall be delivered according to a maintenance level, not to exceed 28 hours per week. This service is available to clients determined eligible for specialized nursing facility level of care by the SEP agency. Maintenance includes cueing, reminding and prompting of previously delivered skills training to keep the client from regressing. Maintenance also includes working with the client and the client's Personal Care Provider to achieve an integrated care plan that will reinforce skills training.
Rule	**10 CCR 2505-10 Section 8.516.10** (There is no definition referenced for the new rule, included the old rule for clarification) A. DEFINTIONS 1. Independent Living Skills Training and Development means services designed and directed at the development and maintenance of the program participant's ability to independently sustain himself/herself physically, emotionally, and economically in the community. 2. Skills training may be provided in the client's residence, in the community or in a group living situation. B. INCLUSIONS 1. Services may include assessment, training, and supervision or assistance to an individual with self care, medication supervision, task completion, communication skill building, interpersonal skill development, socialization, therapeutic recreation, sensory motor skills, mobility or community transportation training, reduction or elimination of maladaptive behaviors, problem solving skill development, benefits coordination, resource coordination, financial management, and household management. 2. All independent living skills training and development shall be documented in the plan of care. 3. Independent Living Skills trainers must be supervised on a monthly basis by a fully licensed or certified occupational therapist, registered nurse, physical therapist, or speech therapist who has experience in the field of brain injury rehabilitation.

	C. PROVIDER CERTIFICATION STANDARDS 1. Providers shall be a health care professional with one year of experience in providing functionally based assessment and skills training of individuals with disabilities, or an individual with a bachelors degree and two years of similar experiences, or an individual with an AA degree in a social service or human relations area with 3 years of experience. 2. All skills trainers must receive monthly supervision from a licensed or certified health care provider as listed above. Supervision of independent living skills trainers shall not be billable as an additional expense to Medicaid but shall be absorbed by the provider as an overhead expense of business. 3. Providers shall develop and administer a training program to all skills trainers which focuses on the specific needs of individuals with brain injury and demonstrates the completion of a 24 hour training program prior to the delivering of services. D. REIMBURSEMENT 1. All independent living skills training must be documented in the plan of care. Monthly treatment plans shall include the goals of the treatment plan, goals met or accomplished, and progress made toward accomplishment of ongoing goals. All plans are subject to review of the Brain Injury Program Coordinator. 2. Reimbursement shall be on an hourly basis. Payment may include travel time to and from the client's residence, to be billed under the same procedure code and rate as independent living services. The time billed for travel shall be listed separately from the time for service provision on each visit but must be documented on the same form. Travel time must be summed for the week and then rounded to the nearest hour for billing purposes. If the travel time to and from a client's residence is 15 minutes one-way, 30 minutes round trip, then the travel time for one week shall be 210 minute (rounded up to 4 hours) for the week. Travel time to one client's residence may not also be billed as travel time from another client's residence, as this would represent duplicate billing for the same time period.
Targeted Population	Persons 16 years of age and older with a brain injury sustained before the age of 65 who meet the hospital, nursing facility or ICF/ID level of care.
Waiver Manager Comment	Service is used to facilitate access to recreational activities rather than for the purposes outlined above.

PROFESSIONAL SERVICES

Waiver	HCBS- Supported Living Services Waiver
Waiver Service Definition	Professional services include Hippo-therapy, Movement Therapy and Massage. These services can be funded only when the provider is licensed, certified, registered and/or accredited by an appropriate national accreditation association in that profession and the intervention is related to an identified medical or behavioral need. The service must be an identified need in the Service Plan. In addition, the service must be an identified need by a licensed Medicaid State Plan therapist/physician and that therapist/physician has identified a goal for the treatment and shall monitor the progress of that goal at least quarterly. The identified "Professional Service" cannot be available under the regular Medicaid State Plan or from a third party source. Passes to community recreation centers when used to access professional services is allowed. Recreational passes shall be purchased in the most cost effective manner(i.e. day passes or monthly passes.) Hippotherapy: A therapeutic treatment strategy that uses the movement of the horse to assist in the development/enhancement of skills: gross motor, sensory integration, attention, cognitive, social, behavioral and communication. Movement Therapy: The use of music and/or dance as a therapeutic tool for the habilitation, rehabilitation and maintenance of behavioral, developmental, physical, social, communication, pain management, cognition and gross motor skills. Massage: The physical manipulation of muscles to ease muscle contractures, spasms, extension, muscle relaxation and muscle tension including Watsu.
Service Limitations	NA
Rule	**10 CCR 2505-10 Section 8.500.94.A(11)** Professional services are provided by licensed, certified, registered or accredited professionals and the intervention is related to an identified medical or behavioral need. Professional services include: a. Hippotherapy includes a therapeutic treatment strategy that uses the movement of the horse to assist in the development or enhancement of skills including gross motor, sensory integration, attention, cognitive, social, behavior and communication. b. Movement therapy includes the use of music or dance as a therapeutic tool for the habilitation, rehabilitation and maintenance of behavioral, developmental, physical, social, communication, or gross motor skills and assists in pain management and cognition. c. Massage includes the physical manipulation of muscles to ease muscle contractures or spasms, increase extension and muscle relaxation and decrease muscle tension and includes watsu. d. Professional services can be reimbursed only when:

	i) The provider is licensed, certified, registered or accredited by an appropriate national accreditation association in the profession, ii) The intervention is related to an identified medical or behavioral need, and iii) The Medicaid State plan therapist or physician identifies the need for the service, establishes the goal for the treatment and monitors the progress of that goal at least quarterly. e. A pass to community recreation centers shall only be used to access professional services and when purchased in the most cost effective manner including day passes or monthly passes. f. The following services are excluded under the HCBS Waiver from reimbursement; i) Acupuncture, ii) Chiropractic care, iii) Fitness trainer = iv) Equine therapy, v) Art therapy, vi) Warm water therapy, viii) Experimental treatments or therapies, and. ix) Yoga.
Targeted Population	Persons 18 years of age and older with a developmental disability who meet the ICF/ID level of care.
Waiver Manager Comment	**Recommendation: Keep professional services due to:** 1. Assists clients to develop physical strength and stamina.

Waiver	**HCBS- Children's Habilitation Residential Program Waiver**
Waiver Service Definition	Professional services include Hippotherapy, movement therapy, and massage therapy. These services can be funded only when the provider is licensed and/or certified in that profession and the intervention is related to an identified medical or behavioral need. The service shall be an identified need in the Service Plan. In addition, the service must be an identified need by a licensed Therapist/Physician who is a Medicaid Provider and that Therapist/Physician has identified a goal for the treatment and shall monitor the progress of that goal at least quarterly. The identified "Professional Service" cannot be available under the regular Medicaid State Plan or from a third party source. Movement Therapy: The use of music and/or dance as a therapeutic tool for the habilitation, rehabilitation, and maintenance of behavioral, developmental, physical, social, communication, pain management, cognition, and gross motor skills.

	Massage: The physical manipulation of muscles to ease muscle contractures, spasms, extension, muscle relaxation, and muscle tension including Watsu. Hippotherapy: A therapeutic treatment strategy that uses the movement of the horse to assist in the development/enhancement of skills: gross motor, sensory integrationattention, cognitive, social, behavioral, and communication.
Service Limitations	NA
Rule	**10 CCR 2505-10 Section 8.508.80.100(E)** Counseling and therapeutic services may include individual and/or group counseling, behavioral or other therapeutic interventions directed at increasing the overall effective functioning of an individual.
Targeted Population	Children and youth who are developmentally disabled as defined in Section 27-10.5-102(11), C.S.R. Children under age 5 who are developmentally delayed are included only when developmental delay is accompanied by significant medical and/or behavioral needs. Children from birth to 21 years of age who are placed through a County Department of Social Services, have a developmental disability and extraordinary service needs, and for whom services cannot be provided at the county negotiated rate.
Waiver Manager Comment	Continue to provide this service

Waiver	**HCBS-Children's Extensive Support Waiver**
Waiver Service Definition	**Professional Services** Professional services include Hippotherapy, Movement Therapy and Massage. These services are only available from a provider who is licensed, certified, registered and/or accredited by an appropriate national accreditation association in that profession and the intervention is related to an identified medical or behavioral need. The service shall be an identified need in the Service Plan. In addition, the service shall be an identified need by a licensed Medicaid State Plan therapist/physician and that therapist/physician has identified a goal for the treatment and monitors the progress towards goal achievement at least quarterly. The identified Professional Service cannot be available under the regular Medicaid State Plan, EPSDT or from a third party source. **Hippotherapy**: A therapeutic treatment strategy that uses the movement of the horse to assist in the development/enhancement of skills: gross motor, sensory integration, attention, cognitive, social, behavioral and communication. **Movement Therapy**: The use of music and/or dance as a therapeutic tool for the habilitation, rehabilitation and maintenance of behavioral, developmental, physical, social, communication, pain management, cognition and gross motor skills. **Massage**: The physical manipulation of muscles to ease muscle contractures, spasms, extension, muscle relaxation and muscle tension including Watsu.
Service Limitations	NA
Rule	**10 CCR 2505-10 Section 8.503.40.A(9)** Professional services are provided by licensed, certified, registered or accredited professionals and the intervention is related to an identified medical or

	behavioral need. Professional services include: a. Hippotherapy includes a therapeutic treatment strategy that uses the movement of the horse to assist in the development or enhancement of skills including gross motor, sensory integration, attention, cognitive, social, behavior and communication. b. Movement therapy includes the use of music or dance as a therapeutic tool for the habilitation, rehabilitation and maintenance of behavioral, developmental, physical, social, communication, or gross motor skills and assists in pain management and cognition. c. Massage includes the physical manipulation of muscles to ease muscle contractures or spasms, increase extension and muscle relaxation and decrease muscle tension and includes watsu. d. Professional services can be reimbursed only when: i) The provider is licensed, certified, registered or accredited by an appropriate national accreditation association in the profession, ii) The intervention is related to an identified medical or behavioral need, and iii) The Medicaid State plan therapist or physician identifies the need for the service, establishes the goal for the treatment and monitors the progress of that goal at least quarterly. e. A pass to community recreation centers shall only be used to access professional services and when purchased in the most cost effective manner including day passes or monthly passes. f. The following services are excluded under the HCBS Waiver from reimbursement; i) Acupuncture, ii) Chiropractic care, iii) Fitness trainer iv) Equine therapy, v) Art therapy, vi) Warm water therapy, viii) Experimental treatments or therapies, and. ix) Yoga.
Targeted Population	Clients ages birth up to 18th birthday Must have developmental delay (age 5 and under) or developmental disability Have a behavior or medical condition so intense it requires near constant line of sight supervision.
Waiver Manager Comment	Low to moderate use: FY PD claims unduplicated client count Hippo-therapy 48, Massage therapy 57; Movement therapy 92; overall waiver unduplicated count 409

	Recommendation: Keep professional services due to: 2. Assists clients to develop physical strength and stamina. 3. Children learn and grow best through activities that are engaging and playful.

SUPPORTED LIVING PROGRAM

Waiver	HCBS- for Persons with Brain Injury Waiver
Waiver Service Definition	Supported Living Program services include but are not limited to: assessment, training and supervision of personal care, activities of daily living, protective oversight and supervision, behavioral management, cognitive supports, interpersonal and social skills development, management of medical needs, physical, speech, and occupational therapies to maintain functionality, financial management, household management, individual activity plans, and recreational and social activities on and off the campus. Services include transportation between therapeutic tasks in the community, recreational outings, and activities of daily living.
Service Limitations	Support Living Program services are available only to a client who is determined eligible for specialized nursing facility level of care by the Single Entry Point (SEP) agency.
Rule	Supported Living means services delivered by a community-based residential program that has been certified by the Department to provide the services defined at Section 25.5-6-703(8), C.R.S. (8) "Supported living" means assistance or support designed to maximize or maintain independence and self-direction on a supportive care campus. Supported living services consist of structured interventions designed to provide: (a) Protective oversight and supervision; (b) Behavioral management and cognitive supports; (c) Interpersonal and social skills development; (d) Improved household management skills to support independence and community integration; and (e) Medical management.
Targeted Population	Persons 16 years of age and older with a brain injury sustained before the age of 65 who meet the hospital, nursing facility or ICF/ID level of care.
Waiver Manager Comment	Need more SLP/residential placement options for individuals with a brain injury

TRANSITIONAL LIVING PROGRAM

Waiver	HCBS- for Persons with Brain Injury Waiver
Waiver Service Definition	The Transitional Living Program provides 24-hour support, supervision and therapeutic services. It is designed to facilitate independent living while transitioning clients into the community. Transitional Living provides assessment, training and supervision of self-care, medication management, sensory and motor skill development, communication skills, interpersonal skills training, socialization training, money management, household maintenance skills and management of medical needs. The program is offered to clients who require assistance in a milieu setting for safety, supervision and comprehensive treatment. Room and board are not included in Medicaid reimbursement. After receiving services in the Transitional Living Program, the client can access other benefits of the HCBS-BI Waiver in order to remain in the community.
Service Limitations	Transitional Living Program Services are available only to clients determined eligible for hospital level of care by the SEP agency and who have sustained a Brain Injury within 18 months of commencing the Transitional Living Program. The program is not to exceed 12 months in duration.
Rule	**10 CCR 2505-10 Section 8.516.30** TRANSITIONAL LIVING A. DEFINITIONS 1. Transitional living means programs, which occur outside of the client's residence, designed to improve the client's ability to live in the community by provision of 24 hour services, support and supervision. 2. Program services include but are not limited to assessment, training. and supervision of self-care, medication management, communication skills, interpersonal skills, socialization, sensory/motor skills, money management, and ability to maintain a household. Programs are normally limited in duration to six months. B. INCLUSIONS 1. All services must be documented in an approved plan of care and be prior authorized by the State Brain Injury Program Coordinator or designated agent. 2. Clients must need available assistance in a milieu setting for safety and supervision and require support in meeting psychosocial needs. 3. Clients must require available paraprofessional nursing assistance on a 24 hour basis due to dependence in activities of daily living, locomotion, or cognition.

	4. The per diem rate paid to transitional living programs shall be inclusive of standard therapy and nursing charges necessary at this level of care. If a client requires extraordinary therapy, additional services may be sought through outpatient services as a benefit of regular Medicaid services. The need for high intensity therapy for a client must be documented and authorized individually through the Brain Injury Program Coordinator. "Extraordinary therapy needs" for purposes of this program, are defined by a client who needs more than three hours per week of any one therapeutic discipline: ie. physical therapy, occupational therapy, or speech therapy. C. EXCLUSIONS 1. Transportation between therapeutic tasks in the community, recreational outings, and activities of daily living is included in the per diem reimbursement rate and shall not be billed as separate charges. 2. Transportation to outpatient medical appointments is exempted from transportation restrictions noted above. 3. Room and board charges are not a billable component of transitional living services. 4. Items of personal need or comfort shall be paid out of money set aside from client's, income, and accounted for in the determination of financial eligibility for the HCBS-BI program. 5. The duration of transitional living services shall not exceed 6 months without additional approval, treatment plan review and reauthorization by the State Brain Injury Program Coordinator. D. CERTIFICATION STANDARDS Transitional living programs shall meet all standards established to operate as an Assisted Living Residence according to C.R.S. 25-1-107, et, seq., 1. The Department of Public Health and Environment shall survey and license the physical facility of Transitional Living Programs. 2. Transitional living programs shall adhere to all additional programmatic, and policy requirements listed in SECTIONS following titled POLICIES, TRAINING, DOCUMENTATION, and HUMAN RIGHTS. 3. The Department of Health Care Policy and Financing shall review and provide certification of programmatic, standards. 4. If the program holds a current Commission of the Accreditation of Rehabilitation Facilities (CARF) accreditation for the specific program for which they are seeking state certification, on-site review for initial certification may be waived. However, on-site reviews of all programs shall occur on at least a yearly basis. 5. The building shall meet all local and state fire and safety codes. E. POLICIES 1. Clients must have sustained recent neurological damage (within 18 months) or have realized a significant, measurable, and documented change in neurological function within the past three months. This change in neurological function must have resulted in hospitalization. 2. The person must be medically stable as defined by having the need for less than one hour per eight hour shift of skilled nursing intervention and being able to actively participate in intensive therapy during the day. 3. Clients, families, medical proxies,: or other substitute decision makers shall be made aware of accepting the inherent risk associated with participation in a community-based transitional living program. Examples might include a greater likelihood of falls in community outings where curbs are present. 4. Understanding that clients of transitional living programs frequently experience behavior which may be a danger to themselves or others, the program will be suitably equipped to handle such behaviors without posing a significant threat to other residents or staff. The transitional living program must have

	written agreements with other providers, in the community who may provide short term crisis intervention to provide a safe and secure environment for a client who is experiencing severe, behavioral difficulties, or who is actively homicidal or suicidal. 5. The history of behavior problems shall not be sufficient grounds for denying access to transitional living services: however, programs shall retain clinical discretion in refusing to serve clients for whom they lack adequate resources to ensure safety of program participants and staff. 6. Upon entry into the program, discharge planning shall begin with the client and family. Transitional living programs shall work with the client and case manager to develop a program of services and support which leads to the location of a permanent residence at the completion of transitional living services. 7. Transitional living programs shall provide assurances that the services will occur in the community or in natural settings and be non-institutional in nature. 8. During daytime hours, the ratio of staff to clients shall be at least 1:3 and overnight, shall be at least 2:8. The use of contract employees, except in the case of an unexpected staff shortage during documented emergencies, is not acceptable. 9. The duration of transitional living services shall not exceed six months without additional approval, treatment plan review and re-authorization by the Brain Injury Program Coordinator. F. TRAINING 1. At a minimum, the program director shall have an advanced degree in a health or human service related profession plus three years experience providing direct services to individuals with brain injury. A bachelor's degree with five years experience or similar combination of education and experience shall be an acceptable substitute for a master's level education. 2. Transitional living programs must demonstrate and document that employees providing direct care and support have the educational background, relevant experience, and/or training to meet the needs of the client. These staff members will have successfully completed a training program of at least 40 hours duration. 3. Facility operators must satisfactorily complete an introductory training course on brain injury and rules and regulations pertaining to transitional living centers prior to certification of the facility. 4. The operator, staff, and volunteers who provide direct client care or protective oversight must be trained in first aid universal precautions, emergency procedures, and at least one staff per shift shall be certified as a medication aide prior to assuming responsibilities. Facilities certified prior to the effective date of these rules shall have sixty days to satisfy this training requirement. 5. Training in the use of universal precautions for the control of infectious or communicable disease shall be required of all operators, staff, and volunteers. Facilities certified prior to the effective date of these rules shall have sixty days to satisfy this training requirement. 6. Staffing of the program must include at least one individual per shift who has certification as a medication aide prior to assuming responsibilities. G. DOCUMENTATION 1. Intake information shall include a completed neuropsychological assessment, all pertinent medical documentation from impatient and outpatient therapy and a detailed social history' to identify key treatment components and the functional implication of treatment goals. 2. Initial treatment plan development and evaluations will occur within a two week period following admission. 3. Goals and objectives reference specific outcomes in the degree of personal and living independence, work productivity, and psychological and social adjustment, quality of life and degree of community participation.

	4. Specific treatment modalities outlined in the treatment plan are systematically implemented with techniques that are consistent functionally based, and active throughout the day. Treatment methods will be appropriate to the goals and will be reviewed and modified as appropriate. 5. Behavioral programs shall contain specific guidelines on treatment parameters and methods. 6. All transitional services must utilize licensed psychologists win two years experience in brain injury services for the oversight of treatment plan development, implementation and revision. There shall be regular contact and meetings with the client and family. Meetings shall include written recommendations and referral suggestions, as well as information on how the family will transition and incorporate treatment modalities into the home environment. 7. Programs shall have a process verified in writing by which a client is made aware of the process for filing a grievance. Complaints by the client or family shall be handled via telephone or direct contact with the client or family. 8. Customer satisfaction surveys will be regularly performed and reviewed. 9. Records must be signed and dated by individuals providing the intervention. Daily progress notes shall be kept for each treatment modality rendered. 10. Client safety in the community will be assessed: safety status and recommendations will be documented. 11. Progress towards the accomplishment of goals is monitored and reported in objective measurable terms on a weekly basis, with formal progress notes submitted to the case manager on a monthly basis. H. HUMAN RIGHTS All people receiving HCBS-BI transitional living services have the following rights: 1. All Human Rights listed in 8.515.80 C. apply. 2. Every person has the right to receive and send sealed correspondence. No incoming or outgoing correspondence will be opened, delayed, or censored by the personnel of the facility. I. REIMBURSEMENT Providers of Transitional Living shall agree to accept the per diem reimbursement negotiated with the Department of Health Care Policy and Financing and will not bill the client in excess of his/her SSI payment or $400 per month, whichever is less for room and board charges. All transitional living services shall be prior authorized through submission to the Brain Injury Program Coordinator. A Medicaid Prior Authorization Request must be submitted with tentative goals and rationale of the need for intensive transitional living services. Transitional living services which extend beyond six months duration, must be reauthorized with attached treatment plan justification and shall be submitted, if appropriate, through the reconsideration process established with the Departmental fiscal agent.
Targeted Population	Persons 16 years of age and older with a brain injury sustained before the age of 65 who meet the hospital, nursing facility or ICF/ID level of care.
Waiver Manager Comment	Need more residential options for individuals with a brain injury

MENTORSHIP

Waiver	HCBS- Supported Living Services Waiver
Waiver Service Definition	Service provided to participants to promote self-advocacy through methods such as instructing, providing experiences, modeling and advising. This service includes assistance in interviewing potential providers, understanding complicated health and safety issues, and assistance with participation on private and public boards, advisory groups and commissions. This service may also include training in child and infant care for parent(s) who themselves have a developmental disability. This service does not duplicate case management or waiver services such as Day Habilitation.
Service Limitations	Mentorship is limited to 192 units per year. Units to provide training to participants for child and infant care may be authorized beyond the 192 units per year.
Rule	**10 CCR 2505-10 Section 8.500.94.A(7)** Mentorship services are provided to clients to promote self-advocacy through methods such as instructing, providing experiences, modeling and advising and include: a. Assistance in interviewing potential providers, b. Assistance in understanding complicated health and safety issues, c. Assistance with participation on private and public boards, advisory groups and commissions, and d. Training in child and infant care for clients who are parenting children. e. Mentorship services shall not duplicate case management or other HCBS-SLS waiver services. f. Mentorship services are limited to one hundred and ninety two (192) units (forty eight (48) hours) per service plan year. One (1) unit is equal to fifteen (15) minutes. g. Units to provide training to clients for child and infant care shall be prior authorized beyond the one hundred and ninety two (192) units per service plan year in accordance with Operating Agency procedures.
Targeted Population	Persons aged 18 and older with a developmental disability who meets ICF/ID level of care.
Waiver Manager	Continue this service as currently provided in the SLS waiver

EPRESSIVE THERAPY

Waiver	HCBS- Children with Life Limiting Illness Waiver
Waiver Service Definition	Expressive Therapy means provision of creative art, music or play therapy which gives children the ability to creatively and kinesthetically express their medical situation. Expressive therapy functions as the interface between the mind and the body. These therapies are based on the theory that creative activity improves the capacity of the body to heal. Therapies may include book writing, painting, music therapy and scrapbook making. Use of these therapies can decrease a client's feelings of isolation, improve communications skills, decrease emotional suffering due to health status, and develop coping skills. Expressive therapy is activity which is not for recreation but related to the care and treatment of the patient's disabling health problems.
Service Limitations	Expressive Therapy is limited to 39 hours per year.
Rule	**10 CCR 2505-10 Section 8.504.2.D** Expressive Therapy means creative art, music or play therapy which provides children the ability to creatively and kinesthetically express their medical situation for the purpose of allowing the client to express feelings of isolation, to improve communication skills, to decrease emotional suffering due to health status, and to develop coping skills. Expressive therapy includes, but is not limited to, book writing, painting, music therapy and scrapbook making. 1. Expressive therapy is limited to 39 hours per every 365 days based on the date the client entered the program.
Targeted Population	The waiver is targeted to children who are considered medically fragile through the age of 18. The child must have a diagnosis of a life limiting illness and meet the hospital level care.
Waiver Manager Comment	The way the provider qualifications are currently written no provider that has a degree in music therapy is able to provide the service. The Department is working to expand provider qualifications for this service.

ALTERNATIVE THERAPY SERVICE

Waiver	HCBS-for Persons with Spinal Cord Injury
Waiver Service Definition	Alternative therapies are limited to acupuncture, chiropractic care, and massage therapy as defined below. Services are to be delivered in an outpatient setting under the supervision of a physician. Acupuncture means the stimulation of anatomical points on the body by penetrating the skin with thin, solid, metallic, single-use needles that are manipulated by the hands or by electrical stimulation for the purpose of bringing about physiologic and /or psychological changes. Chiropractic care means the use of manual adjustments (manipulation or mobilization) of the spine or other parts of the body with the goal of correcting alignment and other musculoskeletal problems. Massage therapy means the systematic manipulation of the soft tissues of the body, (including manual techniques of gliding, percussion, compression, vibration, and gentle stretching) for the purpose of bringing about physiologic, mechanical, and/or psychological changes.
Service Limitations	The utilization of alternative therapies may typically begin at a higher frequency and is expected to decrease as the client progresses. Authorization and payment for the alternative therapies service is limited as follows: During the first 90 days of the initial alternative therapies Care plan, the schedule of services recommended by the supervising physician shall not exceed 15 visits for any one modality or 30 visits for any combination of modalities. After the first 90 days of the initial alternative therapies care plan and in all subsequent alternative therapies care plans, the schedule of services recommended by the supervising physician shall not exceed 12 visits for any one modality or 24 visits for any combination of modalities per 90 day period. Services are limited based on the client's assessed need for services, physician's orders, and prior authorization by case managers up to the cost containment parameters.
Rule	**10 CCR 2505-10 Section 8.517.10 ALTERNATIVE THERAPIES** Alternative Therapies are limited to Acupuncture, Chiropractic Care, and Massage Therapy as defined at Section 8.517.2. 8.517.10.A. Inclusions 1. Acupuncture used for the treatment of conditions or symptoms related to the client's spinal cord injury. 2. Chiropractic Care used for the treatment of conditions or symptoms related to the client's spinal cord injury. 3. Massage Therapy used for the treatment of conditions or symptoms related to the client's spinal cord injury. 8.517.10.B. Exclusions / Limitations 1. Alternative Therapies shall be provided only for the treatment of conditions or symptoms related to the client's spinal cord injury. 2. Alternative therapies shall be limited to the client's assessed need for services as determined by the Supervising Physician and documented in the Alternative Therapies Care Plan. 3. Alternative Therapies shall be provided in an outpatient setting.

4. Alternative Therapies shall be provided only by agencies certified by the Department of Health Care Policy and Financing to have met the certification standards listed at Section 8.517.10.C.
5. Clients receiving Alternative Therapies shall participate in an independent evaluation to determine the effectiveness of this service.
6. The utilization of Alternative Therapies may typically begin at a higher frequency and is expected to decrease as the client progresses.

Authorization and payment for the Alternative Therapies service is limited as follows:

a. During the first 90 days of the initial Alternative Therapies Care Plan, the schedule of services recommended by the Supervising Physician shall not exceed 15 visits for any one modality or 30 visits for any combination of modalities.
b. After the first 90 days of the initial Alternative Therapies Care Plan and in all subsequent Alternative Therapies Care Plans, the schedule of services recommended by the Supervising Physician shall not exceed 12 visits for any one modality or 24 visits for any combination of modalities per 90 day period.

8.517.10.C. Certification Standards

1. Organization and Staffing
   a. Alternative Therapy Centers shall employ or contract with an adequate number of qualified professionals necessary for the provision of Alternative Therapies in accordance with this regulation.
   b. Alternative Therapies must be provided by licensed, certified, and/or registered individuals operating within the applicable scope of practice and under the direction of a Supervising Physician.
   c. Acupuncturists shall be licensed by the Department of Regulatory Agencies, Division of Registrations as required by the Acupuncturists Practice Act (12-29.5-101, C.R.S.) and have at least five years experience practicing Acupuncture at a rate of at least 750 hours per year.
   d. Chiropractors shall be licensed by the State Board of Chiropractic Examiners as required by the Chiropractors Practice Act (12-33-101, C.R.S.) and have at least five years experience practicing Chiropractic Care at a rate of at least 750 hours per year.
   e. Massage Therapists shall be registered by the Department of Regulatory Agencies, Division of Registrations as required by the Massage Therapy Practice Act (12-35.3-101, C.R.S.) and have at least five years experience practicing Massage Therapy at a rate of at least 750 hours per year.
   f. Supervising Physicians shall be licensed to practice medicine in the State of Colorado as required by 12-36-107 et seq., C.R.S. Supervising Physicians must also be board certified in Physical Medicine and Rehabilitation, Internal Medicine, Neurology, and/or Family Practice and have at least five years experience incorporating Alternative Therapies as part of an overall care plan.
2. Environmental Standards
   a. Alternative Therapy Centers shall develop a plan for infection control that is adequate to avoid the sources of and prevent the transmission of infections and communicable diseases. The facility shall also develop a system for identifying, reporting, investigating and controlling infections and communicable diseases of patients and personnel. Sterilization procedures shall be developed and implemented in necessary service areas.
   b. Policies shall be developed and procedures implemented for the effective control of insects, rodents, and other pests.
   c. All wastes shall be disposed in compliance with local, state and federal laws.
   d. A preventive maintenance program to ensure that all essential mechanical, electrical and patient care equipment is maintained in safe and sanitary operating condition shall be provided. Emergency Systems, and all essential equipment and supplies shall be inspected and maintained on a frequent or as needed basis.
   e. Housekeeping services to ensure that the premises are clean and orderly at all times shall be provided and maintained. Appropriate janitorial storage shall be maintained.
   f. Alternative Therapy Centers shall be constructed and maintained to ensure access and safety.
   g. Alternative Therapy Centers shall demonstrate compliance with the building and fire safety requirements of local governments and other state agencies.
3. Failure to comply with the requirements of this regulation may result in the suspension or recovery of payment for services provided and/or

	the revocation of the Alternative Therapy Center provider certification. 8.517.10.D ALTERNATIVE THERAPIES CARE PLAN 1. The Supervising Physician shall: a. Guide the development of the Alternative Therapies Care Plan in coordination with the client and/or client's representative and the Alternative Therapies practitioners as applicable; b. Recommend the appropriate modality, amount, scope, and duration of the Alternative Therapies within the established limits; c. Order only services and/or modalities that are necessary and appropriate; and d. Supervise the Alternative Therapies practitioners and the services provided. 2. The Supervising Physician shall reassess the Alternative Therapies Care Plan at least every three months or more frequently as necessary. The reassessment may include a visit with the client. 3. When recommending the use of Alternative Therapies for the treatment of a condition or symptom related to the client's spinal cord injury, the Supervising Physician should use evidence from published medical literature that demonstrates the effectiveness of Alternative Therapies for the treatment of the condition or symptom. a. Where no evidence exists, the medical judgment of the Supervising Physician and the input of the Alternative Therapies practitioners should guide recommendations. 4. The Supervising Physician may require consultation or referral to other specialists prior to finalization of the Alternative Therapies Care Plan. 5. The Alternative Therapies Care plan shall be developed using any Department prescribed forms or templates. 6. The Alternative Therapies Care Plan shall include at least the following: a. A summary of the client's medical history; b. An assessment of the client's current medical conditions/needs determined by a comprehensive history and physical exam. c. The amount, scope, and duration of each recommended Alternative Therapies modality and the expected outcomes. d. The recommended schedule of services.
Targeted Population	Persons who are 18 years and older with a spinal cord injury who meet nursing facility level of care
Waiver Manager Comment	These are brand new services for Colorado Medicaid HCBS waivers, so we will be determining the utilization of each service with our clients over the next 3 years.

SUBSTANCE ABUSE COUNSELING SERVICES

Waiver	HCBS- for Persons with Brain Injury Waiver
Waiver Service Definition	Substance Abuse Counseling is designed to assist the client in reducing or eliminating the use of alcohol and/or drugs which, if not effectively addressed, may interfere with the person's ability to remain integrated in the community. These services are provided under the HCBS-BI Waiver because they are integral to the rehabilitation and maintenance of brain injured persons in a community setting. Clients will seek substance abuse counseling through the State Plan before utilizing waiver services. Substance abuse services are provided in a non-residential setting and shall include assessment, development of an intervention plan, implementation of the plan and ongoing education and training for the client, family and/or caregivers. When appropriate, periodic reassessment and education regarding appropriate use of prescription medication will be made available. Substance abuse counseling is provided in individual, group and family settings.
Service Limitations	Counseling in the context of family shall be defined in Section 8.515.3.G.3
Rule	**10 CCR 2505-10 Section 8.516.60** SUBSTANCE ABUSE COUNSELING A. DEFINITION Substance abuse programs are individually designed interventions to red ace or eliminate the use of alcohol and/or drugs by the water participant which. if not effectively dealt with, may interfere with the individual's ability to remain integrated in the community. B. INCLUSIONS 1. Only outpatient individual, group, and family counseling services are available through the brain injury waiver program 2. Substance abuse services are provided in a non-residential setting and must include assessment, development of an intervention plan, implementation of the plan, ongoing education and training of the waiver participant, family or caregivers when appropriate, periodic reassessment, education regarding appropriate use of prescription medication, culturally responsive individual and group counseling, family counseling for persons if directly involved in the support system of the client, interdisciplinary care coordination meetings, and an aftercare plan staffed with the case manager. 3. Prior authorization is required after thirty visits have been provided of individual, group, or family counseling or a combination of modalities. Re-authorization requests shall he submitted to the State Brain Injury Program Coordinator. C. EXCLUSIONS Inpatient treatment is not a covered benefit. D. CERTIFICATION STANDARDS 1. Substance abuse services may be provided by any agency or individual licensed or certified by the Alcohol and Drug Abuse Division (ADAD) of the

	Department of Human Services and jointly certified by ADAD and the Department of Health Care Policy and Financing. 2. Programs must demonstrate a fully developed plan entailing the method by which coordination will occur with existing community agencies and support programs to provide ongoing support to individuals with substance abuse problems. The program should promote training to improve the ability of the community resources to provide ongoing supports to individuals with brain injury. 3. Counselors should be certified at the Certified Alcohol Counselor III level or a doctoral level psychologist with the same level of experience in substance abuse counseling. All counseling professionals within the substance abuse area shall receive specialized training prior to providing services to any individual with a brain injury or their family members. A recommended training curriculum will include a three day session combining didactic and experiential components. A test will be administered by the ADAD and the resulting certification shall be valid for a period of two years. E. REIMBURSEMENT Reimbursement will be on an hourly basis per modality as established by the Department. There are three separate modalities allowable under HCBS-BI counseling services including Family Counseling (if the individual is present). Individual Counseling, and Group Counseling.
Targeted Population	Persons 16 years of age and older with a brain injury sustained before the age of 65 who meet the hospital, nursing facility or ICF/ID level of care.
Waiver Manager Comment	Due to tenure of department staff it is unknown at this time if this services is utilized and benefited from as outline above.

PALLIATIVE/SUPPORTIVE CARE

Waiver	HCBS- Children with Life Limiting Illness Waiver
Waiver Service Definition	Palliative/Supportive Care services provided concurrently with curative care services. The registered nurse from the hospice agency or home health will assess the child for the medical services being requested by the physician on the initial assessment, this may be done in conjunction with the CMA case manager to work collaboratively on the prior authorization request for the waiver. Palliative/Supportive Care includes hospice-like services different in scope and with restrictions to the State Plan hospice benefit. Palliative/Supportive Care mirrors the routine home care benefit of the State Plan hospice benefit with services such as skilled nursing, home health aide, physical therapy, occupational therapy, speech/language pathology, and includes alternative therapies not available through other State Plan benefits or waiver services. Alternative therapies such as aromatherapy, pet therapy, and acupuncture which may palliate the client's symptoms are included as long as they do not duplicate expressive therapy or other state plan services available. Palliative/Supportive Care differs from the State Plan hospice benefit because it excludes the requirement for a six month terminal prognosis, and curative care may be obtained concurrent with the palliative care provided. Palliative/Supportive Care is care provided to manage, control, and alleviate symptoms such as pain, nausea, discomfort and anxiety related to the life-limiting diagnosis. Palliative/Supportive Care under this waiver does not include counseling or bereavement services that are normally available under the State Plan routine home care hospice benefit because those are separate waiver services available to waiver recipients.
Service Limitations	There are no limits on the number of services but documentation needs to cover the medical necessity of visits. Palliative/Supportive Care and State Plan home health or hospice benefits may not be provided on the same dates of service. Palliative/Supportive Care is reimbursed on a per diem basis. Providers are required and expected to provide all medically necessary covered services at the amount, frequency, and for the duration prescribed by the attending physician for the per diem reimbursement amount. Waiver Respite care may only be provided for the times when the normal Palliative/Supportive Care services are not provided.
Rule	Palliative/Supportive Care means hospice-like care provided to manage, control, and alleviate symptoms such as pain, nausea, discomfort and anxiety related to a life-limiting diagnosis that may be provided at the same time as curative treatments. **10 CCR 2505-10 Section 8.504.2.F** Palliative/Supportive Care shall not require a six month terminal prognosis for the client. 1. Palliative/Supportive Care includes, but is not limited to: a. Skilled nursing b. Home health aide

	c. Physical therapy d. Occupational therapy e. Speech/language pathology f. Alternative therapies g. Dietary/nutritional counseling or therapy
Targeted Population	The waiver is targeted to children who are considered medically fragile through the age of 18. The child must have a diagnosis of a life limiting illness and meet the hospital level care.
Waiver Manager Comment	Currently, Palliative Care encompasses pain and symptom management, care coordination, dietary/nutritional counseling and integrative therapies. The Department is exploring breaking out the components of the service to allow for better understanding and easier access. Specifically, pain and symptom management would be coupled with care coordination and dietary/nutritional counseling and integrative therapies would become their own service

BEHAVIORAL SERVICES

Waiver	HCBS- for Persons with Brain Injury Waiver (BEHAVIORAL THERAPIES)
Waiver Service Definition	Behavioral Programming and Education are services necessary for the treatment of a client's severe maladaptive behaviors when these services are not available under Medicaid State Plan benefits, other third party liability coverage or other federal or state funded programs, services or supports. Program includes comprehensive assessment of behaviors, development of a structured behavioral intervention plan with specific treatment goals, working one-on-one with the client to implement the intervention plan and determine its feasibility, training family and caregivers to reinforce behavioral programming methods and goals. Periodic reassessment of the individual plan is used to revise the plan, goals and outcomes according to client need.
Service Limitations	NA
Rule	**10 CCR 2505-10 Section 8.516.40 Behavioral Programming** A. DEFINITION 2341488 Behavioral programming and education is an individually developed intervention designed to decrease/control the client's severe maladaptive behaviors which, if not modified, will interfere with the individual's ability to remain integrated in the community. B. INCLUSIONS 1. Programs should consist of a comprehensive assessment of behaviors, development of a structured behavioral intervention plan, and ongoing training of family and caregivers for feedback about plan effectiveness and revision. Consultation with other providers may be necessary to ensure comprehensive application of the program in all facets of the person's environment. 2. Behavioral programs may be provided in the community or in the client's residence unless the residence is a transitional living center which provides behavioral intervention as a treatment component 3. All behavioral programming must be documented in the plan of care and reauthorized after 30 units of service with the Brain Injury Program Coordinator. C. CERTIFICATION STANDARDS 1. The program should have as its director a Licensed Psychologist who has one year of experience in providing neurobehavioral services or services to persons with brain injury or a health care professional such as a Licensed Clinical Social Worker, Registered Occupational Therapist, Registered Physical Therapist, Speech Language Pathologist, Registered Nurse or Masters level Psychologist with three years of experience in caring for persons with neurobehavioral difficulties. Behavioral specialists who directly implement the program shall have two years of related experience in the implementation of

	behavioral management concepts. 2. Behavioral specialists will complete a 24-hour training program dealing with unique aspects of caring for and working with individuals with brain injury if their work experience does not include at least one year of same. D. REIMBURSEMENT Behavioral programming must be documented on the client's care plan and prior authorized through the State Brain Injury Program Coordinator. Behavioral programming services will be paid on an hourly basis as established by the Department
Targeted Population	Persons 16 years of age and older with a brain injury sustained before the age of 65 who meet the hospital, nursing facility or ICF/ID level of care.
Waiver Manager Comment	No concerns with the service

Waiver	**HCBS-for Persons with Developmental Disabilities (BEHAVIORAL THERAPIES)**
Waiver Service Definition	1) Behavioral Consultation Services include consultations and recommendations for behavioral interventions and development of behavioral support plans that are related to the individual's developmental disability and are necessary for the individual to acquire or maintain appropriate adaptive behaviors, interactions with others and behavioral self management. Intervention modalities shall relate to an identified challenging behavioral need of the individual. Specific goals and procedures for the Behavioral Services must be established. Individuals with co-occurring diagnoses of developmental disabilities and Medicaid covered mental health conditions shall have identified needs met by each of the appropriate systems without duplication but with coordination by the Behavioral Services professional to obtain the best outcome for the individual. 2) Behavioral Plan Assessment Services include observations, interviews of direct staff, functional behavioral analysis and assessment, evaluations and completion of a written assessment document. 3) Individual/Group Counseling Services include psychotherapeutic or psychoeducational intervention related to the developmental disability in order for the individual to acquire or maintain appropriate adaptive behaviors, interactions with others and behavioral self-management, to positively impact the individual's behavior or functioning. Counseling may be provided in an individual or group setting and may include Cognitive Behavior Therapy, Systematic Desensitization, Anger Management, Biofeedback, and Relaxation Therapy. 4) Behavioral Line Services include direct 1:1 implementation of the behavioral support plan, under the supervision and oversight of a Behavioral Consultant for acute, short term intervention at the time of enrollment from an institutional setting or to address an identified challenging behavior of an individual at risk of institutional placement and that puts the individual's health and safety and/or the safety of others at risk.
Service Limitations	Exclusions: Services covered under Medicaid EPSDT, for a covered mental health diagnosis in the Medicaid State Plan, covered by a third party source or available from a natural support shall not be reimbursed. Services for the sole purpose of training in basic life skills such as activities of daily living, social skills and adaptive responding are excluded and shall not be reimbursed under Behavioral Services.

	Limits: 1) Behavioral Consultation Services are limited to 80 units per Service Plan Year. One unit is equal to 15 minutes of service. 2) Behavioral Plan Assessment Services are limited to 40 units. There is a limit of one Behavioral Assessment per Service Plan year. One unit is equal to 15 minutes of service. 3) Counseling Services are limited to 208 units per Service Plan year. One unit is equal to 15 minutes of service. 4) Behavioral Line Services are limited to 960 units per Service Plan year. One unit is equal to 15 minutes of service. Requests for Behavioral Line Services units must be prior authorized by the Department's Operating Agency in accordance with Prior Authorization Request procedures that include specific approval criteria.
Rule	**10 CCR 2505-10 Section 8.500.5.A(1)** Behavioral Services are services related to a client's developmental disability which assist a client to acquire or maintain appropriate interactions with others. a. Behavioral services shall address specific challenging behaviors of the client and identify specific criteria for remediation of the behaviors. b. A client with a co-occurring diagnosis of a developmental disability and mental health diagnosis covered in the Medicaid State Plan shall have identified needs met by each of the applicable systems without duplication but with coordination by the behavioral services professional to obtain the best outcome for the client. c. Services covered under Medicaid EPSDT or a covered mental health diagnosis in the Medicaid State Plan, covered by a third party source or available from a natural support are excluded and shall not be reimbursed. Behavioral Services include: i) Behavioral Consultation Services include consultations and recommendations for behavioral interventions and development of behavioral support plans that are related to the client's developmental disability and are necessary for the client to acquire or maintain appropriate adaptive behaviors, interactions with others and behavioral self management. ii) Intervention modalities shall relate to an identified challenging behavioral need of the client. Specific goals and procedures for the behavioral service shall be established. iii) Behavioral consultation services are limited to eighty (80) units per service plan year. One unit is equal to fifteen (15) minutes of service. iv) Behavioral plan assessment services include observations, interviews of direct care staff, functional behavioral analysis and assessment, evaluations and completion of a written assessment document. v) Behavioral Plan Assessment Services are limited to forty (40) units and one (1) assessment per service plan year. One unit is equal to fifteen (15) minutes of service. v). Individual and Group Counseling Services include psychotherapeutic or psycho educational intervention that: 1) Is related to the developmental disability in order for the client to acquire or maintain appropriate adaptive behaviors, interactions with others and behavioral self-management, and 2) Positively impacts the client's behavior or functioning and may include cognitive behavior therapy, systematic desensitization, anger management,

	biofeedback and relaxation therapy. 3) Counseling services are limited to two-hundred and eight (208) units per service plan year. One (1) unit is equal to fifteen (15) minutes of service. Services for the sole purpose of training basic life skills, such as activities of daily living, social skills and adaptive responding are excluded and not reimbursed under behavioral services. vii) Behavioral Line Services include direct one-to-one implementation of the Behavioral Support Plan and is: 1) Under the supervision and oversight of a behavioral consultant, 2) To include acute, short term intervention at the time of enrollment from an institutional setting, or 3) To address an identified challenging behavior of a client at risk of institutional placement and to address an identified challenging behavior that places the client's health and safety or the safety of others at risk. 4) Behavioral Line Services are limited to nine hundred and sixty (960) units per service plan year. One (1) unit is equal to fifteen (15) minutes of service. Requests for an Behavioral Line Services shall be prior authorized in accordance with the Operating Agency's procedures.
Targeted Population	Persons with developmental disabilities age 18 and older who meet the ICF/IID and who require access to 24/7 supervision
Waiver Manager Comment	Keep as is-Waiver Amendments effective 12/1/11 imposed unit limitations and clearly delineated the services and provider qualifications. Need to analyze the full effect and efficacy of these changes and these services.

Waiver	**HCBS- Supported Living Services Waiver (BEHAVIORAL THERAPIES)**
Waiver Service Definition	Same as DD Waiver
Service Limitations	Same as DD Waiver
Rule	**10 CCR 2505-10 Section 8.500.94.A(2)** Behavioral services are services related to the client's developmental disability which assist a client to acquire or maintain appropriate interactions with others. a. Behavioral services shall address specific challenging behaviors of the client and identify specific criteria for remediation of the behaviors. b. A client with a co-occurring diagnosis of a developmental disability and mental health diagnosis covered in the Medicaid state plan shall have identified needs met by each of the applicable systems without duplication but with coordination by the behavioral services professional to obtain the best outcome for the client. c. Services covered under Medicaid EPSDT or a covered mental health diagnosis in the Medicaid State Plan, covered by a third party source or available from a natural support are excluded and shall not be reimbursed.

	d. Behavioral Services: i) Behavioral consultation services include consultations and recommendations for behavioral interventions and development of behavioral support plans that are related to the client's developmental disability and are necessary for the client to acquire or maintain appropriate adaptive behaviors, interactions with others and behavioral self management. ii) Intervention modalities shall relate to an identified challenging behavioral need of the client. Specific goals and procedures for the behavioral service shall be established. iii). Behavioral consultation services are limited to eighty (80) units per service plan year. One (1) unit is equal to fifteen (15) minutes of service. iv) Behavioral plan assessment services include observations, interviews of direct care staff, functional behavioral analysis and assessment, evaluations and completion of a written assessment document. v) Behavioral plan assessment services are limited to forty (40) units and one (1) assessment per service plan year. One (1) unit is equal to fifteen (15) minutes of service. vi) Individual or group counseling services include psychotherapeutic or psychoeducational intervention that: 1) Is related to the developmental disability in order for the client to acquire or maintain appropriate adaptive behaviors, interactions with others and behavioral self-management, and 2) Positively impacts the client's behavior or functioning and may include cognitive behavior therapy, systematic desensitization, anger management, biofeedback and relaxation therapy. 3) Counseling services are limited to two hundred and eight (208) units per service plan year. One (1) unit is equal to fifteen (15) minutes of service. Services for the sole purpose of training basic life skills, such as activities of daily living, social skills and adaptive responding are excluded and not reimbursed under behavioral services. vii) Behavioral line services include direct one on one (1:1) implementation of the behavioral support plan and are: 1) Under the supervision and oversight of a behavioral consultant, 2) To include acute, short term intervention at the time of enrollment from an institutional setting, or 3) To address an identified challenging behavior of a client at risk of institutional placement, and that places the client's health and safety or the safety of others at risk 4) Behavioral line services are limited to nine hundred and sixty (960) units per service plan year. One (1) unit is equal to fifteen (15) minutes of service. All behavioral line services shall be prior authorized in accordance with Operating Agency procedure
Targeted Population	Persons aged 18 and older with a developmental disability who meets ICF/ID level of care
Waiver Manager Comment	Same as DD Waiver

Waiver	HCBS- Children's Habilitation Residential Program Waiver (BEHAVIORAL SERVICES)
Waiver Service Definition	Behavioral Services are therapeutic services that are not covered by State Plan Medicaid. These are therapies that specialize in behavioral interventions related to the child's developmental disability and not a medical or mental health diagnosis. Behavioral Services identified in the service plan include individual and/or group counseling and behavioral interventions that are overtly related to the individual's developmental disability and are needed for the individual to acquire or maintain appropriate interactions with others. Intervention modalities must relate to an identified challenging behavior need of the person. Specific criteria for remediation of the behavior must be established. The provider(s) will be identified in the service plan and will be at the minimum qualification level necessary to achieve the specific criteria for remediation. If an individual has a covered mental health diagnosis, an assessment from a mental health center must be completed. All mental health services will be provided through State Plan Medicaid. If a determination is made that behavioral services are needed, treatment for mental health and behavioral services can run concurrently. A determination must be made from the completed mental health assessment that the identified challenging behavior(s) are not due to mental health but are a result of their developmental disability.
Service Limitations	NA
Rule	10 CCR 2505-10 Section 8.508.100 (E) 8.508.100 E. Counseling and therapeutic services may include individual and/or group counseling, behavioral or other therapeutic interventions directed at increasing the overall effective functioning of an individual.
Targeted Population	Children and youth who are developmentally disabled as defined in Section 27-10.5-102(11), C.S.R. Children under age 5 who are developmentally delayed are included only when developmental delay is accompanied by significant medical and/or behavioral needs. ********** Children from birth to 21 years of age who are placed through a County Department of Social Services, have a developmental disability and extraordinary service needs, and for whom services cannot be provided at the county negotiated rate.
Waiver Manager Comment	Continue to Provide this Service

Waiver	HCBS- Children With Autism Waiver (BEHAVIORAL THERAPIES)
Waiver Service Definition	Home and Community Based Services for Children with Autism (HCBS-CWA) benefits shall be provided within Cost Containment and shall be provided in a group or individual setting. Behavioral therapies may include: Intensive developmental behavioral therapies developed specific to the client's needs including conditioning, biofeedback or reinforcement techniques; Treatment goals that are consistent with building elementary verbal skills, teaching imitation, establishing

	appropriate toy play or interactive play with other children, teaching appropriate expression of emotions and behaviors, and where necessary, reducing self stimulation and aggressive behaviors; One on one behavior therapy conducted with the client and Line Staff, following a specific protocol established by the Lead Therapist; Training or modeling for parents or a guardian so that the behavioral therapies can continue in the home.
Service Limitations	Behavioral therapies shall only be a benefit if they are not available under Medicaid EPSDT coverage, Medicaid State Plan benefits, third party liability coverage or by other means. Benefits shall be limited to three years, either contiguous or intermittent with a one year extension based on medical necessity as stated by the client's physician and upon approval by the Department. The annual cost of benefits per client shall not exceed $25,000 or available funds whichever is less.
Rule	**10 CCR 2505-10 Section 8.519.2.B Behavioral Therapies** 8.519.2.B. Behavioral therapies shall be provided in a group or individual setting. 8.519.2.C. Behavioral therapies shall only be a benefit if they are not available under Medicaid EPSDT coverage, Medicaid State Plan benefits, third party liability coverage or by other means. Behavioral therapies may include: 1. Intensive developmental behavioral therapies specifically created to meet the client's needs including conditioning, biofeedback or reinforcement techniques. 2. Treatment goals that are consistent with building elementary verbal skills, teaching imitation, establishing appropriate toy play or interactive play with other children, teaching appropriate expression of emotions and behaviors, and where necessary, reducing self stimulation and aggressive behaviors. 3. One-on-one behavior therapy between a client and a therapist following a specific protocol established by the Lead Therapist. Therapy may be implemented by a Lead Therapist, Senior Therapist, or Line Staff. 4. Training or modeling for parents or a guardian so that the behavioral therapies can continue in the home. Training or modeling shall be: a. Directed toward instruction on therapies and use of equipment specified in the Care Plan. b. Carried out in the presence of and for the direct benefit of the client. 8.519.2.D. Benefits shall be limited to three years, either contiguous or intermittent with a one-year extension based on medical necessity as stated by the client's physician and upon approval by the Department. 8.519.2.E. The annual cost of benefits per client shall not exceed $25,000 or available funds whichever is less.
Targeted Population	Targeted to children up to the age of 6 who have a diagnosis of autism and meet the ICF/ID level of care.
Waiver Manager Comment	Legislation was recently passed that will required annual assessments of behavioral interventions to either prove effectiveness or require change in treatment methodologies. The state is in the process of implementing this legislation.

Waiver	HCBS-Children's Extensive Support Waiver (BEHAVIORAL SERVICES)
Waiver Service Definition	1) Behavioral Consultation Services include consultations and recommendations for behavioral interventions and development of behavioral support plans that are related to the individual's developmental disability and are necessary for the individual to acquire or maintain appropriate adaptive behaviors, interactions with others and behavioral self management. Intervention modalities shall relate to an identified challenging behavioral need of the individual. Specific goals and procedures for the Behavioral Services must be established. Individuals with co-occurring diagnoses of developmental disabilities and Medicaid covered mental health conditions shall have identified needs met by each of the appropriate systems without duplication but with coordination by the Behavioral Services professional to obtain the best outcome for the individual. 2) Behavioral Plan Assessment Services include observations, interviews of direct staff, functional behavioral analysis and assessment, evaluations and completion of a written assessment document. 3) Individual/Group Counseling Services include psychotherapeutic or psycho-educational intervention related to the developmental disability in order for the individual to acquire or maintain appropriate adaptive behaviors, interactions with others and behavioral self-management, to positively impact the individual's behavior or functioning. Counseling may be provided in an individual or group setting and may include Cognitive Behavior Therapy, Systematic Desensitization, Anger Management, Biofeedback, and Relaxation Therapy. 4) Behavioral Line Services include direct implementation of the behavioral support plan, under the supervision and oversight of a Behavioral Consultant for intervention to address social/emotional issues and/or with an identified challenging behavior that puts the individual's health and safety and/or the safety of others at risk.
Service Limitations	Services covered under Medicaid EPSDT, for a covered mental health diagnosis in the Medicaid State Plan, covered by a third party source or available from a natural support shall not be reimbursed. Services for the sole purpose of training in basic life skills such as activities of daily living, social skills and adaptive responding are excluded and shall not be reimbursed under Behavioral Services. The unit limit for completion of a Behavioral Plan Assessment is 40 units. There is a limit of one Behavioral Plan Assessment per Service Plan year.
Rule	**10 CCR 2505-10 Section 8.503.40 A(3) Behavioral Therapies** Behavioral Services are services related to a client's developmental disability which assist a client to acquire or maintain appropriate interactions with others. a. Behavioral Services shall address specific challenging behaviors of the client and identify specific criteria for remediation of the behaviors. b. A client with a co-occurring diagnosis of developmental disabilities and mental health diagnosis covered in the Medicaid state plan shall have identified needs met by each of the applicable systems without duplication but with coordination by the behavioral services professional to obtain the best outcome for the client. c. Services covered under Medicaid EPSDT or a covered mental health diagnosis in the Medicaid State Plan, covered by a third party source or available from a natural support are excluded and shall not be reimbursed. d. Behavioral Services include: i. Behavioral Consultation Services include consultations and recommendations for behavioral interventions and development of behavioral support plans that are related to the client's developmental disability and are necessary for the client to acquire or maintain appropriate adaptive behaviors, interactions with others and behavioral self management.

	a) Intervention modalities shall relate to an identified challenging behavioral need of the client. Specific goals and procedures for the behavioral service must be established. ii. Behavioral Plan Assessment Services include observations, interviews of direct staff, functional behavioral analysis and assessment, evaluations and completion of a written assessment document. 1) Behavioral plan assessment services are limited to forty (40) units and one assessment per service plan year. One unit is equal to fifteen (15) minutes of service. iii. Individual and group counseling services include psychotherapeutic or psychoeducational intervention that: 1.) Is related to the developmental disability in order for the client to acquire or maintain appropriate adaptive behaviors, interactions with others and behavioral self-management, and 2.) Positively impacts the client's behavior or functioning and may include cognitive behavior therapy, systematic desensitization, anger management, biofeedback and relaxation therapy. iv. Behavioral Line Services include direct implementation of the behavioral plan under the supervision and oversight of a behavioral consultant, for intervention to address social or emotional issues or with an identified challenging behavior that puts the individual's health and safety or the safety of others at risk.
Targeted Population	Children with a developmental delay/disability under age 18 who meet the ICF/IID Level of Care
Waiver Manager Comment	Continue to provide this service as is currently in the CES waiver

BEHAVIORAL ASSESSMENT

Waiver	HCBS-for Persons with Developmental Disabilities
Waiver Service Definition	BEHAVIORAL ASSESSMENT IS NOT AN AVAILABLE SERVICE IN THIS WAIVER-It is a sub component service of the Behavioral Services in the HCBS-DD waiver
Service Limitations	40 units/1 Assessment per SP year
Rule	10 CCR 2505-10 Section 8.503.40 A (3) Behavioral Therapies
Targeted Population	Persons with developmental disabilities age 18 and older who meet the ICF/IID Level of Care
Waiver Manager Comment	Keep this subcomponent service with the established unit limitation

Waiver	HCBS- Children's Habilitation Residential Program Waiver
Waiver Service Definition	A Behavioral Assessment would be provided to those children who have a documented and demonstrated need for behavioral services and have not resided with the same provider for more than 90 days. The Behavioral Assessment would result in a behavior plan which would then be used and implemented by the foster parent(s) or staff. A Behavioral Assessment could include observations, interviews of staff, a functional behavior analysis and assessment, evaluations, and completions of a written assessment. The Behavioral Assessment does not duplicate services provided by the Behavioral Health Organization or the Medicaid State Plan.
Service Limitations	No more than one behavioral assessment every two years unless otherwise authorized by the Waiver Administrator. (Max. 700 hours)
Rule	Rule in progress
Targeted Populaton	Children and youth who are developmentally disabled as defined in Section 27-10.5-102(11), C.S.R. Children under age 5 who are developmentally delayed are included only when developmental delay is accompanied by significant medical and/or behavioral needs.

	********** Children from birth to 21 years of age who are placed through a County Department of Social Services, have a developmental disability and extraordinary service needs, and for whom services cannot be provided at the county negotiated rate.
Waiver Manager Comment	HCPF – Dear Stakeholder letter dated June 7,2007 outlines criteria approved for use by BHO and their providers in assessment and treatment of mental health conditions for individuals with developmental disabilities.

Waiver	**HCBS-Children's Extensive Support Waiver**
Waiver Service Definition	**Behavior Services** 1) Behavioral Consultation Services include consultations and recommendations for behavioral interventions and development of behavioral support plans that are related to the individual's developmental disability and are necessary for the individual to acquire or maintain appropriate adaptive behaviors, interactions with others and behavioral self management. Intervention modalities shall relate to an identified challenging behavioral need of the individual. Specific goals and procedures for the Behavioral Services must be established. Individuals with co-occurring diagnoses of developmental disabilities and Medicaid covered mental health conditions shall have identified needs met by each of the appropriate systems without duplication but with coordination by the Behavioral Services professional to obtain the best outcome for the individual. 2) Behavioral Plan Assessment Services include observations, interviews of direct staff, functional behavioral analysis and assessment, evaluations and completion of a written assessment document. 3) Individual/Group Counseling Services include psychotherapeutic or psycho-educational intervention related to the developmental disability in order for the individual to acquire or maintain appropriate adaptive behaviors, interactions with others and behavioral self-management, to positively impact the individual's behavior or functioning. Counseling may be provided in an individual or group setting and may include Cognitive Behavior Therapy, Systematic Desensitization, Anger Management, Biofeedback, and Relaxation Therapy. 4) Behavioral Line Services include direct implementation of the behavioral support plan, under the supervision and oversight of a Behavioral Consultant for intervention to address social/emotional issues and/or with an identified challenging behavior that puts the individual's health and safety and/or the safety of others at risk.
Service Limitations	The unit limit for completion of a Behavioral Plan Assessment is 40 units. There is a limit of one Behavioral Plan Assessment per Service Plan year.
Rule	8050.40.A. 3. Behavioral Services are services related to a client's developmental disability which assist a client to acquire or maintain appropriate interactions with others. a. Behavioral Services shall address specific challenging behaviors of the client and identify specific criteria for remediation of the behaviors. b. A client with a co-occurring diagnosis of developmental disabilities and mental health diagnosis covered in the Medicaid state plan shall have identified needs met by each of the applicable systems without duplication but with coordination by the behavioral services professional to obtain the best outcome for the client. c. Services covered under Medicaid EPSDT or a covered mental health diagnosis in the Medicaid State Plan, covered by a third party source or available from a natural support are excluded and shall not be reimbursed. d. Behavioral Services include: i. Behavioral Consultation Services include consultations and recommendations for behavioral interventions and development of

	behavioral support plans that are related to the client's developmental disability and are necessary for the client to acquire or maintain appropriate adaptive behaviors, interactions with others and behavioral self management. a) Intervention modalities shall relate to an identified challenging behavioral need of the client. Specific goals and procedures for the behavioral service must be established. ii. Behavioral Plan Assessment Services include observations, interviews of direct staff, functional behavioral analysis and assessment, evaluations and completion of a written assessment document. 1) Behavioral plan assessment services are limited to forty (40) units and one assessment per service plan year. One unit is equal to fifteen (15) minutes of service. iii. Individual and group counseling services include psychotherapeutic or psychoeducational intervention that: 1.) Is related to the developmental disability in order for the client to acquire or maintain appropriate adaptive behaviors, interactions with others and behavioral self-management, and 2.) Positively impacts the client's behavior or functioning and may include cognitive behavior therapy, systematic desensitization, anger management, biofeedback and relaxation therapy. iv. Behavioral Line Services include direct implementation of the behavioral plan under the supervision and oversight of a behavioral consultant, for intervention to address social or emotional issues or with an identified challenging behavior that puts the individual's health and safety or the safety of others at risk.
Targeted Population	Clients ages birth up to 18th birthday Must have developmental delay (age 5 and under) or developmental disability Have a behavior or medical condition so intense it requires near constant line of sight supervision.
Waiver Manager Comment	Low Assessment use: FY PD claims unduplicated client count (Behavioral assessment 26 with overall unduplicated waiver count 409 **Recommendation: Keep this service due to:** 1. Assessment is needed to support the need for Behavioral services. Behavioral assessment is not a standalone service in the Federally approved waiver. It is included under behavioral services. Behavioral assessment is the only Behavioral service limited in the HCBS-CES waiver. No recommendations for change to this service.

BEREAVEMENT SERVICES

Waiver	HCBS- Children with Life Limiting Illness Waiver
Waiver Service Definition	Grief/loss or anticipatory grief counseling and bereavement counseling provided by a Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor (LPC), Licensed Psychologist or non-denominational Chaplain/Spiritual Care counselor with experience working with clients with life-limiting illnesses and their families and according to hospice industry established practice guidelines. Counseling is provided to decrease a client's feelings of isolation, improve communications skills, decrease emotional suffering due to health status, and develop coping skills. Counseling is provided for the client and the caregiver/family members to alleviate the feelings of devastation and loss related to a diagnosis and prognosis for limited lifespan, surrounding the failing health status of the client, and impending death of a child. Counseling is provided to the participant and/or family members in order to guide and help them cope with the participant's illness and the related stress that accompanies the continuous, daily care required by a terminally ill child. Enabling the participant and family members to manage this stress improves the likelihood that the child with a life-threatening condition will continue to be cared for at home, thereby preventing premature and otherwise unnecessary institutionalization. Bereavement activities and opportunities for dialog offer the family a mechanism for expressing emotion and asking questions about death and grieving in a safe environment thereby potentially decreasing complications for the family after the child dies. Bereavement counseling is initiated and billed while the child is on the waiver but may continue after the death of the child for a period of up to 6 months.
Service Limitations	Limited to 98 hours every 365 days based on the date the client entered the program. Client/Family/Caregiver Counseling will be provided according to the assessment of the client in the continuum of care after a diagnosis of a life-limiting illness or condition. When a child is first diagnosed with the illness, the child and family might need a significant amount of anticipatory grief/loss counseling that may taper off during the treatment phase when the child has some improvement or remission of symptoms. As the child's health deteriorates, counseling services may be required at an intensive level. Bereavement services are included in the reimbursement for the 98 hours per year of counseling provided prior to the child's death. Providers are required to provide up to one year of bereavement counseling following the death of the waiver participant. During the past year, the Bereavement services have been utilized by those families that have suffered a loss. The services are continued for 6 months following the demise of the child. A Master prepared Social Worker, Counselor, Licensed Psychologist or non-denominational Chaplain/Spiritual Care Counselor shall be the direct provider for this service and acuity level is determined by professional assessment of need. When available and appropriate, State Plan services will be utilized prior to waiver services for the child or family.
Rule	**10 CCR 2505-10 Section 8.504.2.C** Client/Family/Caregiver Counseling means grief/loss or anticipatory grief counseling and bereavement counseling that assist the client, family or caregiver

	to decrease emotional suffering due to the client's health status, to decrease feelings of isolation or to cope with the client's life-limiting diagnosis. 8.504.2.C. Client/Family/Caregiver Counseling shall be provided in individual or group setting. 1. Client/Family/Caregiver Counseling shall only be a benefit if it is not available under Medicaid EPSDT coverage, Medicaid State Plan benefits, third party liability coverage or by other means. 2. Client/Family/Caregiver Counseling shall be limited to 98 hours per every 365 days based on the date the client entered the program. 3. Family/Caregiver Counseling shall be available to family members for bereavement counseling for up to one year following the death of the client.
Targeted Population	The waiver is targeted to children who are considered medically fragile through the age of 18. The child must have a diagnosis of a life limiting illness and meet the hospital level care.
Waiver Manager Comment	Currently this service is available under the counseling category. The Department is working to separate it out as a distinct service in an effort to allow for easier access coupled with the need to have better tracking of utilization.

SUPPORTED COMMUNITY CONNECTIONS

Waiver	HCBS-for Persons with Developmental Disabilities
Waiver Service Definition	Community Connection Services available as part of the DAY HABILITATION SERVICE.
Service Limitations	
Rule	
Targeted Population	
Waiver Manager Comment	

Waiver	HCBS- Children's Habilitation Residential Program Waiver
Waiver Service Definition	Supported Community Connections services are provided one-on-one to deliver instruction for documented severe behavior problems that are being demonstrated by the waiver participant while in the community, i.e. physically or sexually aggressive to others and/or exposing themselves. This service is not duplicative of State Plan benefits or those services offered by the Behavioral Health Organization. These activities are conducted in a setting within the community where participants interact with non-disabled individuals (other than the individual that is providing the service to the participant). Supported Community Connections is an additional service provided by a Medicaid provider to work with the child one-on-one while in the community for no more than five (5) hours per week. The child will receive the Supported Community Connections service by the same individual during the service span in order to provide consistency. The targeted behavior, measurable goal(s), and work plan must be clearly articulated in the Service Plan.
Service Limitations	Maximum of 5 hours per week. Requests to increase hours can be made to the waiver administrator on a case-by-case basis.
Rule	10 CCR 2505-10, Section 8.508

Targeted Population	Children and youth who are developmentally disabled as defined in Section 27-10.5-102(11), C.S.R. Children under age 5 who are developmentally delayed are included only when developmental delay is accompanied by significant medical and/or behavioral needs. ********** Children from birth to 21 years of age who are placed through a County Department of Social Services, have a developmental disability and extraordinary service needs, and for whom services cannot be provided at the county negotiated rate.
Waiver Manager Comment	Services provided through this program serve as an alternative to ICF/ID placement for children birth to 21 years of age who meet criteria and Level of Need Screening Guidelines.

Waiver	**HCBS-Children's Extensive Support Waiver**
Waiver Service Definition	**Community Connector** Supports the abilities and skills necessary to enable the individual to access typical activities and functions of community life such as those chosen by the general population. Community Connections provides a wide variety of opportunities to facilitate and build relationships and natural supports in the community while utilizing the community as a learning environment to provide services and supports as identified in the participant's service plan. These activities are conducted in a variety of settings in which participants interact with non-disabled individuals (other than those individuals who are providing services to the participant). These types of services may include socialization, adaptive skills, and personnel to accompany and support the individual in community settings, resources necessary for participation in activities and supplies related to skill acquisition, retention, or improvement. Community Connections are provided on a one-to-one basis as a learning environment to provide instruction when identified in the Service Plan.
Service Limitations	Limited to the cost containment of the waiver
Rule	8.503.40.A. 4. Community Connector Services are intended to provide assistance to the client to enable the client to integrate into the client's residential community and access naturally occurring resources. Community connector services shall: a. Support the abilities and skills necessary to enable the client to access typical activities and functions of community life such as those chosen by the general population. b. Utilize the community as a learning environment to assist the client to build relationships and natural supports in the client's residential community. c. Be provided to a single client in a variety of settings in which clients interact with individuals without disabilities, and d. The cost of admission to professional or minor league sporting events, movies, theater, concert tickets or any activity that is entertainment in nature or any food or drink items are specifically excluded under the HCBS-CES waiver and shall not be reimbursed.

Targeted Population	Clients ages birth up to 18th birthday Must have developmental delay (age 5 and under) or developmental disability Have a behavior or medical condition so intense it requires near constant line of sight supervision.
Waiver Manager Comment	Moderate use: FY PD claims unduplicated client count 130; overall waiver unduplicated count 409 **Recommendation: Further discussion is needed. Cautiously recommend to keep service with consideration of the following:** 1. Service needs to be re-examined. Distinction is vague between Community Connector, Behavioral Line staff and Respite. Often it appears Community Connector is inappropriately used as a more expensive alternative to Respite (for clients who cannot exceed the Respite limit) or Behavioral Line staff (because the rate is higher.) 2. Remove "resources necessary for participation in activities and supplies" from the service description because these items would be required for all participating in the activity and are not needed due to the child's disability.

EXTENDED STATE PLAN SERVICES

The services included in a waiver must not duplicate services that are provided under the State plan. However, through a waiver, a state may augment the services that it provides under the State plan. When a state wants to enhance the amount, duration or frequency of a State plan service but otherwise the scope of the service is the same as the State plan service, the service is considered an "extended State plan" service. For example, under a waiver, the number of home health aide visits that are allowed under the State plan can be augmented. The amount chargeable as waiver services is the amount incurred after any limits in State plan services are exhausted. In this part of the table, list any other extended State plan services that are included in the waiver. In the service specifications for these services, note that the service is covered under the State plan and describe how the amount, duration or frequency of the service differs from the State plan. While a waiver service may be similar in scope to a State plan service, it would be considered an "other" service rather than an extended State Plan service if the service delivery modality (i.e., availability of participant direction) is different under the waiver.

Services that a state could cover under the State plan but does not are considered "other" services or statutory services (e.g., personal care) as the case may be, not extended state plan services. When a service is covered under the waiver that is similar to but has a different scope and/or uses different types of providers than the service covered under the State plan, it is considered an "other" service, not an extended state plan service. A service is not considered to be an extended State plan service if it cannot be reimbursed in whole or in part under the State plan.

When children are served in a waiver, the services that are included in the waiver must take into account the availability of enhanced Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services. Since Federal requirements concerning EPSDT services mandate that Medicaid eligible children receive all medically necessary services listed in §1905(a) of the Act that they require regardless of whether such services are specifically included in the State plan, the waiver may not provide for the coverage of services that could be furnished to children under EPSDT. If a waiver targets children exclusively, it may not provide for the coverage of any service that can be offered through the State plan.

Colorado's Extended State Plan Services include:

Dental and Vision

DENTAL SERVICES

Waiver	HCBS-for Persons with Developmental Disabilities
Waiver Service Definition	Dental services through the waiver are available to individuals age 21 and over. Covered Dental Services are for diagnostic and preventative care to abate tooth decay, restore dental health and are medically appropriate. Services include preventative, basic and major services. These dental services require prior authorization at the local Community Centered Board (CCB) level pursuant to the DDD Prior Authorization Request (PAR) Process.
Service Limitations	Dental services under the waiver are provided only when the services are not available through the Medicaid State Plan due to not meeting the need for medical necessity as defined in Health Care Policy and Financing rules at 10 CCR 2505-10, 8.011.11 or available through a third party. Dental Services under the waiver are not available to a client eligible for EPSDT services. General limitations to dental services (i.e. frequency) will follow Department Guidelines using industry standards and are limited to the most cost effective and efficient means to alleviate or rectify the dental issues associated with the individual. Implants are not a covered service for participants who smoke daily due to substantiated increased rate of implant failures for chronic smokers. Subsequent implants are not a covered service when prior implants fail. Full mouth implants and/or crowns are not covered. Services not covered under the waiver Dental Services include, but are not limited to cosmetic dentistry, orthodontia, emergency extractions, intraveneous sedation, general anesthesia and hospital fees. Cosmetic dentistry is defined as aesthetic treatments designed to improve the appearance of the teeth and/or smile (e.g. whitening, contouring, veneers). Preventative and Basic services are limited to $2,000 per Service Plan year. Major services are limited to $10,000 for the five (5) year renewal period of the waiver.
Rule	**10 CCR 2505-10 Section 8.500.5.A(3)** Dental services are available to individuals age twenty one (21) and over and are for diagnostic and preventative care to abate tooth decay, restore dental health, are medically appropriate and include preventative, basic and major dental services. a. Preventative services include: i). Dental insurance premiums and co-pays/co-insurance, i) Periodic examination and diagnosis, ii) Radiographs when indicated, iv). Non-intravenous sedation, v). Basic and deep cleanings,

	vi). Mouth guards, vii). Topical fluoride treatment, and X). Retention or recovery of space between teeth when indicated. b. Basic services include: i) Fillings, ii) Root canals, iii) Denture realigning or repairs, iv) Repairs/re-cementing crowns and bridges, v) Non-emergency extractions including simple, surgical, full and partial vi) Treatment of injuries, or vii) Restoration or recovery of decayed or fractured teeth c. Major services include: i) Implants when necessary to support a dental bridge for the replacement of multiple missing teeth or is necessary to increase the stability of dentures, crowns, bridges, and dentures. The cost of implants is only reimbursable with prior approval in accordance with Operating Agency procedures. ii) Crowns iii) Bridges iv) Dentures. Implants are a benefit only when the procedure is necessary to support a dental bridge for the replacement of multiple missing teeth, or is necessary to increase the stability of dentures. The cost of implants is reimbursable only with prior approval. e. Implants shall not be a benefit for a client who uses tobacco daily due to a substantiated increased rate of implant failures for tobacco users. Subsequent implants are not a benefit when prior implants fail. f. Dental services are provided only when the services are not available through the Medicaid state plan due to not meeting the need for medical necessity as defined in Health Care Policy and Financing rules at 10 CCR 2505-10, Section 8011.11 or available through a third party. General limitations to dental services including frequency will follow the Operating Agency's guidelines using industry standards and are limited to the most cost effective and efficient means to alleviate or rectify the dental issue associated with the client. g. Dental services do not include cosmetic dentistry, procedures predominated by specialized prosthodotic, maxillo-facial surgery, craniofacial surgery or orthodontia, which includes, but is not limited to: i) Elimination of fractures of the jaw or face, ii) Elimination or treatment of major handicapping malocclusion, or iii) Congenital disfiguring oral deformities. h. Cosmetic dentistry is defined as aesthetic treatment designed to improve the appearance of the teeth or smile, including teeth whitening, veneers,

	contouring and implants or crowns solely for the purpose of enhancing appearance. i. Preventative and basic services are limited to $2,000 per service plan year. Major services are limited to $10,000 for the five (5) year renewal period of the waiver.
Targeted Population	Persons with developmental disabilities age 18 and older who meet the ICF/IID Level of Care and who require 24/7 access to supervision
Waiver Manager Comment	Continue to provide this service as amended in the HCBS-DD Waiver 12/1/11.

Waiver	**HCBS- Supported Living Services Waiver**
Waiver Service Definition	Same as DD Waiver
Service Limitations	Same as DD Waiver
Rule	**10 CCR 2505-10 Section 8.500.94.A(4)** Dental services are available to individuals age twenty one (21) and over and are for diagnostic and preventative care to abate tooth decay, restore dental health, are medically appropriate and include preventative, basic and major dental services. a. Preventative services include: i) Dental insurance premiums and co-payments ii) Periodic examination and diagnosis, iii) Radiographs when indicated, iv) Non-intravenous sedation, v) Basic and deep cleanings, vi) Mouth guards, vii) Topical fluoride treatment, xi) Retention or recovery of space between teeth when indicated, and b. Basic services include: i) Fillings, ii) Root canals,

	iii) Denture realigning or repairs, iv) Repairs/re-cementing crowns and bridges, v) Non-emergency extractions including simple, surgical, full and partial, vi) Treatment of injuries, or vii) Restoration or recovery of decayed or fractured teeth, c. Major services include: i) Implants when necessary to support a dental bridge for the replacement of multiple missing teeth or is necessary to increase the stability of, crowns, bridges, and dentures. The cost of implants is only reimbursable with prior approval in accordance with Operating Agency procedures. ii) Crowns iii) Bridges iv) Dentures d. Dental services are provided only when the services are not available through the Medicaid state plan due to not meeting the need for medical necessity as defined in Health Care Policy and Financing rules at 10 CCR 2505-10, 8011.11 or available through a third party. General limitations to dental services including frequency will follow the Operating Agency's guidelines using industry standards and are limited to the most cost effective and efficient means to alleviate or rectify the dental issue associated with the client e. Implants shall not be a benefit for clients who use tobacco daily due to substantiated increased rate of implant failures for chronic tobacco users. f. Subsequent implants are not a covered service when prior implants fail. g. Full mouth implants or crowns are not covered. h. Dental services do not include cosmetic dentistry, procedures predominated by specialized prosthodotic, maxillo-facial surgery, craniofacial surgery or orthodontia, which includes, but is not limited to: i) Elimination of fractures of the jaw or face, ii) Elimination or treatment of major handicapping malocclusion, or iii) Congenital disfiguring oral deformities. i. Cosmetic dentistry is defined as aesthetic treatment designed to improve the appearance of the teeth or smile, including teeth whitening, veneers, contouring and implants or crowns solely for the purpose of enhancing appearance. j. Preventative and basic services are limited to two thousand ($2,000) per service plan year. Major services are limited to ten thousand ($10,000) for the five (5) year renewal period of the waiver.
Targeted Population	Persons aged 18 and older with a developmental disability who meet ICF/ID level of care
Waiver Manager	Continue to provide this service in the HCBS-SLS Waiver as amended 12/1/11

VISION SERVICES

Waiver	HCBS-for Persons with Developmental Disabilities
Waiver Service Definition	Vision services are provided only when the services are not available through the Medicaid State Plan due to not meeting the need for medical necessity as defined in Health Care Policy and Financing rules at 8.011.11 or available through a third party resource. Vision services under the waiver are not available to a client eligible for EPSDT services. Vision services are provided by a licensed Optometrist or physician and include eye exams and diagnosis, glasses, contacts, and other medically necessary methods used to improve specific dysfunctions of the vision systems. Lasik and other similar types of procedures shall be approved prior to service delivery and are allowable when the procedure is necessary due to documented specific behavioral complexities (i.e. constant destruction of eye glasses) associated with the participant that make other more traditional remedies impractical.
Service Limitations	NA
Rule	**10 CCR 2505-10 Section 8.500.5.A(8)** Vision Services include eye exams or diagnosis, glasses, contacts or other medically necessary methods used to improve specific dysfunctions of the vision system when delivered by a licensed optometrist or physician for a client who is at least twenty-one (21) years of age. a. Lasik and other similar types of procedures are only allowable when: i) The procedure is necessary due to the client's documented specific behavioral complexities that result in other more traditional remedies being impractical or not cost effective. ii) Prior authorized in accordance with Operating Agency procedures.
Targeted Population	Participants with developmental disabilities age 18 and older requiring 24/7 access to supervision
Waiver Manager Comment	Continue to provide this service as is in the HCBS-DD Waiver

Waiver	**HCBS- Supported Living Services Waiver**
Waiver Service Definition	These services are provided only when the services are not available through the Medicaid State Plan due to not meeting the need for medical necessity as defined in Health Care Policy and Financing rules at 8.011.11 or available through a third party resource. Vision services are provided by a licensed Optometrist or physician and include eye exams and diagnosis, glasses, contacts, and other medically necessary methods used to improve specific dysfunctions of the vision systems. Lasik and other similar types of procedures are only prior approved and allowable when the procedure is necessary due to documented specific behavioral complexities (i.e. constant destruction of eye glasses) associated with the participant that make other more traditional remedies impractical.
Service Limitations	NA
Rule	**10 CCR 2505-10 Section 8.500.94.A(16)** Vision services include eye exams or diagnosis, glasses, contacts or other medically necessary methods used to improve specific dysfunctions of the vision system when delivered by a licensed optometrist or physician for a client who is at least 21 years of age a. Lasik and other similar types of procedures are only allowable when: b. The procedure is necessary due to the client's documented specific behavioral complexities that result in other more traditional remedies being impractical or not cost effective, and c. Prior authorized in accordance with Operating Agency procedures.
Targeted Population	Persons with developmental disabilities age 18 and older who meet the ICF/IID Level of Care and who require 24/7 access to supervision
Waiver Manager Comment	Continue to provide this service as is in the HCBS-SLS Waiver

Waiver	**HCBS-Children's Extensive Support Waiver (VISION)**
Waiver Service Definition	Vision therapy is provided only when the services are not available through the Medicaid State Plan or EPSDT due to not meeting the need for medical necessity as defined in Health Care Policy and Financing rules at 8.011.11 or available through a third party resource. Vision therapy is a sequence of activities individually prescribed and monitored by a doctor of optometry or ophthalmology to develop efficient visual skills and processing. It is based on the results of standardized tests, the needs of the participant and the participant's signs and symptoms. It is used to treat eye movement disorders, inefficient eye teaming, misalignment of the eyes, poorly developed vision, focusing problems and visual information processing disorders to enhance visual skills and performing visual tasks.
Service Limitations	NA

Rule	**10 CCR 2505-10 Section 8.503.40.A(13)** Vision service a. Vision therapy is a sequence of activities individually prescribed and monitored by a Doctor of Optometry or Ophthalmology to develop efficient visual skills and processing. It is based on the results of standardized tests, the needs of the client and the client's signs and symptoms. It is used to treat eye movement disorders, inefficient eye teaming, misalignment of the eyes, poorly developed vision, focusing problems and visual information processing disorders to enhance visual skills and performing visual tasks. b. The following items are specifically excluded under the HCBS-CES waiver and not eligible for reimbursement: i) Eye glasses as a benefit under Medicaid State Plan, ii) Contacts, or iii) General vision checks c. Vision therapy is provided only when the services are not available through the Medicaid State Plan or EPSDT and due to not meeting the need for medical necessity as defined in Health Care Policy and Financing rules at 10 CCR 2505-10,Section 8.208.1 or available through a third party resource.
Targeted Population	Clients ages birth up to 18th birthday Must have developmental delay (age 5 and under) or developmental disability Have a behavior or medical condition so intense it requires near constant line of sight supervision.
Waiver Manager Comment	Low use: FY PD claims unduplicated client count 2 with overall waiver unduplicated count 409 **Recommendation: Keep this service, no changes recommended.** 1. This service provides eye exercises to improve learning and visual attention. This reduces frustration and anxiety resulting in positive behavioral changes. 2. Supports behavioral services.

SERVICES IN SUPPORT OF PARTICIPANT DIRECTION

When a state provides the opportunity for participants to direct some or all of their waiver services, the state must make available certain supports to waiver participants who do so. These supports include "financial management services" and "information and assistance" to support waiver participants in directing and managing their services.

When the waiver provides opportunities for participants to direct some or all of their waiver services, indicate in this part of the table whether either of these supports (along with any other supports for participant direction as defined by the state) are covered as waiver services. Please note that these supports for participant direction do not necessarily have to be provided as a distinct waiver service (for example, supports for participant direction may be offered in conjunction with the provision of waiver case management services. Please note, however, that when the supports for participant direction are coupled with traditional case management services, the rules set forth in CMS-2237-IFC apply. Both types of supports also may be furnished as administrative activities rather than as waiver services.

Colorado offers two services in support participant directed and include:

Consumer Directed Attendant Support Services

In-Home Supportive Services

CONSUMER DIRECTED SUPPORT SERVICES (CDASS)

Waiver	**HCBS-Elderly, Blind and Disabled Waiver**
Waiver Service Definition	Services that assist an individual in accomplishing activities of daily living including health maintenance, personal care, homemaker activities, and protective oversight. Health maintenance activities are those routine and repetitive activities of daily living which require skilled assistance for health and normal bodily functioning, and which would be carried out by an individual with a disability if he or she were physically/cognitively able. Personal Care services are those routine and repetitive activities of daily living which require non-skilled assistance for health and normal bodily functioning and which would be carried out by an individual with a disability if he or she were physically/cognitively able. Personal Care includes accompanying the client outside the home when associated with the delivery of a personal care task. Homemaker services are general household activities provided in the home of an eligible client to maintain a healthy and safe home environment for a client, when the person ordinarily responsible for these activities is absent or unable to manage these tasks. Protective oversight is supervision of the client to prevent at risk behavior that may result in harm to the client. These services are provided by an attendant under the supervision of the client or the client's authorized representative. The client, or the authorized representative, is responsible for hiring, training, recruiting, setting wages, scheduling, and in other ways managing the attendant.
Service Limitations	Consumer Directed Attendant Support Services offered in this waiver are limited based on the client's assessed need for services and prior authorization by case managers up to cost containment parameters. In addition, spouses, guardians and family members are limited to providing CDASS under the guidelines described in Appendix C-2, d and e.
Rule	**10 CCR 2505-10 Section 8.510** CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES 8.510.1 DEFINITIONS Adaptive Equipment means a device(s) that is used to assist with completing activities of daily living. Allocation means the funds determined by the case manager and made available by the Department to clients receiving Consumer Directed Attendant Support Services (CDASS) and administered by the Fiscal Management Services (FMS) authorized for attendant support services and administrative fees paid to the FMS. Attendant means the individual who meets qualifications in § 8.510.8 who provides CDASS as determined by § 8.510.3 and is hired through the contracted FMS organization. Attendant Support Management Plan (ASMP) means the documented plan for clients to manage their care as determined by § 8.510.4 which is reviewed and approved by the Case Manager. Authorized Representative (AR) means an individual designated by the client or the legal guardian, if appropriate, who has the judgment and ability to direct CDASS on a client's behalf and meets the qualifications as defined at § 8.510.6 and § 8.510.7. Benefits Utilization System (BUS) means the web based data system maintained by the Department for recording case management activities associated

	with Long Term Care (LTC) services. Case Management Agency (CMA) means a Department approved agency within a designated service area where an applicant or client can obtain Long Term Care case management services. Case Manager means an individual who meets the qualifications to perform case management activities by contract with the Department. Consumer Directed Attendant Support Services (CDASS) means the service delivery option for services that assist an individual in accomplishing activities of daily living when included as a waiver benefit that may include health maintenance, personal care, and homemaker activities. CDASS Training means the required training, including a final, comprehensive assessment, provided by the Department or its designee to a client/AR who is interested in directing CDASS. Continued Stay Review (CSR) means a periodic face to face review of a client's condition and service needs by a Case Manager to determine a client's continued eligibility for LTC services in the client's residence. Cost Containment means the cost of providing care in the community is less than or equal to the cost of providing care in an institutional setting based on the average aggregate amount. The cost of providing care in the community shall include the cost of providing Home and Community Based Services. Department means the Department of Health Care Policy and Financing Eligibility means a client qualifies for Medicaid based on the applicable eligibility category and the client's individual financial circumstances, including, but not limited to, income and resources. Fiscal Management Services organization (FMS) means the entity contracted with the Department as the employer of record for Attendants, to provide personnel management services, fiscal management services, and skills training to a client/AR receiving CDASS. Functional Eligibility means an applicant or client meets the criteria for LTC services as determined by the Department's prescribed instrument as outlined defined in § 8.401. Functional Needs Assessment means a component of the Assessment process which includes a comprehensive evaluation using the ULTC Instrument to determine if the client meets the appropriate Level of Care (LOC). Home and Community Based Services (HCBS) means a variety of supportive services delivered in conjunction with Colorado Medicaid Waivers to clients in community settings. These services are designed to help older persons and persons with disabilities remain living at home. Inappropriate Behavior means offensive behavior which includes: documented verbal, sexual and/or physical abuse. Verbal abuse may include threats, insults or offensive language over a period of time. Licensed Medical Professional means a person who has completed a 2-year or longer program leading to an academic degree or certificate in a medically related profession. This is limited to those who possess the following medical licenses: physician, physician assistant and nurse governed by the Colorado Medical License Act. Long Term Care (LTC) services means Nursing Facilities, Intermediate Care Facilities for the Mentally Retarded (ICF/MR), Home and Community Based Services (HCBS), Long Term Home Health or the Program of All-inclusive Care for the Elderly (PACE), Swing Bed and Hospital Back Up Program (HBU). Long Term Care Certification Period means the designated period of time in which a client is functionally eligible to receive LTC services not to exceed

	one year. Prior Authorization Request (PAR) means the Department prescribed form that assures the provider that the service is medically necessary and a Colorado Medical Assistance Program benefit. Notification means the routine methods in which the Department or its designee conveys information about CDASS. Including but not limited to the CDASS web site, client statements, Case Manager contact, or FMS contact. Reassessment means a review of the Assessment, to determine and document a change in the client's condition and/or client's service needs. Stable Health means a medically predictable progression or variation of disability or illness. 8.510.2 ELIGIBILITY 8.510.2.A. To be eligible for CDASS, an individual shall meet all of the following: 1. Choose the CDASS service delivery option 2. Meet medical assistance Financial Eligibility requirements 3. Meet Long Term Care Functional Eligibility requirements 4. Be eligible for an HCBS Waiver with the CDASS option 5. Demonstrate a current need for Attendant support 6. Document a pattern of stable health that necessitates a predictable pattern of Attendant support and appropriateness of CDASS services 7. Provide a statement from the primary care physician attesting to the client's ability to direct his or her care with sound judgment or a required AR with the ability to direct the care on the client's behalf 8. Complete all aspects of the ASMP and training and demonstrate the ability to direct care or have care directed by an AR 8.510.3 CDASS SERVICES 8.510.3.A Covered services shall be for the benefit of only the client and not for the benefit of other persons living in the home. 8.510.3.B Services include: 1. Homemaker. General household activities provided by an Attendant in a client's home to maintain a healthy and safe environment for the client. Homemaker activities shall be applied only to the permanent living space of the client and multiple attendants may not be reimbursed for duplicating household tasks. Tasks may include the following activities or teaching the following activities: a. Routine light housekeeping such as: dusting, vacuuming, mopping, and cleaning bathroom and kitchen areas b. Meal preparation c. Dishwashing d. Bed making e. Laundry

	f. Shopping for necessary items to meet basic household needs 2. Personal care. Services furnished to an eligible client in the client's home to meet the client's physical, maintenance, and supportive needs. Including a. Eating/feeding which includes assistance with eating by mouth using common eating utensils such as forks, knives, and straws b. Respiratory assistance with cleaning or changing oxygen equipment tubes, filling the distilled water reservoir, and moving the cannula or mask from the client's face c. Skin care preventative in nature when skin is unbroken; including the application of non-medicated/non-prescription lotions and/or sprays and solutions, rubbing of reddened areas, and routine foot checks for people with diabetes d. Bladder/Bowel Care: i) Assisting client to and from the bathroom ii) Assistance with bed pans, urinals, and commodes iii) Changing of incontinence clothing or pads iv) Emptying Foley or suprapubic catheter bags only if there is no disruption of the closed system v) Emptying ostomy bags e. Personal hygiene: i) Bathing including washing, shampooing, and shaving ii) Grooming iii) Combing and styling of hair iv) Trimming, cutting, and soaking of nails v) Basic oral hygiene and denture care f. Dressing assistance with ordinary clothing and the application of non-prescription support stockings and application of orthopedic devices such as splints and braces or artificial limbs g. Transferring a client when the client has sufficient balance and strength to assist with and can direct the transfer h. Assistance with mobility i. Positioning when the client is able to verbally or non-verbally identify when the position needs to be changed including simple alignment in a bed, wheelchair or other furniture j. Assistance with self administered medications when the medications have been preselected by the client, a family member, a nurse or a pharmacist and are stored in containers other than the prescription bottles, such as medication minders and medication reminding: i) Medication minders must be clearly marked as to the day and time of dosage and must be kept in a way as to prevent tampering ii) Medication reminding includes only inquiries as to whether medications were taken, verbal prompting to take medications, handing the appropriately

	marked medication minder container to the client and opening the appropriately marked medication minder if the client is unable k. Cleaning and basic maintenance of durable medical equipment l. Protective oversight when the client requires supervision to prevent or mitigate disability related behaviors that may result in imminent harm to people or property m. Accompanying includes going with the client, as necessary on the care plan, to medical appointments, and errands such as banking and household shopping. Accompanying the client to provide one or more personal care services as needed during the trip. Companionship is not a benefit of CDASS 3. Health Maintenance Activities. Routine and repetitive health related tasks, which are necessary for health and normal bodily functioning that a person with a disability is unable to physically carry out. Services may include: a. Skin care provided when the skin is broken or a chronic skin condition is active and could potentially cause infection Skin care may include: wound care, dressing changes, application of prescription medicine, and foot care for people with diabetes when prescribed by a licensed medical professional b. Nail care in the presence of medical conditions that may involve peripheral circulatory problems or loss of sensation c. Mouth care performed when: i) there is injury or disease of the face, mouth, head or neck ii) in the presence of communicable disease iii) the client is unconscious iv) oral suctioning is required d. Dressing including the application of anti-embolic or other prescription pressure stockings and orthopedic devices such as splints, braces, or artificial limbs if considerable manipulation is necessary e. Feeding: i) When oral suctioning is needed on a stand-by or other basis ii) When there is high risk of choking that could result in the need for emergency measures such as CPR or the Heimlich maneuver as demonstrated by a swallow study iii) Syringe feeding iv) Feeding using apparatus f. Exercise prescribed by a licensed medical professional including passive range of motion g. Transferring a client when he/she is unable to assist or the use of a lift such as a Hoyer is needed h. Bowel care provided to a client including digital stimulation, enemas, care of ostomies, and insertion of a suppository if the client is unable to assist i. Bladder care when it involves disruption of the closed system for a Foley or suprapubic catheter, such as changing from a leg bag to a night bag and care of external catheters j. Medical management required by a medical professional to monitor: blood pressures, pulses, respiratory assessment, blood sugars, oxygen

	saturations, pain management, intravenous, or intramuscular injections k. Respiratory care: i) Postural drainage ii) Cupping iii) Adjusting oxygen flow within established parameters iv) Suctioning of mouth and nose v) Nebulizers vi) Ventilator and tracheostomy care vii) Prescribed respiratory equipment 8.510.4 ATTENDANT SUPPORT MANAGEMENT PLAN 8.510.4.A The client/AR shall develop a written ASMP which shall be reviewed by the FMS and approved by the Case Manager. CDASS shall not begin until the Case Manager approves the plan and provides a start date. The ASMP is required by the FMS upon initial training and shall be modified when there is a change in the client's needs. The plan shall describe the individual's: 1. Current health status 2. Needs and requirements for CDASS 3. Plans for securing CDASS 4. Plans for handling emergencies 5. Assurances and plans regarding direction of CDASS Services, as described at 10 CCR 2505 -10, § 8.510.3 and § 8.510.6 if applicable 6. Plans for management of the budget within the client's Individual Allocation 7. Designation of an Authorized Representative 8. Designation of regular and back-up employees approved for hire 8.510.4.B. If ASMP is disapproved by the Case Manager, the client has the right to review that disapproval. The client shall submit a written request to the CMA stating the reason for the review and justification of the proposed ASMP. The client's most recently approved ASMP shall remain in effect while the review is in process. 8.510.5 TRAINING ACTIVITIES 8.510.5.A. When necessary to obtain the goals of the ASMP, the client/AR shall verify that each attendant has been or will be trained in all necessary health maintenance activities prior to performance by the attendant. 8.510.5.B The verification requirement of 8.510.5.A above will be on a form provided by the FMS and returned to the FMS with the client/AR completed employment packet.

	8.510.6 CLIENT/AR RESPONSIBILITES 8.510.6.A. Client/AR responsibilities for CDASS Management: 1. Attend FMS Training; clients who cannot attend training shall designate an AR 2. Develop an ASMP 3. Determine wages for each Attendant not to exceed the rate established by the Department 4. Determine the required credentials for Attendants 5. Establish hiring agreements, as required by the FMS with each Attendant, outlining wages, services to be provided (limited to Personal Care, Homemaker or Health Maintenance Activities), schedules and working conditions 6. Ensure FMS receives hiring agreements prior to Attendants providing services 7. Completing previous employment reference checks on Attendants 8. Follow all relevant laws and regulations applicable to client's supervision of Attendants 9. Explain the role of the FMS to the Attendant 10. Budget for Attendant care within the established monthly and CDASS Certification Period Allocation 11. Review all Attendant timesheets and statements for accuracy of time worked, completeness, and client/AR and Attendant signatures. Timesheets shall reflect actual time spent providing CDASS services 12. Review and submit approved Attendant timesheets to FMS by the established timelines for Attendant reimbursement 13. Authorize the FMS to make any changes in the Attendant wages 14. Understand that misrepresentation or false statements may result in administrative penalties, criminal prosecution, and/or termination from CDASS. Client/AR is responsible for assuring timesheets submitted are not altered in any way and that any misrepresentations are immediately reported to the FMS 15. Completing and managing all paperwork and maintaining employment records 8.510.6.B. Client/AR responsibilities for CDASS Services: 1. Recruit, hire, fire and manage Attendants 2. Train Attendants to meet client needs 3. Terminate Attendants who are not meeting client needs 8.510.6.C. Client/AR responsibilities for Verification: 1. Sign and return a responsibilities acknowledgement form for activities listed in 8.510.6 and to the Case Manager. 8.510.6.D. Clients receiving CDASS services have the following Rights:

	1. Right to receive instruction on managing CDASS 2. Right to receive program materials in accessible format 3. Right to receive notification of changes to CDASS 4. Right to participate in Department sponsored opportunities for input. 5. CDASS clients have the right to transition back to Personal Care, Homemaker, and Home Health Aide and Nursing services provided by an agency at any time. A client who wishes to transition back to an agency-provided services shall contact the Case Manager. The Case Manager shall coordinate arrangements for the services 6. A client/AR may request a re-assessment, as described at § 8.390.1 (N), if his or her level of service needs have changed. 7. A client/AR may revise the ASMP at any time with CM approval. CM shall notify FMS of changes. 8.510.7 AUTHORIZED REPRESENTATIVES 8.510.7.A. CDASS clients who require an AR may not serve as an AR for another CDASS client. 8.510.7.B. Authorized Representatives shall not receive reimbursement for AR services and shall not be reimbursed for CDASS services as an Attendant for the client they represent 8.510.8 ATTENDANTS 8.510.8.A. Attendants shall be at least 18 years of age and demonstrate competency in caring for the client to the satisfaction of the client/AR. 8.510.8.B. Attendants may not be reimbursed for more than 24 hours of CDASS service in one day for one or more clients collectively. 8.510.8.C. Authorized Representatives shall not be employed as an Attendant for the client. 8.510.8.D. Attendants must be able to perform the tasks on the Service Plan they are being reimbursed for and the client must have adequate Attendants to assure compliance with all tasks on the service plan. 8.510.8.E. Attendants shall not represent themselves to the public as a licensed nurse, a certified nurse's aide, a licensed practical or professional nurse, a registered nurse or a registered professional nurse. 8.510.8.F. Attendants shall not have had his or her license as a nurse or certification as a nurse aide suspended or revoked or his application for such license or certification denied. 8.510.8.G. The FMS shall be the employer of record for all Attendants. The FMS shall comply with all laws including those regarding worker's compensation insurance, unemployment compensation insurance, withholding of all federal and state taxes, compliance with federal and state laws regarding overtime pay and minimum wage requirements. The FMS shall comply with Department regulations at 10 CCR 2505 and the contract with the Department. 8.510.8.H. Attendants shall receive an hourly wage based on the rate negotiated between the Attendant and the client/AR not to exceed the amount established by the Department. The FMS shall make all payments from the client's Individual Allocation under the direction of the client/AR within the limits established by the Department. 8.510.8.I. Attendants may not attend FMS training during instruction.

	8.510.9 START OF SERVICES 8.510.9.A. The start date shall not occur until all of the requirements defined at 10 C.C.R. 2505-10, § 8.510.2, 8.510.4, 8.510.5, 8.510.6 and 8.510.8 have been met. 8.510.9.B. The Case Manager shall approve the ASMP, establish a certification period, submit a PAR and receive a PAR approval before a client is given the start date and can begin CDASS. 8.510.9.C. The FMS shall process the Attendant's employment packet within the Department's prescribed timeframe and ensure the client has a minimum of two approved Attendants prior to starting CDASS. 8.510.9.D. The FMS will not reimburse Attendants for services provided prior to the CDASS start date. Attendants are not approved until the FMS provides the client/AR with an employee number and confirms employment status. 8.510.9.E. If a client is transitioning from a Hospital, Nursing Facility, or HCBS agency services the CM shall coordinate with the Discharge Coordinator to ensure the discharge date and CDASS start date correspond. 8.510.10 SERVICE SUBSTITUTION 8.510.10.A. Once a start date has been established for CDASS, the Case Manager shall establish an end date and disenroll the individual from any other Medicaid-funded Attendant support including home health effective as of the start date of CDASS. 8.510.10.B. Case Managers shall not authorize, on the PAR, concurrent payments for CDASS and other waiver service delivery options for Personal Care services, Homemaker services, and Health Maintenance Activities for the same individual. 8.510.10.C. Clients may receive up to sixty days of Medicaid acute home health agency based services directly following acute episodes as defined by 8.523.11. Client allocations shall not be changed for sixty days in response to an acute episode unless acute home health services are unavailable. If acute home health is unavailable, a client's allocation may be temporarily adjusted to meet a client's need. 8.510.10.D. Clients may receive Hospice services in conjunction with CDASS services. CDASS service plans shall be modified to ensure no duplication of services. 8.510.11 ENDING CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES 8.510.11.A. If an individual chooses to use an alternate care option, an institutional setting, or is terminated involuntarily, a client will be terminated from CDASS when the Case Manager has secured an adequate alternative to CDASS in the community. 8.510.11.B. Prior to a client being terminated for reasons other than those listed in section 8.510.13, the following steps may be taken: 1. Mandatory re-training conducted by the FMS 2. Required designation of an AR if one is not in place, or mandatory re-designation of an AR if one has already been assigned 3. Discontinuation according to the following: i) The notice shall provide the client/AR with the reasons for termination and with information about the client's rights to fair hearing and appeal procedures, in accordance with 10 C.C.R. 2505-10, § 8.057. Once notice has been given for termination, the client/AR shall contact the Case Manager for assistance in obtaining other home care services. The Case Manager has thirty (30) calendar days prior to the date of termination to discontinue CDASS services and begin alternate care services. Exceptions may be made to the thirty (30) day advance notice requirement when the Department has documented that there is danger to the client or to the Attendant(s). The Case Manager shall notify the FMS of the date on which the client is being

	terminated from CDASS. 8.510.12 TERMINATION 8.510.12.A. Clients may be terminated for the following reasons: 1. The client/AR fails to comply with CDASS program requirements 2. The client/AR demonstrates an inability to manage Attendant support 3. A client/AR no longer meets program criteria due to deterioration in physical or cognitive health 4. The client/AR spends the monthly Allocation in a manner indicating premature depletion of funds 5. The client's medical condition causes an unsafe situation for the client, as determined by the treating physician 6. The client provides false information or false records as determined by the Department 8.510.12.B Clients who are terminated according to § 8.510.12 may be re-enrolled for future CDASS service delivery 8.510.13 INVOLUNTARY TERMINATION 8.510.13.A. Clients may be involuntarily terminated for the following reasons: 1. A client/AR no longer meets program criteria due to deterioration in physical or cognitive health AND refuses to designate an AR to direct services 2. The client/AR demonstrates a consistent pattern of overspending their monthly Allocation leading to the premature depletion of funds AND the Department has determined that adequate attempts to assist the client/AR to resolve the overspending have failed 3. The client/AR exhibits Inappropriate Behavior toward Attendants, Case Managers, or the FMS, and the Department has determined that the FMS has made adequate attempts to assist the client/AR to resolve the Inappropriate Behavior, and those attempts have failed 4. Documented misuse of the monthly Allocation by client/AR has occurred 5. Intentional submission of fraudulent CDASS documents to Case Managers, the Department or the FMS 6. Instances of convicted fraud and/or abuse 8.510.13.B. Termination may be initiated immediately for clients being involuntarily terminated 8.510.13.C. Clients who are involuntarily terminated according to § 8.510.13 may not be re-enrolled in CDASS as a service delivery option. 8.510.14 CASE MANAGEMENT FUNCTIONS 8.510.14.A. The Case Manager shall review and approve the ASMP completed by the client/AR. The Case Manager shall notify the client/AR of the approval and establish a certification period and Allocation. 8.510.14.B. If the Case Manager determines that the ASMP is inadequate to meet the client's CDASS needs, the Case Manager shall assist the client/AR with further development of the ASMP. 8.510.14.C. The Case Manager shall calculate the Individual Allocation for each client who chooses CDASS as follows: 1. Calculate the number of Personal Care, Homemaker, and Health Maintenance Activities hours needed on a monthly basis using the Department

	prescribed method. The needs determined for the Allocation should reflect the needs in the ULTC assessment tool and the service plan. The Case Manager shall use the Departments established rate for Personal Care, Homemaker, and Health Maintenance Activities to determine the client's Allocation. 2. The Allocation should be determined using the Department prescribed method at the initial enrollment and at CSR, and should always match the client's need for services. 8.510.14.D. Prior to FMS training or when an allocation changes, the Case Manager shall provide written notification of the Individual Allocation to each client. 8.510.14.E. A client/AR who believes he or she needs a change in Attendant support, may request the Case Manager to perform a reassessment. If the reassessment indicates that a change in Attendant support is justified, the client/AR shall amend ASMP and the Case Manager shall complete a PAR revision indicating the increase and submit it to the Department's fiscal agent. The Case Manager shall provide notice of the change to client/AR and make changes in the BUS. 8.510.14.F. In approving an increase in the individual Allocation, the Case Manager shall consider all of the following: 1. Any deterioration in the client's functioning or change in the natural support condition 2. The appropriateness of Attendant wages as determined by Department's established rate for equivalent services 3. The appropriate use and application of funds to CDASS services 8.510.14.G. In reducing an Individual Allocation, the Case Manager shall consider: 1. Improvement of functional condition or changes in the available natural supports 2. Inaccuracies or misrepresentation in previously reported condition or need for service 3. The appropriate use and application of funds to CDASS services 8.510.14.H. Case Managers shall notify the state fiscal agent to cease payments for all existing Medicaid-funded Personal Care, Homemaker, Health Maintenance Activities and/or Long Term Home Health as defined under the Home Health Program at 10 C.C.R. 2505-10, § 8.520 et seq. as of the client's CDASS start date. 8.510.14.I. For effective coordination, monitoring and evaluation of clients receiving CDASS, the Case Manager shall: 1. Contact the CDASS client/AR once a month during the first three months to assess their CDASS management, their satisfaction with care providers and the quality of services received. Case Managers may refer clients to the FMS for assistance with payroll and budgeting 2. Contact the client quarterly, after the first three months to assess their implementation of service plans, CDASS management issues, and quality of care, CDASS expenditures and general satisfaction 3. Contact the client/AR when a change in AR occurs and contact the client/AR once a month for three months after the change takes place 4. Review monthly FMS reports to monitor client spending patterns and service utilization to ensure appropriate budgeting and follow up with the client/AR when discrepancies occur 5. Utilize Department overspending protocol when needed to assist clients 8.510.14.J. Reassessment: For clients receiving CDASS, the Case Manager shall conduct an interview with each client/AR every six months and at least

	every 12 months, the Interview shall be conducted face to face. The interview shall include review of the ASMP and documentation from the physician stating the client/AR's ability to direct care. 8.510.15 ATTENDANT REIMBURSEMENT 8.510.15.A. Attendants shall receive an hourly wage not to exceed the rate established by the Department and negotiated between the Attendant and the client/AR hiring the Attendant. The FMS shall make all payments from the client's Individual Allocation under the direction of the client/AR. Attendant wages shall be commensurate with the level of skill required for the task and wages shall be justified on the ASMP. 8.510.15.B. Once the client's yearly Allocation is used, further payment will not be made by the FMS, even if timesheets are submitted. Reimbursement to Attendants for services provided when a client is no longer eligible for CDASS or when the client's Allocation has been depleted are the responsibility of the client. 8.510.15.C. Allocations shall not exceed the monthly cost containment cap. The Department may approve an over cost containment Allocation if it meets prescribed Department criteria. 8.510.16 REIMBURSEMENT TO FAMILY MEMBERS 8.510.16.A. Family members/legal guardians may be employed by the FMS to provide CDASS, subject to the conditions below. For the purposes of this section, family shall be defined as all persons related to the client by virtue of blood, marriage, adoption, or common law. 8.510.16.B. The family member and/or legal guardian shall be employed by the FMS and be supervised by the client/AR if providing CDASS. 8.510.16.C. The family member and/ or legal guardian being reimbursed as a Personal Care, Homemaker, and/or Health Maintenance Activities Attendant shall be reimbursed at an hourly rate by the FMS which employs the family member and/or legal guardian, with the following restrictions: 1. A family member and/or legal guardian shall not be reimbursed for more than forty (40) hours of CDASS in a seven day period from 12:00am on Sunday to 11:59pm on Saturday. 2. Family member wages shall be commensurate with the level of skill required for the task and should not deviate greatly from that of a non-family member Attendant unless there is evidence of a higher level of skill. 3. A member of the client's household may only be paid to furnish extraordinary care as determined by the Case Manager. Extraordinary care is determined by assessing whether the care to be provided exceeds the range of care that a family member would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the client and avoid institutionalization. Extraordinary care shall be documented on the service plan. 8.510.16.D. A client/AR must provide a planned work schedule to the FMS a minimum of two weeks in advance of beginning CDASS, and variations to the schedule shall be supplied to the FMS when billing as submitted on the FMS timesheets. 8.510.16.E. A client/AR who choose a family member as a care provider, shall document the choice on the Attendant Support Services management plan.
Targeted Population	Persons who are able to direct their own care and manage the provision of their own services, without an agency. Adults 18-64 with physical disabilities and seniors 65+ with functional deficits – NH Level of Care
Waiver Manager	In general, this is a good service delivery option that is working well. Consistent policy and training of case managers and clients is needed to achieve

Comment	consistency of practice in certain areas: allocation development, protective oversight, emergencies, overspending.

Waiver	**HCBS- Community Mental Health Supports Waiver**
Waiver Service Definition	Services that assist an individual to accomplish activities of daily living including health maintenance, personal care, homemaker activities, and protective oversight. Health maintenance activities are those routine and repetitive activities of daily living which require skilled assistance for health and normal bodily functioning, and which would be carried out by an individual with a disability if he or she were physically/cognitively able. Personal Care services are those routine and repetitive activities of daily living which require non-skilled assistance for health and normal bodily functioning and which would be carried out by an individual with a disability if he or she were physically/cognitively able. Personal Care includes accompanying the client outside the home when associated with the delivery of a personal care task. Homemaker services are general household activities provided in the home of an eligible client to maintain a healthy and safe home environment for a client, when the person ordinarily responsible for these activities is absent or unable to manage these tasks. Protective oversight is supervision of the client to prevent at risk behavior that may result in harm to the client. These services are provided by an attendant under the supervision of the client or the client's authorized representative. The client, or the authorized representative, is responsible for hiring, training, recruiting, setting wages, scheduling, and in other ways managing the attendant.
Service Limitations	Consumer Directed Attendant Support Services offered in this waiver are limited based on the client's assessed need for services and prior authorization by case managers up to cost containment parameters. In addition, spouses, guardians and family members are limited to providing CDASS under the guidelines described in Appendix C-2, d and e.
Rule	Same as EBD Waiver: **10 CCR 2505-10 Section 8.510**
Targeted Population	Persons 18 years and older with a major mental illness who meet nursing facility level of care
Waiver Manager Comment	43 clients use this CMHS service out of 2,803 for FY2011. Though this service deliver option isn't highly utilized in this waiver, those who do use the service feel it is beneficial as they can hire attendant's who have previous knowledge of their specific mental health needs.

Waiver	HCBS-for Persons with Spinal Cord Injury
Waiver Service Definition	Services that assist an individual in accomplishing activities of daily living including health maintenance, personal care, homemaker activities, and protective oversight. Health maintenance activities are those routine and repetitive activities of daily living which require skilled assistance for health and normal bodily functioning, and which would be carried out by an individual with a disability if he or she were physically/cognitively able. Personal Care services are those routine and repetitive activities of daily living which require non-skilled assistance for health and normal bodily functioning and which would be carried out by an individual with a disability if he or she were physically/cognitively able. Personal Care includes accompanying the client outside the home when associated with the delivery of a personal care task. Homemaker services are general household activities provided in the home of an eligible client to maintain a healthy and safe home environment for a client, when the person ordinarily responsible for these activities is absent or unable to manage these tasks. Protective oversight is supervision of the client to prevent at risk behavior that may result in harm to the client. These services are provided by an attendant under the supervision of the client or the client's authorized representative. The client, or the authorized representative, is responsible for hiring, training, recruiting, setting wages, scheduling, and in other ways managing the attendant.
Service Limitations	Consumer Directed Attendant Support Services offered in this waiver are limited based on the client's assessed need for services and prior authorization by case managers up to cost containment parameters. In addition, spouses, guardians and family members are limited to providing CDASS under the guidelines described in Appendix C-2, d and e.
Rule	Same as EBD Waiver: **10 CCR 2505-10 Section 8.510**
Targeted Population	Persons 18 years and older who have a spinal cord injury and meet nursing facility level of care.
Waiver Manager Comment	This waiver has just been implemented and there is not enough data to adequately assess how this service delivery option is utilized in this waiver. With the idea that individuals who were on the EBD waiver would transfer to the SCI waiver, if eligible, we wanted to keep as many of the EBD services as possible in order to make a more seamless transition for clients.

In-Home Supportive Services (IHSS)

Waiver	**HCBS-Elderly, Blind and Disabled Waiver**
Waiver Service Definition	Services that are provided by an attendant and include health maintenance activities support for activities of daily living or instrumental activities of daily living, personal care services, and homemaker services. Such services are provided under the direction of the client, or an authorized representative who is designated by the client.
Service Limitations	In Home Support Services offered in this waiver are limited based on the client's assessed need for services and prior authorization by case managers up to cost containment parameters. Payment will not be made for services furnished to a client by the person's spouse. Family members may be reimbursed up to the limitations established in Appendix C-2, e of the waiver application.
Rule	**10 CCR 2505-10 Section 8.552** : IN HOME SUPPORT SERVICES 8.552.1 DEFINITIONS Case Manager means an individual who determines functional eligibility and provides case management services to individuals eligible under the HCBS-Children's Waiver program at 10 C.C.R. 2505-10, Section 8.506.7 or the HCBS-EBD Waiver program 10 C.C.R. 2505-10, Section 8.485. Health Maintenance Activities means those routine and repetitive health related tasks, which are necessary for health and normal bodily functioning, that an individual with a disability would carry out if he/she were physically able, or that would be carried out by family members or friends if they were available. These Activities include, but are not limited to, catheter irrigation, administration of medication, enemas and suppositories and wound care. In Home Support Services (IHSS) means services that are provided by an attendant and include Health Maintenance Activities and support for activities of daily living which include homemaker and personal care services. IHSS Plan means a written plan of IHSS between the client and/or the client's guardian or authorized representative and the IHSS agency. The Plan shall include a statement of allowable attendant and personal care service hours, a detailed listing of amount, scope and duration services to be provided, a dispute resolution process, who will be providing each services, and shall be signed by the client or the client's authorized representative, where appropriate, and the IHSS agency. 8.552.2 ELIGIBILITY 8.552.2.A. To be eligible for IHSS a client shall: 1. Be found eligible for either the Home or Community Based Services - Elderly Blind and Disabled (HCBS-EBD) or Children's Waiver; and 2. Provide a statement from his/her primary physician stating that the client or client's guardian has sound judgment and the ability to self direct care or the client has an authorized representative who has the judgment and ability to assist in acquiring and using services. For a client with an unstable medical condition, the physician's statement shall include a recommendation regarding whether additional in-home monitoring is necessary and if so, the amount and scope of the in-home monitoring.

	8.552.2.B. A client shall no longer be eligible when: 1. The client is no longer eligible for either the Home or Community Based Services - Elderly Blind and Disabled or Children's Waiver. 2. The client's medical condition deteriorates causing an unsafe situation as documented by the primary physician. 3. The client refuses to designate an authorized representative if the client is unable to direct his/her own care as documented by the primary physician. 8.552.3 CLIENT RIGHTS AND RESPONSIBILITIES 8.552.3.A. A client or client's authorized representative has the right to: 1. Present a person(s) of his/her own choosing to the IHSS agency as a potential attendant. 2. Train and schedule attendant(s) to meet his/her needs. 3. Dismiss attendants who are not meeting his/her needs. 8.552.4 PROVIDER ELIGIBILITY 8.552.4.A. The IHSS agency shall conform to all certification standards and procedures set forth at 10 C.C.R. 2505-10, Section 8.487 and shall meet additional requirements set forth in 8.552.5. 8.552.4.B. The IHSS agency may be terminated from participation in the program pursuant to 10 C.C.R. 2505-10, Section 8.076. 8.552.5 PROVIDER RESPONSIBILITIES 8.552.5.A. The IHSS agency shall offer peer counseling including, but not limited to cross-disability peer counseling, information and referral services and individual and systems advocacy to all clients. 8.552.5.B. The IHSS agency shall provide 24-hour back-up service to clients at any time a scheduled attendant is not available, whether the attendant's absence is anticipated or unforeseen. 8.552.5.C. The IHSS agency shall provide intake and orientation service to clients or authorized representatives who are new to IHSS. Orientation shall include instruction in the philosophy, policies and procedures of IHSS and information concerning client rights and responsibilities. 8.552.5.D. The IHSS agency shall assist the client in selecting an attendant, if needed. 8.552.5.E. The IHSS agency shall ensure that a current IHSS Plan is in the client's record and send the IHSS Plan to the appropriate single entry point agency case manager within five days after any change in the Plan. 8.552.5.F. The IHSS agency shall contract with or have on staff a licensed health care professional who is at the minimum a registered nurse. The health care professional shall provide oversight and monitoring of the following activities: 1. Verification and documentation of attendant skills and competency to perform IHSS and basic consumer safety procedures. 2. Counsel attendant staff on difficult cases and potentially dangerous situations. 3. Consult with the client, authorized representative or attendant in the event a medical issue arises. 4. Investigate complaints and critical incidents within 10 working days.

	5. Assure that the attendant is following directives found in the IHSS Plan. 8.552.5.G. The IHSS agency shall assure and document that all attendants have received basic training in the provision of IHSS. In lieu of basic training, the IHSS agency's licensed professional may administer a skills validation test. 8.552.5.H. Attendant training shall include, but not be limited to: 1. Development of interpersonal skills focused on addressing the needs of persons with disabilities. 2. Overview of IHSS. 3. Instruction on basic first aid administration. 4. Instruction on safety and emergency procedures. 5. Instruction on infection control techniques, including universal precautions. 8.552.5.I. Training may be modified if an attendant demonstrates competence in a given area. 8.552.5.J. Training and skills validation shall be completed prior to service delivery unless waived by the client or authorized representative to prevent interruption in services. In no event shall the training or skills validation be postponed for more than 30 days after services begin. 8.552.5.K. The IHSS agency shall allow the client or authorized representative to provide individualized attendant training that is specific to his/her own needs and preferences. 8.552.5.L. The IHSS agency shall provide functional skills training to assist clients and/or authorized representatives in developing skills and resources to maximize their independent living and personal management of health care. 8.552.5.M. The IHSS agency may discontinue IHSS to a client when: 1. Equivalent care in the community has been secured; or 2. The client has exhibited inappropriate behavior toward the attendant and the Department has determined that the IHSS agency has made adequate attempts at dispute resolution and dispute resolution has failed. Inappropriate behavior includes, but is not limited to, documented verbal, sexual and/or physical abuse. 8.552.5.N. The IHSS agency shall provide 30 days advance written notice to the client detailing the inappropriate behavior prior to discontinuing services. Upon provider discretion, the provider may allow the client and/or client representative to use the 30 day notice period to correct the problem. 8.552.5.O. The IHSS agency shall send a copy of the 30 day written discontinuation notice to the single entry point case manager the same day the notice is sent to the client. 8.552.6 SINGLE ENTRY POINT RESPONSIBILITIES 8.552.6.A. The single entry point case manager shall ensure cost effectiveness and non-duplication of services by: 1. Documenting the discontinuation of previously authorized long-term home health services that shall be replaced by IHSS. 2. Documenting for new clients the long-term home health services that are available in lieu of IHSS. 3. Documenting and justifying any need for both long-term home health services and IHSS.

	4. Ensuring all required information is in the client's IHSS Plan. 5. Authorizing cost effective and non-duplicative services via the prior authorization request (PAR). 6. Reviewing the IHSS PAR and giving approval prior to services rendered. The PAR shall include the IHSS Plan delineating the services to be provided, the physician's statement, the authorized representative's signed statement when appropriate. The PAR shall include a dispute resolution process in the form of either a discharge policy or a client rights and responsibilities policy signed by the client. 8.552.7 REIMBURSEMENT 8.552.7.A. Reimbursement for IHSS shall occur only upon approval of the IHSS Care Plan and after the PAR has been submitted and approval received by the single entry point case manager. 8.552.7.B. For IHSS personal care and homemaker services, the reimbursement rate shall be the same as for personal care and homemaker services under the HCBS-EBD Waiver set forth at 10 C.C.R. 2505-10 Section 8.489. 8.552.7.C. For IHSS Health Maintenance Activities the reimbursement rate shall be a blended average equal to 1/8th of a two-hour home health aid visit. The unit of service shall be 15 minutes.
Targeted Population	Persons who are able to direct their own care and manage the provision of their own services or designate an authorized representative to do so. Adults 18-64 with physical disabilities and seniors 65+ with functional deficits – NH Level of Care
Waiver Manager Comment	In general, this is a good service delivery option that is working well. This service delivery option is not used as frequently as CDASS, primarily because rules limit the amount of care provided by a family member. Rule change is needed so that it is a viable option along -side CDASS as a consumer-directed option. Increasing the provider pool and availability in rural settings is also needed.

Waiver	**HCBS-for Persons with Spinal Cord Injury**
Waiver Service Definition	Services that are provided by an attendant and include health maintenance activities support for activities of daily living or instrumental activities of daily living, personal care services, and homemaker services. Such services are provided under the direction of the client, or an authorized representative who is designated by the client.
Service Limitations	In Home Support Services offered in this waiver are limited based on the client's assessed need for services and prior authorization by case managers up to cost containment parameters. All IHSS attendants must be employed by an agency certified by the Department to provide this service. Payment will not be made for services furnished to a client by the person's spouse. Family members may be reimbursed up to the limitations established in Appendix C-2-d&e of the waiver application. Clients and/or authorized representatives choosing IHSS shall have no duplication of Personal Care services, Homemaker services and/or Health Maintenance Activities through CDASS, Personal Care agency, Homemaker agency or Home Health Agency.

Rule	Same as EBD Waiver: **10 CCR 2505-10 Section 8.552**
Targeted Population	Persons who are 18 years and older with a spinal cord injury who meet nursing facility level of care
Waiver Manager Comment	As this is a new waiver, this service is unable to be determined to be beneficial for this population. Many comments from providers of the IHSS delivery option have been that the rules need to be more explicit and there need to be more providers of this consumer-directed service option in rural communities.

Waiver	**Children's Home and Community Based Services Waiver**
Waiver Service Definition	In Home Support Services (IHSS) for the CHCBS waiver is a service that is limited in the CHCBS waiver to Health Maintenance Activities. The child's need for this service has been determined to be extraordinary. Health maintenance activities are those routine and repetitive activities of daily living which require skilled assistance for health and normal bodily functioning, and which would be carried out by the child of the same age if he or she were physically/cognitively able. Extraordinary care is determined by assessing that the activity as one that that a parent would not normally provide as part of a normal household routine and that a child's parents and/or legal is not legally guardian is not responsible to provide. an IHSS Plan means a written plan of IHSS between the child's parent and/or legal guardian or authorized representative and the IHSS agency. The Plan shall include a statement of allowable attendant and personal care service hours, a detailed listing of amount, scope and duration services to be provided, a dispute resolution process, which will be providing each service, and shall be signed by the child's parent and/or legal guardian or the child's authorized representative, where appropriate, and the IHSS agency.
Service Limitations	IHSS services are offered in this waiver and are limited based on the client's assessed need for services and prior authorization by case managers and must meet the level of care for a nursing facility. The child's parent and/or legal guardian must provide a statement from his/her primary physician stating that the child's parent and/or legal guardian has sound judgment and the ability to self direct care the child's care or the client has an authorized representative who has the judgment and ability to assist in acquiring and using services. For a child with an unstable medical condition, the physician's statement shall include a recommendation regarding whether additional in-home monitoring is necessary and if so, the amount and scope of the in-home monitoring. The child must meet the level of care for a nursing facility. A CHCBS child's parents and/or legal guardian must choose between IHSS or CDASS services.
Rule	Same as EBD Waiver: **10 CCR 2505-10 Section 8.552**

THE COLORADO CHOICE TRANSITIONS (CCT) PROGRAM

LAUNCHES EARLY 2013!

Part of the federal Money Follows the Person Rebalancing Demonstration, Colorado Choice Transitions (CCT) is a 5 year grant program with the primary goal of facilitating the transition of Medicaid clients from long-term care facilities to the community using home and community-based services (HCBS) and supports. Services are intended to promote independence, improve the transition process, and support people in the community. CCT participants will have access to HCBS waiver services as well as demonstration services. Participants will be enrolled in the program for 365 days, and at the conclusion of the their participation, they will enroll on to one of five HCBS waivers (Persons who are Elderly, Blind and Disabled, Persons with Brain Injury, Community Mental Health Supports , Supported Living Services, or Persons with Developmental Disabilities) as long as they remain Medicaid eligible.

In order to participate, clients must meet long-term care Medicaid eligibility requirements; must reside in a long-term care facility for a period of no less than ninety days (90); and must be willing to move to qualified housing as defined in federal statute.

The enhanced home and community-based demonstration services available to CCT participants will include:

- Assistive Technology, Extended
- Caregiver Education
- Community Transition Services
- Dental Services
- Enhanced Nursing Services
- Home Delivered Meals
- Home Modifications, Extended
- Independent Living Skills Training
- Intensive Case Management
- Peer Mentorship
- Substance Abuse Counseling, Transitional
- Transitional Behavioral Health Supports
- Transitional Specialized Day Rehabilitation
- Vision Services

COLORADO CHOICE TRANSITIONS/MONEY FOLLOWS THE PERSON

	Assistive Technology, Extended
Service Definition	Devices, items, pieces of equipment, or product system used to increase, maintain, or improve functional capabilities of clients and training in the use of the technology when the cost is not otherwise covered through the State Plan durable medical equipment benefit or home modification waiver benefit or available through other means.
Notes	Training for assistive technology can be provided by independent living skills providers when appropriate. Assessment by approved professional needs to take into account the clients ability to use and integrate the device into their daily life.
Example Activities	Adaptive cooking utensils Communication devices such as PDAs Environmental control units
Minimum Documentation	Assessment completed by Occupational Therapist/Physical Therapist/Speech Therapist or other approved professional Prior Authorization Request approvals Training of client and/or support system
Targeted Population	Elderly, Physically Disabled, Developmentally Disabled, Mentally Ill
Allowable Modes of Delivery	Face-to-face
Provider/Staff Standards	Approved Vendor
CAP	Maximum: $1,000.00
Place of Service	Group Home, Home
Rule	**10 CCR 2505-10 Section 8.555.1** Assistive Technology means devices, items, pieces of equipment, or product system used to increase, maintain, or improve functional capabilities of clients and training in the use of the technology when the cost is not otherwise covered through the State Plan durable medical equipment benefit or home modification waiver benefit or available through other means.

	Caregiver Education
Service Definition	Educational and coaching services that assist clients and family members to recruit other family members and friends to form an informal caregiver network to share care giving responsibilities.
Notes	Training for crucial informal support network on service availability, appropriate expectations, health and safety issues, problem-solving, caregiving, best practices and models for organizing and coordinating informal support networks. Training will include assisting the client, family and other informal supports with implementing the strategies and techniques into their daily routine of caregiving. Strategies and techniques are intended to facilitate greater structure of supports and a community of care for client and caregivers to mitigate stress and conflict and to share responsibility for caregiving. Models such as Share the Care™, Caring for You, Caring for Me: Education and Support For Family & Professional Caregivers, Coping with Caregiving, and American Red Cross Family Caregiving Program may be used. Taking into consideration the client's preferences for support, and at the direction of the client, this service is designed to help clients and family members and friends who provide caregiver responsibilities.
Example Activities	Training activities might include helping clients and caregivers identify: What does caregiving look like for your family member or loved one? What does caregiving look like for the caregivers? How do caregivers identify client needs? How do clients ask for help for what they need? How to do clients match people with the assistance or support they need? What do clients expect of their caregivers? What tasks will the caregiver be expected to perform? What does the caregiving schedule look like and how does it fit the needs of both the client and the caregiver? Daily? Weekly? Monthly? Yearly?
Minimum Documentation	Log notes; Training curriculum; Individual data form; Caregiving schedule; Telephone tree of caregivers; Assessment notes; Record of completion of training by caregivers.
Targeted Population	Elderly, Physically Disabled, Developmentally Disabled, Mentally Ill
Allowable Modes of	Face-to-Face, telephone, Family (HS), On-Site

Delivery	
Provider/Staff Standards	Bachelor's Level Bachelor's degree in Health and Human services or related field. Documentation on file that trainer or facilitator has completed training in proven caregiver education model.
CAP	15 minute units; Maximum of 900 units or 15 hours
Place of Service	Office, Group Home, Home, Temp. Lodging
Rule	10 CCR 2505-10 Section 8.555.1 Caregiver Support Service means educational and coaching services that assist clients and family members to recruit other family members and friends to form an informal caregiver network to share caregiving responsibilities.

	Community Transition Service
Service Definition	Services that are provided by a Transition Coordination Agency and include items essential to move a client from a nursing facility and establish community-based residence. Community transition services include the cost of coordination activities such as assisting client in filling out subsidized housing application, security and utility deposits, moving expenses, one-time pest eradication, one-time cleaning expenses, and essential household furnishings such as beds, linens, utensils, pots and pans, and dishes. Items for entertainment and convenience are not included.
Notes	Services provided by a Transition Coordination Agency (TCA) to help an individual relocate to a community setting upon discharge from a Long Term Care (LTC) facility. Services extend from initial referral to CTS to 30 days after discharge from facility. CTS include the purchase of items essential to move a client from a Skilled Nursing Facility, Institute for Mental Disease, or Intermediate Care Facility – for Individuals with Intellectual Disabilities to establish a community-based residence. Examples include security and utility deposits, moving expenses, one-time pest eradication one-time cleaning expenses and essential household items such as beds, linens, utensils, pots and pans, dishes, etc.
Example Activities	Coordination of transition team; Assessment of community needs; Accessing community resources; Assistance with non-Medicaid applications; Assistance with setting up household – purchasing essential items.
Minimum Documentation	Community Transition Services Referral Form Release of information (confidentiality) Form

	Self-Assessment Transition Tool Transition Assessment Transition Plan Transition team meeting notes Client log notes Authorization Request Form Community Transition Report Monthly Referral Log Signed CCT Informed Consent form
Targeted Population	Elderly, Physically Disabled, Developmentally Disabled, Mentally Ill
Allowable Modes of Delivery	Face-to-face
Provider/Staff Standards	Less than Bachelor's (HM)
CAP	$1,500 per transition
Place of Service	Community Mental Health Center, Home, ICF-ID, NF, SNF, Inpatient Hospital
Rule	**10 CCR 2505-10 Section 8.553 COMMUNITY TRANSITION SERVICES** 8.553.1 DEFINITIONS Authorization Request means a request submitted by the Transition Coordination Agency to the Single Entry Point agency to authorize payment for delivery of Community Transition Services. Community Transition Services (CTS) means activities essential to move a client from a skilled nursing facility and establish a community-based residence. Independent Living Core Services means information and referral services; independent living skills training; peer counseling, including cross-disability peer counseling; and individual and systems advocacy. Transition Coordinator means a person employed by a Transition Coordination Agency to provide Transitional Case Management. Transition Coordination Agency (TCA) means an agency that is certified by the Department to provide CTS and provides at least two Independent Living Core Services. Transitional Case Management means case management exclusively supporting a client's transition from a skilled nursing facility to a community-based residences.

	Dental, Extended
Service Definition	Dental services that are inclusive of diagnostic, preventive, periodontal and prosthodontic services, as well as basic restorative and oral surgery procedures to restore the client to functional dental health. Services are available for clients 21 and over and may not duplicate services available through the Medicaid State Plan.
Notes	Services require prior authorization by the Department pursuant to the CCT Prior Authorization Request (PAR) process.
Example Activities	Examination Routine cleaning Denture fitting Fillings Non-emergency extractions
Minimum Documentation	Dental Services Statement to include: Treatment plan Date of service Specific procedures to be completed Providers name American Dental Association claim form
Targeted Population	Elderly, Physically Disabled, Mentally Ill
Allowable Modes of Delivery	Face-to-face
Provider/Staff Standards	DDS
CAP	$8,000.00 dollar lifetime maximum
Place of Service	Office, Outpatient Hospital, Ambulatory Surgery Center
Rule	**10 CCR 2505-10 Section 8.555.1** Dental Services means dental services that are inclusive of diagnostic, preventive, periodontal and prosthodontic services, as well as basic restorative and oral surgery procedures to restore the client to functional dental health and not available through the Medicaid State Plan.

	Enhanced Nursing
Service Definition	Medical care coordination provided by a nurse for medically complex clients who are at risk for negative health outcomes associated with fragmented medical care and poor communication between primary care physicians, nursing staff, case managers, community-based providers and specialty care providers.
Notes	Enhanced Nursing Professionals serve as the liaison to discharging facilities and community-based care provided in the qualified residence into which the participant is transitioning. These services are provided only during the first 30 days post-transition. With Departmental approval service may be provided pre-transition or if client is re-institutionalized for less than 30 days and is expected to return to community. Service is limited to medically complex individuals. A medically complex condition is one that is persistent and substantially disabling or life threatening: Requires treatment and services across a variety of domains of care Is associated with conditions that have severe consequences Affects multiple organ systems Requires coordination of management by multiple specialties Treatments carry a risk of serious complications
Example Activities	Assisting with LTC facility discharge planning process; Coordinating care; Providing TA/Training between the sending facility and receiving provider(s); Communicating with discharge facility, home health agency, and intensive case manager daily regarding service planning and coordination; Monitoring progress and/or identifying setbacks and problem solving with care coordination team; Medication reconciliation.
Minimum Documentation	Client demographic information; Start and end time/duration; Each contact with and on behalf of client; Nature and extent of service; Date and place of service delivery; Mode of contact (telephone/face-to face); Names and titles of facility staff communicated with; Documentation of training provided to HCBS provider staff; Plan of care; Plan to maintain client in home, etc; Phone tree or something comparable to provide the client with support.
Targeted Population	Elderly, Physically Disabled, Developmentally Disabled, Mentally Ill

Allowable Modes of Delivery	Face-to-face, Video Conf., Telephone, Individual, Family (HR)
Provider/Staff Standards	Registered Nurse
CAP	15 minute units, maximum 50 units
Place of Service	CMHS, Office, Outpatient Hospital, Group Home, Home, ICF-MR, NF, SNF, Temp. Lodging, Inpt. Hospital, Inpt. PF, ER
Rule	**10 CCR 2505-10 Section 8.555.1** Enhanced Nursing Services means medical care coordination provided by a nurse for medically complex clients who are at risk for negative health outcomes associated with fragmented medical care and poor communication between primary care physicians, nursing staff, case managers, community-based providers and specialty care providers

	Home Delivered Meals
Service Definition	Nutritious meals delivered to homebound clients who are unable to prepare their own meals and have no outside assistance.
Notes	Includes the preparation and delivery of nutritious meals that meet 33 1/3% of the most current Dietary Reference Intakes. Meals can be delivered hot, frozen, or shelf stable depending on the ability of the consumer, or caregiver, to complete the preparation of the meal. Additional nutrition education, nutrition screening, and/or nutrition counseling may occur as a component of this service. Case manager will assist in assessment of consumer to determine appropriate type of meal (e.g. hot, frozen, or shelf stable). Meals may be provided more often during initial weeks after discharge from an institution. Nutrition service provider agencies will set up a delivery schedule based on the type of meal provided. Follow-up activities by the nutrition service provider will occur to ensure satisfaction with the meal and to determine if additional nutrition education and/or nutrition counseling is necessary.
Example Activities	Delivery of hot, frozen or shelf stable meal Nutrition counseling Nutrition education Nutrition screening
Minimum Documentation	Consumer demographic information; Start and end time/duration; Documentation of special diet requirements;

	Determination of the type of meal (e.g. hot, frozen, shelf stable); Date and place of service delivery; Monitoring and follow-up (contacting consumer/others to ensure consumer is satisfied with the meal); Provision of nutrition counseling, if appropriate; and Maintenance of appropriate documentation.
Targeted Population	Elderly, Physically Disabled, Mentally Ill
Allowable Modes of Delivery	Face-to-face
Provider/Staff Standards	Registered Dietician Staff involved in the preparation and delivery of meals must complete food safety training every six months.
CAP	Minimum: 1 meal per day; Maximum: 2 meals per day, 7 days per week
Place of Service	Temp. Lodging, Home
Rule	**10 CCR 2505-10 Section 8.555.1** Home Delivered Meals means nutritious meals delivered to homebound clients who are unable to prepare their own meals and have no outside assistance.

	Home Modifications, Extended
Service Definition	Physical adaptations to the home, required by the client's plan of care, necessary to ensure the health, welfare, safety and independence of the client above and beyond the cost of caps that exist in applicable Home and Community-Based (HCBS) waivers.
Notes	Benefit applies only after $10,000 for qualified service cap is reached in waivers with home modification benefit.
Example Activities	Installation of ramps or grab bars; Accessible shower or other bathroom facilities; Lowered kitchen sink, cabinets; Widening of doorways; Installation of specialized electric and plumbing systems necessary to accommodate medical equipment and supplies.

Minimum Documentation	Evaluation completed by a licensed professional such as occupational or physical therapist. Evaluation must demonstrate necessity for home modification; Counties that require licensed contractors need to submit proof of licensure to Department; Detailed bid of project submitted to Department along with Prior Authorization Request.
Targeted Population	Elderly, Physically Disabled, Developmentally Disabled, Mentally Ill
Allowable Modes of Delivery	NA
Provider/Staff Standards	Home Modification Providers shall be licensed in the city or county in which they propose to provide Home Modification services to perform the work proposed, if required by that city or county.
CAP	$5,000.00 dollar lifetime maximum
Place of Service	Group Home, Home
Rule	**10 CCR 2505-10 Section 8.555.1** Extended Home Modifications means physical adaptations to the home, required by the client's plan of care, necessary to ensure the health, welfare, safety and independence of the client above and beyond the cost of caps that exist in applicable Home and Community-Based (HCBS) waivers.

	Independent Living Skills Training (ILST)
Service Definition	Services designed to improve or maintain a client's physical, emotional, and economic independence in the community with or without supports.
Notes	Includes assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills which takes place in the participant's home, other residential living arrangement, and the community. Includes nutritional training and guidance, especially for those with special dietary requirements. Skills training to include assistive technology when appropriate. Assessment given by intensive case managers combined with client's self assessment will be the basis for the independent living goals established by the client and the life skills trainer. Skills training will be directed towards accomplishment of these goals. Life skills trainer, client and intensive case manager are expected to have monthly contacts to monitor progress towards meeting independent living goals and to optimize independence by the conclusion of enrollment in the CCT program.

	Focus of activities will be on improving independence with IADLs, such as attendant management, financial management, housekeeping, transportation, using the telephone, shopping, laundry, medication management, appointment management, etc.
Example Activities	Daily assistance/training/coaching in cooking, housekeeping, laundry, other in-home activities; Grocery shopping, meal - planning, nutrition; Budgeting, financial management, money handling, and consumer skills; Prompting/coaching client to manage medical appointments, medical supplies and prescriptions, clothing, seasonal needs and shopping; Coaching with using and navigating public transportation; Other help with recreation and community access and orientation; Establishing schedule for attendants; Advocating for one's self to ensure needs and wants are expressed in care planning; Preventing or making known issues of abuse, neglect, or exploitation; Assisting with integrating into the community.
Minimum Documentation	Log notes; Monthly skills training plans will be developed and documented in plan of care; Skills training plans shall include goals, goals met or not met, and progress made towards accomplishment of ongoing goals; All independent living skills training and development will be documented in the plan of care.
Targeted Population	Elderly, Physically Disabled, Mentally Ill
Allowable Modes of Delivery	Face-to-face, on-site
Provider/Staff Standards	Bachelor's Level, Health care or human service professional with one year of experience in providing functionally based assessment and skills training of elderly individuals, or persons with mental illness or disabilities; an individual with a bachelors degree and two years of similar experience.
CAP	15 minute units, 24 units per day
Place of Service	CMHC, Office, Group Home, Home, Temp. Lodging, Community
Rule	**10 CCR 2505-10 Section 8.555.1** Independent Living Skills Training means services designed to improve or maintain a client's physical, emotional, and economic independence in the community with or without supports.

	Intensive Case Management
Service Definition	Case management services to assist clients in assessing needed home and community-based services, Medicaid State Plan services and non-Medicaid supports and services to support the clients' return to the community from placement in a qualified institution and to aid the client in attaining their transition and independent living goals.
Notes	***Case management involves linking the consumer to the direct delivery of needed services, but is not itself the direct delivery of a service to which the consumer has been referred.*** Weekly contacts are required for the duration of the assigned client's enrollment. Weekly contacts can either be home visits or telephone calls based on necessity. On the date of discharge, the case manager is required to conduct a home visit with the client and transition coordinator to ensure the client is safe, confirm the start of services and to alleviate any concerns the client may have with their transition. Case manager is required to conduct a check-in with the client 48 hours post-discharge. Three additional home visits are required in the first month of program enrollment. Best practice is joint visit between the transition coordination agency and the case management agency within 30 days of discharge. All critical incidents will be reported via the department approved process and investigated. Necessary follow-up to remediate the situation will be at the discretion of the case manager. Hospitalizations and reinstitutionalizations should be documented as soon as possible to adjust CCT enrollment period. Services assist individuals' access to needed long-term services and supports (LTSS), Medicaid State Plan services, non-Medicaid supports and services to support clients in their return to the community from institutional placement, and to aid the client in attaining their transition and independent living goals identified in the Consumer Transition Guides. Case managers are expected to coordinate with other local agencies, such as Mental Health Centers, for the purpose of joint service planning and the arrangement of services. Case Manager is responsible for: Assessing needs; Determining eligibility; Service planning and authorization; Care coordination; Risk mitigation; Service monitoring; Monitoring the health, welfare and safety of the client; and Promotion of client's self-advocacy.
Example Activities	Confirm CCT eligibility requirements by verifying client had qualified nursing home stay and moved to a qualified community residence. Assess the need for service(s), identifying and investigating available resources, explaining options to participant and assisting with referral and procurement of services. Contact with clients' family members or informal supports to assist client with accessing services. Conduct home visits and telephone calls for the purpose of monitoring and reassessing the health, welfare and safety of the client to determine appropriateness of services and client satisfaction. Report, investigate and remediate critical incidents.

	Develop risk mitigation plan with client to prevent reinstitutionlization and critical incidents. Modify as needed particularly following a discharge after reinstitutionlization or after a critical incident. Coordinate care with mental health centers for clients with mental illness. Assess and monitor progress with achieving goals and increased independence. Seek input from medical and service providers to inform assessment and monitoring activities. Verify with client that he/she is making medical appointments. Resource development to ensure client has access to providers and services.
Minimum Documentation	Client demographic information Duration of each contact Each contact with and on behalf of client Nature and extent of service Date and place of service delivery Mode of contact (face-to-face/telephone) Issues addressed (CCT services, family, income/ support, legal, medication, educational, housing, interpersonal, medical/dental/behavioral health, vocational, behavioral services, other client issues) Client's response Progress toward care plan goals and objectives Type of activity and specific functions oAssessment o Care plan indicating that client was provided choice o Referrals o Monitoring and follow-up o Critical Incidents Conflict mitigation
Targeted Population	Elderly, Physically Disabled, Developmentally Disabled, Mentally Ill
Allowable Modes of Delivery	Face-to-face, video conf., telephone, on-site
Provider/Staff Standards	Bachelor's Level Degree must be a health, human service, social work or related field. Minimum two years case management experience working with

	long-term services and supports in the geographic region of the case management agency. Two years case management experience can be substituted for a Bachelor's level degree.
CAP	NA
Place of Service	CMHC, Office, Group Home, Home, ICF-MR, NF, SNF, Temp. Lodging, Inpt. Hospital, Inpatient PF, ER, PF-PHP, Pharmacy, Community
Rule	**10 CCR 2505-10 Section 8.555.1** Intensive Case Management means case management services to assist clients' access to needed home and community-based services, Medicaid State Plan services and non-Medicaid supports and services to support the clients' return to the community from placement in a qualified institution and to aid the client in attaining their transition goals.

	Peer Mentorship
Service Definition	Services provided by peers to promote self-advocacy and encourage community living among clients by instructing and advising on issues and topics related to community living, describing real-world experiences as example and modeling successful community living and problem-solving.
Notes	Services provided to participants by peers to promote self-advocacy by instructing, providing experiences, modeling and advising. For MFP clients, peers will provide mentoring throughout the first year of the transition. This service includes problem-solving transition-related issues and managing anxiety. Additionally, peer mentors can assist with interviewing potential providers, understanding complicated health and safety issues, and participating on private and public boards, advisory groups and commissions. This service does not duplicate case management or waiver services such as Day Habilitation.
Example Activities	Listening and providing support Problem solving Sharing their knowledge of community resources. Assisting with community integration.
Minimum Documentation	Start and end time/duration; Nature and extent of service; Mode of contact (telephone/face-to-face); Description of peer mentorship activities such as accompanying CCT clients to complicated medical appointments or to attend board, advisory and commissions meetings, and support provided interviewing potential providers; Client's response; Progress toward Service Plan goals and objectives;

	Provider's signature and date.
Targeted Population	Elderly, Physically Disabled, Developmentally Disabled, Mentally Ill
Allowable Modes of Delivery	Face-to-face, telephone
Provider/Staff Standards	Peer Specialist; Peer Mentorship services will be provided by staff who: Have a disability, or are close to someone who does; Have successfully achieved independent living; Are willing to assist others to achieve their own independent living goals; Reside in community after successful transition from a LTC facility.
CAP	NA
Place of Service	CMHC, Office, Outpatient Hospital, Group Home, Home, ICF-MR, NF, SNF, Temp Lodging, Inpt. Hospital, ER, Pharmacy, Community
Rule	**10 CCR 2505-10 Section 8.555.1** Mentorship Services means services provided by peers to promote self-advocacy and encourage community living among clients by instructing and advising on issues and topics related to community living, describing real-world experiences as example and modeling successful community living and problem-solving.

	Substance Abuse Counseling, Transitional
Service Definition	Enhanced individual or group substance abuse counseling, behavioral interventions, or consultations to address issues, symptoms, and/or behaviors that are exacerbated during the transition period and negatively affect the client's sobriety. Services can be provided in the home or office setting.
Notes	Services are anticipated to be accessed with greater frequency within the first 60-90 days post transition to assist stabilization in the community and adherence to intervention plan.
Example Activities	Individual therapy session Group therapy session Family therapy session
Minimum	Assessment; Development of an intervention plan;

Documentation	Documentation of education and training plan for the client, family and/or caregivers; Log notes describing progress and/or issues with maintaining sobriety.
Targeted Population	Elderly, Physically Disabled, Developmentally Disabled, Mentally Ill
Allowable Modes of Delivery	Face-to-Face, Video Conf., Telephone, Individual, Group, Family (HR), On-Site
Provider/Staff Standards	LCSW (AJ)/LSW/LMFT/LPC Must have proof of certification as a Certified Addictions Counselor (CAC) level III.
CAP	NA
Place of Service	CMHC, Office, Group Home, Home, NF, Temp. Lodging, ER
Rule	**10 CCR 2505-10 Section 8.555.1** Substance Abuse (Transitional) means enhanced individual or group substance abuse counseling, behavioral interventions, or consultations to address issues, symptoms, and/or behaviors that are exacerbated during the transition period and negatively affect the client's sobriety. Services can be provided in the home or office setting.

	Transitional Behavioral Health Supports
Service Definition	Services by a qualified paraprofessional to support a client during the transition period to mitigate issues, symptoms, and/or behaviors that are exacerbated during the transition period and negatively affect the client's stability in the community.
Notes	Frequency of services will be higher than typical behavioral health services. Services will be provided in the client's home or other community based settings. When necessary, a community mental health center will develop behavioral health plan prior to discharge from the nursing facility or ICF/IID. The behavioral health support specialist will help develop and implement the behavioral health plan. Individuals with behavioral health conditions face additional barriers to community integration, including: • Insufficient understanding and limited provider competency in dealing with psychiatric disorders, making providers reluctant to serve these individuals. • Need for a process for identifying and connecting individuals with psychiatric or substance abuse disorders with appropriate long-term services and support options. • Limited services and support options appropriate for individuals with co-occurring behavioral disorders. • Limited availability of substance abuse services for adults under Medicaid.

	• A need for integrative care for both physical and behavioral health. • High level of need for services provided in settings other than office.
Example Activities	Problem-solving challenges of transition De-escalating emotional situations Coaching to resolve maladaptive behaviors Coaching family members and friends to follow a behavior plan Coaching to set up reminders to take medication Assistance with navigating the community mental health provider intake process Assessing and accompanying clients to community resources and support groups as needed Assisting with community integration.
Minimum Documentation	Date of service (DOS); Start and end time/duration; Participant demographic information; Specific activity provided and POS; Participants response; Providers dated signature, title/position; Participants' progress toward his/her person-centered goals identified in the treatment/service plan.
Targeted Population	Elderly, Physically Disabled, Mentally Ill
Allowable Modes of Delivery	Face-to-face, video conf., telephone, individual, family (HR), on-site
Provider/Staff Standards	Bachelor's Level Supervised by licensed clinician. Unlicensed professional with bachelor's degree plus two years experience in human services and behavior modification. Staff employed or contracted by established mental health provider agency.
CAP	NA
Place of Service	CMHC, Office, Group Home, Home, ICF-MR, NF, SNF, Temp Lodging, Inpt. Hospital, ER, Pharmacy
Rule	**10 CCR 2505-10 Section 8.55.1**

	Behavioral Health Support means services by a paraprofessional to support a client during the transition period to mitigate issues, symptoms, and/or behaviors that are exacerbated during the transition period and negatively affect the client's stability in the community

	Transitional Specialized Day Rehabilitation Services
Service Definition	Services offered in a group setting designed and directed at the development and maintenance of the client's ability to independently, or with support, sustain himself/herself physically, emotionally and economically in the community.
Notes	Includes assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that takes place in a non-residential setting, separate from the participant's private residence or other residential living arrangement, except when due to medical and/or safety needs. Focus of activities will be on improving independence with IADLs including: 1. Housekeeping 2. Laundry 3. Transportation 4. Medication management 5. Shopping 6. Using the telephone 7. Food preparation 8. Financial management 9. Appointment management
Example Activities	Education in scheduling transportation; Training on managing finances such as balancing a checkbook; Group classes creating to do or grocery lists, cooking; Coaching on how to use the telephone.
Minimum Documentation	Assessment Log notes Attendance sheet Activities list Progress report Independent Living Plan Goals
Targeted Population	Elderly, Physically Disabled, Mentally Ill

Allowable Modes of Delivery	Group, On-Site
Provider/Staff Standards	Less than Bachelor Level Bachelor's degree or higher Degree from an accredited college or university in the area of Education, Social Work, Psychology or related field and one year of successful experience in human services, or an Associate's Degree from an Accredited college and two years of successful experience in human services, or four years successful experience in human services. Must be 18 years or older.
CAP	NA
Place of Service	CMHC, Community Setting
Rule	**10 CCR 2505-10 Section 8.55.1** Specialized Day Rehabilitation means services offered in a group setting designed and directed at the development and maintenance of the client's ability to independently, or with support, sustain himself/herself physically, emotionally and economically in the community.

	Vision Services
Service Definition	Services that include eye exams and diagnosis, glasses, contacts, and other medically necessary methods to improve specific vision system problems when not available through the Medicaid State Plan. Services available through Medicare are not covered.
Notes	NA
Example Activities	NA
Minimum Documentation	Results of eye exam, including diagnoses; Prescriptions; Patient medical record; Invoice for services rendered, including types of exam procedures utilized, exact cost of glasses, contacts.
Targeted Population	Elderly, Physically Disabled, Mentally Ill
Allowable Modes of Delivery	Face-to-face, on-site
Provider/Staff Standards	Optometrist or Ophthalmologist

CAP	Maximum: $1,000.00 dollars
Place of Service	Office, outpatient hospital
Rule	**10 CCR 2505-10 Section 8.555.1** Vision Services means services that include eye exams and diagnosis, glasses, contacts, and other medically necessary methods to improve specific vision system problems when not available through the Medicaid State Plan.