2. For a client with only a spouse at home, an additional amount based on a reasonable assessment of need but not to exceed the SSI standard; and

3. For a client with a spouse plus other dependents at home, or with other dependents only at home, an amount based on a reasonable assessment of need but not to exceed the appropriate AFDC grant level; and

4. Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party including:

    a. Health insurance premiums (other than Medicare), deductibles. or coinsurance charges, (including Medicaid copayments)

    b. Necessary medical or remedial care recognized under state law but not covered under the Medicaid State Plan.

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

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

**8.503 CHILDREN'S EXTENSIVE SUPPORT WAIVER PROGRAM (CES)**

**8.503 DEFINITIONS**

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

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

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

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

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

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

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

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

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

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

DEVELOPMENTAL DELAY means a child who is:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

An adoptive parent,

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

A spouse or,

The client's child.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### 8.503.10 HCBS-CES WAIVER ADMINISTRATION

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

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

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

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

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

8.503.10.F. HCBS-CES waiver:

1. Shall not constitute an entitlement to services from either the Department or the Operating Agency,

2. Shall be subject to annual appropriations by the Colorado general assembly,

3. Shall limit the utilization of the HCBS-CES waiver based on the federally approved capacity, cost containment, the maximum costs and the total appropriations, and,

4. May limit the enrollment when utilization of the HCBS-CES waiver program is projected to exceed the spending authority.

**8.503.20 GENERAL PROVISIONS**

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

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

2. HCBS-CES waiver is waived from the requirements of Section 1902(a) (10) (b) of the Social Security Act concerning comparability of services. The availability and comparability of services may not be consistent throughout the state of Colorado.

3. A client enrolled in the HCBS-CES waiver shall be eligible for all other Medicaid services for which the client qualifies and shall first access all benefits available under the Medicaid State Plan or Medicaid EPSDT prior to accessing services under the HCBS-CES waiver. Services received through the HCBS-CES waiver may not duplicate services available through the Medicaid State Plan.

**8.503.30 CLIENT ELIGIBILITY**

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

1. Is unmarried and less than eighteen years of age,

2. Be determined to have a developmental disability which includes developmental delay if under five (5) years of age,

3. Can be safely served in the community with the type and amount of HCBS-CES waiver services available and within the federally approved capacity and cost containment limits of the HCBS-CES waiver,

4. Meet ICF/MR level of care as determined by the Functional Needs Assessment,

5. Meet the Medicaid financial determination for LTC eligibility as specified at 10 CCR 2505-10, Section 8.100 *et seq.* and,

6. Reside in an eligible HCBS-CES waiver setting as defined as the following:

   a.) With biological, adoptive parent(s), or legal guardian,

   b.) In an out-of-home placement and can return home with the provision of HCBS-CES waiver services with the following requirement that must be approved by the HCBS-CES waiver administrator:

      i.) The case manger will work in conjunction with the residential caregiver to develop a transition plan that includes timelines and identified services or supports requested during the time the client is not residing in the family home.

7. Be determined to meet the Federal Social Security Administration's definition of disability,

8. Be determined by the Utilization Review Contractor (URC) to meet the additional targeting criteria eligibility for HCBS-CES waiver. The additional targeting criterion includes the following:

   a.) The individual demonstrates a behavior or has a medical condition that requires direct human intervention, more intense than a verbal reminder, redirection or brief observation of status, at least once every two hours during the day and on a weekly average of once every three hours during the night. The behavior or medical condition must be considered beyond what is typically age appropriate and due to one or more of the following conditions:

      i. A significant pattern of self-endangering behavior or medical condition which, without intervention will result in a life threatening condition or situation. Significant pattern is defined as the behavior or medical condition that is harmful to self or others as evidenced by actual events occurring within the past six months,

      ii.) A significant pattern of serious aggressive behavior toward self, others or property. Significant pattern is defined as the behavior is harmful to self or others, is evidenced by actual events occurring within the past six months, or

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

   b). The above conditions shall be evidenced by third party statement or data that is corroborated by written evidence that:

      i) The individual's behavior or medical needs have been demonstrated, or

      ii.) In the instance of an annual reassessment, that in the absence of the existing interventions or preventions provided through the HCBS-CES waiver that the intensity and frequency of the behavior or medical condition would resume to a level that would meet the criteria listed above.

c Examples of acceptable evidence shall not be older than six months and shall include but not be limited to any of the following:

i.) Medical records,

ii) Professional evaluations and assessments,

iii.) Insurance claims,

iv) Behavior pharmacology clinic reports,

v.) Police reports,

vi) Social Services reports, or

vii.) Observation by a third party on a regular basis.

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

1. Receives at least one (1) HCBS-CES waiver service each calendar month,

2. Is not simultaneously enrolled in any other HCBS waiver, and

3. Is not residing in a hospital, nursing facility, ICF/MR, other institution or correctional facility.

**8.503.40 HCBS-CES WAIVER SERVICES**

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

1. Adaptive Therapeutic Recreational Equipment and Fees are services which assist a client to recreate within the client's community. These services include recreational equipment that is adapted specific to the client's disability and not those items that a typical age peer would commonly need as a recreation item.

a. The cost of item shall be above and beyond what is typically expected for recreation and recommended by a doctor or therapist.

b. Adaptive recreational equipment may include adaptive bicycle, adaptive stroller, adaptive toys, floatation collar for swimming, various types of balls with internal auditory devices and other types of equipment appropriate for the recreational needs of a client with a developmental disability.

c. A pass for admission to recreation centers for the client only when the pass is needed to access a professional service or to achieve or maintain a specific therapy goal as recommended and supervised by a doctor or therapist. Recreation passes shall be purchased as day passes or monthly passes, whichever is the most cost effective.

d. Adaptive therapeutic recreation fees include those for water safety training.

e The following items are specifically excluded under HCBS-CES waiver and not eligible for reimbursement:

i. Entrance fees for zoos,

i.) Museums,

ii.) Butterfly pavilion,

iii.) Movie, theater, concerts,

iv.) Professional and minor league sporting events,

v.) Outdoors play structures,

vi. Batteries for recreational items; and,

vii. Passes for family admission to recreation centers.

f. The maximum annual allowance for adaptive therapeutic recreational equipment and fees is one thousand (1,000.00) dollars per service plan year.

2. Assistive Technology includes services, supports or devices that assist a client to increase maintain or improve functional capabilities. This may include assisting the client in the selection, acquisition, or use of an assistive technology device and includes:

a. The evaluation of the assistive technology needs of a client, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the client in the customary environment of the client,

b Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices,

c. Training or technical assistance for the client, or where appropriate, the family members, guardians, care-givers, advocates, or authorized representatives of the client,

d. Warranties, repairs or maintenance on assistive technology devices purchased through the HCBS-CES waiver, and

e. Adaptations to computers, or computer software related to the client's disability. This specifically excludes cell phones, pagers, and internet access unless prior authorized in accordance with the Operating Agency's procedures.

f Assistive Technology devices and services are only available when the cost is higher than typical expenses, and are limited to the most cost effective and efficient means to meet the need and are not available through the Medicaid State Plan or third party resource.

g Assistive Technology recommendations shall be based on an assessment provided by a qualified provider within the provider's scope of practice.

h When the expected cost is to exceed two thousand five hundred (2,500) dollars per device three estimates shall be obtained and maintained in the case record.

i. Training and technical assistance shall be time limited, goal specific and outcome focused.

j The following items and services are specifically excluded under HCBS-CES waiver and not eligible for reimbursement:

i. Purchase, training or maintenance of service animals,

ii. Computers,

iii. In home installed video monitoring equipment,

iv. Medication reminders,

v. Hearing aids,

vi Items or devices that are generally considered to be entertainment in nature including but not limited to CDs, DVDs, iTunes®, any type of games,

vii. training, or adaptation directly related to a school or home educational goal or curriculum; or

viii. items considered as typical toys for children.

k. The total cost of Home Accessibility Adaptations, Vehicle Modifications, and Assistive Technology shall not exceed ten thousand (10,000) dollars over the five (5) year life of the HCBS-CES waiver without an exception granted by the Operating Agency. Costs that exceed this limitation may be approved for services, items or devices to ensure the health and safety of the client or that enable the client to function with greater independence in the home, or decrease the need for paid assistance in another HCBS-CES waiver service on a long-term basis. Requests for an exception shall be prior authorized in accordance with the Operating Agency's procedures.:

i. The Operating Agency shall respond to exception requests within thirty (30) days of receipt.

3. Behavioral Services are services related to a client's developmental disability which assist a client to acquire or maintain appropriate interactions with others.

a. Behavioral Services shall address specific challenging behaviors of the client and identify specific criteria for remediation of the behaviors.

b. A client with a co-occurring diagnosis of developmental disabilities and mental health diagnosis covered in the Medicaid state plan shall have identified needs met by each of the applicable systems without duplication but with coordination by the behavioral services professional to obtain the best outcome for the client.

c. Services covered under Medicaid EPSDT or a covered mental health diagnosis in the Medicaid State Plan, covered by a third party source or available from a natural support are excluded and shall not be reimbursed.

d. Behavioral Services include:

i. Behavioral Consultation Services include consultations and recommendations for behavioral interventions and development of behavioral support plans that are related to the client's developmental disability and are necessary for the client to acquire or maintain appropriate adaptive behaviors, interactions with others and behavioral self management.

a) Intervention modalities shall relate to an identified challenging behavioral need of the client. Specific goals and procedures for the behavioral service must be established.

ii. Behavioral Plan Assessment Services include observations, interviews of direct staff, functional behavioral analysis and assessment, evaluations and completion of a written assessment document.

1) Behavioral plan assessment services are limited to forty (40) units and one assessment per service plan year. One unit is equal to fifteen (15) minutes of service.

iii. Individual and group counseling services include psychotherapeutic or psychoeducational intervention that:

1.) Is related to the developmental disability in order for the client to acquire or maintain appropriate adaptive behaviors, interactions with others and behavioral self-management, and

2.) Positively impacts the client's behavior or functioning and may include cognitive behavior therapy, systematic desensitization, anger management, biofeedback and relaxation therapy.

iv. Behavioral Line Services include direct implementation of the behavioral plan under the supervision and oversight of a behavioral consultant, for intervention to address social or emotional issues or with an identified challenging behavior that puts the individual's health and safety or the safety of others at risk.

4. Community Connector Services are intended to provide assistance to the client to enable the client to integrate into the client's residential community and access naturally occurring resources. Community connector services shall:

a. Support the abilities and skills necessary to enable the client to access typical activities and functions of community life such as those chosen by the general population.

b. Utilize the community as a learning environment to assist the client to build relationships and natural supports in the client's residential community.

c. Be provided to a single client in a variety of settings in which clients interact with individuals without disabilities, and

d. The cost of admission to professional or minor league sporting events, movies, theater, concert tickets or any activity that is entertainment in nature or any food or drink items are specifically excluded under the HCBS-CES waiver and shall not be reimbursed.

5. Home Accessibility Adaptations are physical adaptations to the primary residence of the client, that are necessary to ensure the health and safety of the client or that enable the client to function with greater independence in the home. All adaptations shall be the most cost effective means to meet the identified need. Such adaptations include:

   a. The installation of ramps,

   b. Widening or modification of doorways,

   c. Modification of bathroom facilities to allow accessibility, and assist with needs in activities of daily living.

   d. The installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment or supplies that are necessary for the health and safety of the client, and

   e. Safety enhancing supports such as basic fences or basic door and window alarms;

   f. The following items are specifically excluded from Home Accessibility Adaptations and shall not be reimbursed:

      i. Adaptations or improvements to the home that are considered to be on-going homeowner maintenance and are not related to the client's disability,

      ii.) Carpeting,

      iii.) Roof repair,

      iv.) Central air conditioning,

      v.) Air duct cleaning,

      vi.) Whole house humidifiers,

      vii.) Whole house air purifiers,

      viii.) Installation and repair of driveways and sidewalks,

      viii.) Monthly or ongoing home security monitoring fees,

      ix.) Home furnishings of any type,

      x.) Adaptations to rental units when the adaptation is not portable and cannot move with the renter, and

      xi.) Luxury upgrades.

   g. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation to:

      i. Improve entrance or egress to a residence; or,

      ii. Configure a bathroom to accommodate a wheelchair.

h. Any request to add square footage to the home shall be prior authorized in accordance with Operating Agency procedures.

i. All devices and adaptations shall be provided in accordance with applicable state or local building codes and applicable standards of manufacturing, design and installation. Medicaid State Plan, EPSDT or third party resources shall be utilized prior to authorization of HCBS-CES waiver services.

j. The total cost of Home Accessibility Adaptations, Vehicle Modifications, and Assistive Technology shall not exceed ten thousand (10,000) dollars over the five (5) year life of the HCBS-CES waiver without an exception granted by the Operating Agency. Costs that exceed this limitation may be approved for services, items or devices to ensure the health and safety of the client, enable the client to function with greater independence in the home, or decrease the need for paid assistance in another HCBS-CES waiver service on a long-term basis. Requests to exceed the limit shall be prior authorized in accordance with Operating Agency procedure.

6. Homemaker Services are provided in the client's home and are allowed when the client's disability creates a higher volume of household tasks or requires that household tasks are performed with greater frequency. There are two types of Homemaker Services:

a. Basic Homemaker Services includes cleaning, completing laundry, completing basic household care or maintenance within the client's primary residence only in the areas where the client frequents.

i This assistance may take the form of hands-on assistance by actually performing a task for the client or cueing to prompt the client to perform a task.

ii. Lawn care, snow removal, air duct cleaning and animal care are specifically excluded under HCBS-CES waiver and shall not be reimbursed.

b. Enhanced Homemaker Services include Basic Homemaker Services with the addition of either procedures for habilitation or procedures to perform extraordinary cleaning.

i. Habilitation services shall include direct training and instruction to the client in performing basic household tasks including cleaning, laundry, and household care which may include some hands-on assistance by actually performing a task for the client or enhanced prompting and cueing.

ii. The provider shall be physically present to provide step by step verbal or physical instructions throughout the entire task:

1) When such support is incidental to the habilitative services being provided,

2) To increase independence of the client,

c. Incidental Basic Homemaker Service may be provided in combination with Enhanced Homemaker Services; however, the primary intent must be to provide habilitative services to increase independence of the client.

d. Extraordinary cleaning are those tasks that are beyond routine sweeping, mopping, laundry or cleaning and require additional cleaning or sanitizing due to the client's disability.

7. Parent Education provides unique opportunities for parents or other care givers to learn how to support the child's strengths within the context of the child's disability and enhances the parent's ability to meet the special needs of the child. Parent Education includes:

    a. Consultation and direct service costs for training parents and other care givers in techniques to assist in caring for the client's needs, including sign language training,

    b. Special resource materials,

    c. Cost of registration for parents or caregivers to attend conferences or educational workshops that are specific to the client's disability,

    d. Cost of membership to parent support or information organizations and publications designed for parents of children with disabilities.

    e. The maximum service limit for parent education is one thousand (1,000) units per service plan year.

    f. The following items are specifically excluded under the HCBS-CES waiver and not eligible for reimbursement:

        i) Transportation,

        ii) Lodging,

        iii). Food, or

        iv). Membership to any political organizations or any organization involved in lobby activities.

8. Personal Care is assistance to enable a client to accomplish tasks that the client may complete without assistance if the client did not have a disability. This assistance may take the form of hands-on assistance by actually performing a task for the client or cueing to prompt the client to perform a task.

    a. Personal care services include assistance with basic self care tasks that include performing hygiene activities, bathing, eating, dressing, grooming, bowel, bladder and menstrual care.

    b. Personal care services may be provided on an episodic, emergency or on a continuing basis. When personal care service is required it shall be provided by the HCBS-CES waiver only to the extent the Medicaid State Plan or third party resource does not cover the service.

    c. If the annual Functional Needs Assessment identifies a possible need for skilled care then the client shall obtain a home health assessment.

9. Professional Services are provided by a licensed, certified, registered or accredited professional and the intervention is related to an indentified 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.

      iv). The following items are excluded under the HCBS-CES waiver and are not eligible for reimbursement:

         1) Acupuncture,

         2) Chiropractic care,

         3) Fitness training (personal trainer),

         4) Equine therapy,

         5) Art therapy,

         6) Warm water therapy,

         7) Therapeutic riding,

         8) Experimental treatments or therapies, and

         9) Yoga.

10. Respite is provided to clients on a short-term basis, because of the absence or need for relief of the primary caregivers of the client.

   a. Respite may be provided:

i.) In the client's home, private residence,

ii.) The private residence of a respite care provider, or

iii.) In the community.

b. Respite is to be provided in an age appropriate manner.

i.) The eligible client age twelve (12) or older may receive respite during the time the care-giver works because same age typical peers do not need ongoing supervision at that age and the need for the respite is based on the client's disability.

ii.) A client eleven (11) years of age and younger, will not receive respite during the time the parent works, pursues continuing education or volunteers, because this is a typical expense for all parents of young children.

c. When the cost of care during the time the parents works is more for an eligible client, eleven (11) years of age or younger, than it is for same age peers, then respite may be used to pay the additional cost. Parents shall be responsible for the basic and typical cost of child care.

d. Respite may be provided for siblings, age eleven (11) and younger, who reside in the same home of an eligible client when supervision is needed so the primary caretaker can take the client to receive a state plan benefit or a HCBS-CES waiver service.

e. Respite shall be provided according to an individual or group rates as defined below:

i) Individual: the client receives respite in a one-on-one situation. There are no other clients in the setting also receiving respite services. Individual respite occurs for ten (10) hours or less in a twenty four (24)-hour period.

ii) Individual day: the client receives respite in a one-on-one situation for cumulatively more than ten (10) hours in a twenty four (24)-hour period. A full day is ten (10) hours or greater within a twenty four (24)- hour period.

iii) Overnight group: the client receives respite in a setting which is defined as a facility that offers twenty four (24)-hour supervision through supervised overnight group accommodations. The total cost of overnight group within a twenty four (24)-hour period shall not exceed the respite daily rate.

iv) Group: the client receives care along with other individuals, who may or may not have a disability. The total cost of group within a twenty four (24)-hour period shall not exceed the respite daily rate. The following limitations to respite service shall apply:

1) Sibling care is not allowed for care needed due to parent's work, volunteer, or education schedule or for parental relief from care of the sibling.

f. Federal financial participation shall not to be claimed for the cost of room and board except when provided, as part of respite care furnished in a facility approved pursuant to 2 CCR 503-1 Section 16.221 by the state that is not a private residence.

g. The total amount of respite provided in one service plan year may not exceed an amount equal to thirty (30) day units and one thousand eight hundred eighty (1,880) individual units. The Operating Agency may approve a higher amount based on a need due to the client's age, disability or unique family circumstances.

h. Overnight group respite may not substitute for other services provided by the provider such as Personal Care, Behavioral Services or services not covered by the HCBS-CES waiver.

i. Respite shall be reimbursed according to a unit rate or daily rate whichever is less. The daily overnight or group respite rate shall not exceed the respite daily rate.

j. The purpose of respite is to provide the primary caregiver a break from the ongoing daily care of a client. Therefore, additional respite units beyond the service limit will not be approved for clients who receive skilled nursing, certified nurse aid services, or home care allowance from the primary caregiver.

11. Specialized Medical Equipment and Supplies include: devices, controls, or appliances that are required due to the client's disability and that enable the client to increase the client's ability to perform activities of daily living or to safely remain in the home and community. Specialized Medical Equipment and Supplies include:

a. Kitchen equipment required for the preparation of special diets if this results in a cost savings over prepared foods;

b. Specially designed clothing for a client if the cost is over and above the costs generally incurred for a client's clothing;

c. Maintenance and upkeep of specialized medical equipment purchased through the HCBS-CES waiver.

d. The following items are specifically excluded under the HCBS-CES waiver and not eligible for reimbursement:

i) Items that are not of direct medical or remedial benefit to the client vitamins, food supplements, any food items, prescription or over the counter medications, topical ointments, exercise equipment, hot tubs, water walkers, resistance water therapy pools, experimental items or wipes for any purpose other incontinence.

12. Vehicle Modifications are adaptations or alterations to an automobile or van that is the client's primary means of transportation, to accommodate the special needs of the client, are necessary to enable the client to integrate more fully into the community and to ensure the health, and safety of the client.

a. Upkeep and maintenance of the modifications are allowable services.

b. Items and services specifically excluded from reimbursement under the HCBS-CES waiver include:

i) Adaptations or improvements to the vehicle that are not of direct medical or remedial benefit to the client,

ii) Purchase or lease of a vehicle, and

iii) Typical and regularly scheduled upkeep and maintenance of a vehicle

c. The total cost of Home Accessibility Adaptations, Vehicle Modifications, and Assistive Technology shall not exceed ten thousand (10,000) dollars over the five (5) year life of the HCBS-CES waiver without an exception granted by the Operating Agency. Costs that exceed this limitation may be approved for services, items or devices to ensure the health and safety of the client, enable the client to function with greater independence in the home, or decrease the need for paid assistance in another HCBS-CES waiver service on a long-term basis. Approval for a higher amount will include a thorough review of the current request as well as past expenditures to ensure cost-efficiency, prudent purchases and no unnecessary duplication.

13. Vision service

a. Vision therapy is a sequence of activities individually prescribed and monitored by a Doctor of Optometry or Ophthalmology to develop efficient visual skills and processing. It is based on the results of standardized tests, the needs of the client and the client's signs and symptoms. It is used to treat eye movement disorders, inefficient eye teaming, misalignment of the eyes, poorly developed vision, focusing problems and visual information processing disorders to enhance visual skills and performing visual tasks.

b. The following items are specifically excluded under the HCBS-CES waiver and not eligible for reimbursement:

i) Eye glasses as a benefit under Medicaid State Plan,

ii) Contacts, or

iii) General vision checks

c. Vision therapy is provided only when the services are not available through the Medicaid State Plan or EPSDT and due to not meeting the need for medical necessity as defined in Health Care Policy and Financing rules at 10 CCR 2505-10,Section 8.208.1 or available through a third party resource.

**8.503.50 SERVICE PLAN**

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

1. The service plan shall:

a. Address the client's assessed needs and personal goals, including health and safety risk factors either by HCBS-CES waiver services or any other means,

b. Be in accordance with the Department's and the Operating Agency's rules, policies and procedures,

c. Be entered and verified in the Department prescribed system within ten (10) business days,

d. Describe the types of services to be provided, the amount, frequency and duration of each service and the type of provider for each service,

e. Include a statement of agreement, and.

f. Be updated or revised at least annually or when warranted by changes in the HCBS-CES waiver client's needs,

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

a. Between HCBS-CES waiver services and institutional care,

b. Among HCBS-CES waiver services, and

c. Among qualified providers.

**8.503.60 WAITLIST PROTOCOL**

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

1. The Community Centered Board shall determine if an applicant has developmental delay if under age five (5), or developmental disability if over age five (5) prior to submitting the HCBS-CES waiver application to the utilization review contractor. Only a client who is determined to have a developmental delay or developmental disability may apply for HCBS-CES waiver.

2. In the event a client who has been determined to have a developmental delay is placed on the wait list prior to age five (5), and that client turns five (5) while on the HCBS-CES waiver wait list, a determination of developmental disability must be completed in order for the client to remain on the wait list.

3. The case management agency shall complete the Functional Needs Assessment, as defined in Department rules, to determine the client's Level Of Care.

4. The case management agency shall complete the HCBS-CES waiver application with the participation of the family. The completed application and a copy of the Functional Needs Assessment that determines the client meets the ICF/MR level of care shall be submitted to the Utilization Review Contractor within fourteen (14) calendar days of parent signature.

5. Supporting documentation provided with the HCBS-CES waiver application shall not be older than six (6) months at the time of submission to the utilization review contractor.

6. The utilization review contractor shall review the HCBS-CES waiver application. In the event the utilization review contractor needs additional information, the case management agency shall respond within two (2) business days of request.

7. Any client determined eligible for services under the HCBS-CES waiver when services are not immediately available within the federally approved capacity limits of the HCBS-CES waiver, shall be eligible for placement on a single statewide wait list in the order in which the utilization review contractor received the eligible HCBS-CES waiver application. Applicants denied program enrollment shall be informed of the client's appeal rights in accordance with 10 CCR 2505-10, Section 8.057.

8. The case management agency will create or update the consumer record to reflect the client is waiting for the HCBS-CES waiver with the wait list date as determined by the utilization review contractor.

**8.503.70 ENROLLMENT**

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

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

    a. If it has been less than six (6) months since the review to determine wait list eligibility by the Utilization Review Contractor and there has been no change in the client's condition, the case management agency shall complete the Functional Needs Assessment and the parent may submit a letter to the case management agency in lieu of the HCBS-CES waiver application stating there has been no change.

    b. If there has been any change in the client's condition the case management agency shall complete a Functional Needs Assessment and the HCBS-CES waiver application which shall be submitted to the Utilization Review Contractor.

3. Services and supports shall be implemented pursuant to the service plan within 90 days of the parent or guardian signature.

4. All continued stay review enrollments shall be completed and submitted to the utilization review contractor at least thirty (30) days and not more than ninety (90) days prior to the end of the current enrollment period.

**8.503.80 CLIENT RESPONSIBILITIES**

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

1. Provide accurate information regarding the client's ability to complete activities of daily living, daily and nightly routines and medical and behavioral conditions.

2. Cooperate with providers and case management agency requirements for the HCBS-CES waiver enrollment process, continued stay review process and provision of services;

3. Cooperate with the local Department of Human Services in the determination of financial eligibility;

4. Complete the HCBS-CES waiver application with fifteen calendar days of the authorized initial enrollment date as determined by the HCBS-CES waiver coordinator or in the event of a continued stay review, at least thirty (30) days prior to the end of the current certification period;

5. Complete the Service Plan within thirty calendar days of determination of HCBS-CES waiver additional targeting criteria eligibility as determined by the Utilization Review Contractor;

6. Notify the case manager within thirty (30) days after changes:

    a. In the client's support system, medical condition and living situation including any hospitalizations, emergency room admissions, nursing home placements or ICF/MR placements;

    b. That may affect Medicaid financial eligibility such as prompt report of changes in income or resources;

    c. When the client has not received an HCBS-CES waiver service for one calendar month;

    d. In the client's care needs; and,

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

**8.503.90 PROVIDER REQUIREMENTS**

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

1. Conform to all state established standards for the specific services they provide under HCBS-CES waiver,

2. Maintain program approval and certification from the Operating Agency,

3. Maintain and abide by all the terms of their Medicaid provider agreement with the Department and with all applicable rules and regulations set forth in 10 CCR 2505-10, Section 8.130,

4. Discontinue HCBS-CES waiver services to a client only after documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide HCBS-CES waiver services,

5. Have written policies governing access to duplication and dissemination of information from the client's records in accordance with state statutes on confidentiality of information at Section 25.5-1-116, C.R.S., as amended,

6. When applicable, maintain the required licenses and certifications from the Colorado Department of Public Health and Environment, and

7. Maintain client records to substantiate claims for reimbursement according to Medicaid standards.

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

1. All applicable provisions of 27, Article 10.5, C.R.S., et seq. and all rules and regulations as set forth in 2 CCR 503-1, Section 16.100 *et seq.*,

2. All federal or state program reviews or financial audit of HCBS-CES waiver services,

3. The Operating Agency's on-site certification reviews for the purpose of program approval, on-going program monitoring or financial and program audits,

4. Requests from the County Departments of Human Services to access records of clients and to provide necessary client information to determine and re-determine Medicaid financial eligibility,

5. Requests by the Department of the Operating Agency to collect, review and maintain individual or agency information on the HCBS-CES waiver, and

6. Requests by the case management agency to monitor service delivery through targeted case management activities.

**8.503.100 TERMINATION OR DENIAL OF HCBS-CES MEDICAID PROVIDER AGREEMENTS**

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

1. The provider is in violation of any applicable certification standard or provision of the provider agreement and does not adequately respond to a corrective action plan within the prescribed period of time. The termination shall follow procedures at 10 CCR 2505-10, Section 8.130 *et seq.*

2. A change of ownership occurs. A change in ownership shall constitute a voluntary and immediate termination of the existing provider agreement by the previous owner of the agency and the new owner must enter into a new provider agreement prior to being reimbursed for HCBS-CES waiver services.

3. The provider or its owner has previously been involuntarily terminated from Medicaid participation as any type of Medicaid service provider.

4. The provider or its owner has abruptly closed, as any type of Medicaid provider, without proper prior client notification.

5. The provider fails to comply with requirements for submission of claims pursuant to 10 CCR 2505-10, Section 8.040.2 or after actions have been taken by the Department, the Medicaid Fraud Control Unit or their authorized agents to terminate any provider agreement or recover funds.

6. Emergency termination of any provider agreement shall be in accordance with procedures at 10 CCR 2505-10, Section 8.050.

**8.503.110 ORGANIZED HEALTH CARE DELIVERY SYSTEM**

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

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

2. The OHCDS shall maintain a Medicaid provider agreement with the Department to deliver HCBS-CES waiver services according to the current federally approved waiver.

3. The OHCDS may contract or employ for delivery of HCBS-CES waiver services.

4. The OCHDS shall:

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

    b. Ensure that services are delivered according to the HCBS-CES waiver definitions and as identified in the client's service plan,

    c. Ensure the contractor maintains sufficient documentation to support the claims submitted, and

    d. Monitor the health and safety of HCBS-CES waiver clients receiving services from a subcontractor.

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

    a. Establish reimbursement rates that are consistent with efficiency, economy and quality of care,

    b. Establish written policies and procedures regarding the process that will be used to set rates for each service type and for all providers,

    c. Ensure that the negotiated rates are sufficient to promote quality of care and to enlist enough providers to provide choice to clients

    d. Negotiate rates that are in accordance with the Department's established fee for service rate schedule and Operating Agency procedures,

        i.) Manually priced items that have no maximum allowable reimbursement rate assigned, nor a Manufacturer's Suggested Retail Price (MSRP), shall be reimbursed at the lesser of the submitted charges or the sum of the manufacturer's invoice cost, plus 13.56 percent.

    e. Collect and maintain the data used to develop provider rates and ensure data includes costs for the services to address the client's needs, that are allowable activities within the HCBS-CES waiver service definition and that supports the established rate, and

    f. Maintain documentation of provider reimbursement rates and make it available to the Department, its Operating Agency and Centers for Medicare and Medicaid Services (CMS).

    g. Report by August 31 of each year, the names, rates and total payment made to the contractor.

**8.503.120 PRIOR AUTHORIZATION REQUESTS**

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

1. A Prior Authorization Request shall be submitted to the Operating Agency through the Department's designated information management system.

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

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

    a. Consistent with the client's documented medical condition and functional capacity as indicated in the Functional Needs Assessment,

    b. Adequate in amount, frequency and duration in order to meet the client's needs and within the limitations set forth in the current federally approved HCBS-CES waiver, and

    c. Not duplicative of another authorized service, including services provided through:

        i.) Medicaid State Plan benefits,

        ii.) Third party resources,

        iii.) Natural supports,

        iv.) Charitable organizations, or

        v.) Other public assistance programs.

4. Services delivered without prior authorization shall not be reimbursed except for provision of services during an emergency pursuant to 10 CCR 2505-10, Section 8.058.4.

**8.503.130 RETROSPECTIVE REVIEW PROCESS**

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

1. Identified in the service plan is based on the client's identified needs as stated in the Functional Needs Assessment,

2. Have been requested and approved prior to the delivery of services,

3. Provided to a client are in accordance with the service plan, and

4. Provided are within the specified HCBS service definition in the federally approved HCBS-CES waiver.

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

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

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

**8.503.140 PROVIDER REIMBURSEMENT**

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

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

   a. Services are provided by a qualified provider as specified in the federally approved HCBS-CES waiver,

   b. Services have been prior authorized,

   c. Services are delivered in accordance to the frequency, amount, scope and duration of the service as identified in the client's service plan, and

   d. Required documentation of the specific service is maintained and sufficient to support that the service is delivered as identified in the service plan and in accordance with the service definition.

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

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

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

**8.503.150 CLIENT RIGHTS**

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

**8.503.160 APPEAL RIGHTS**

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

1. The Applicant is determined not to have a developmental delay or developmental disability,

2. The Applicant is determined eligible or ineligible for Medicaid LTC services,

3. The Applicant is determined eligible or ineligible for placement on a waitlist for Medicaid LTC services,

4. An Adverse Action occurs that affects the client's HCBS-CES waiver enrollment status through termination or suspension,

5. An Adverse Action occurs that affects the provision of HCBS-CES waiver services or,

6. The Applicant or client requests such information.

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

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

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

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

1. The applicant, parent or legal guardian fails to submit the Medicaid financial application for LTC to the financial eligibility site within thirty (30) days of LTC referral,

2. A client, parent or legal guardian fails to submit financial information for re-determination for LTC to the financial eligibility site within the required re-determination timeframe,

3. The County Income Maintenance Technician has determined the client no longer meets financial eligibility criteria as set forth in 10 CCR 2505-10, Section 8.100,

4. The client cannot be served safely within the cost containment as identified in the HCBS-CES waiver,

5. The client requires twenty four (24) hour supports provided through Medicaid state plan,

6. The resulting total cost of services provided to the client, including Targeted Case Management, home health and HCBS-CES waiver services, exceeds the cost containment as identified in the HCBS-CES waiver,

7. The client enters an institution for treatment with duration that continues for more than thirty (30) days,

8. The client is detained or resides in a correctional facility, and

9. The client enters an institute for mental illness with a duration that continues for more than thirty (30) days.

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

1. A HCBS-CES waiver service is reduced, terminated or denied because it is not a demonstrated need in the Functional Needs Assessment or because it is not available through the current federally approved HCBS-CES waiver,

2. A service plan for HCBS-CES waiver services exceed the limits as set forth in the in the federally approved HCBS-CES waiver,

3. The parent or legal guardian has failed to schedule an appointment for the Functional Needs Assessment of the client, service plan, or 6 month visit two (2) times in a thirty (30) day consecutive period,

4. The parent or legal guardian has failed to keep three (3) scheduled assessment appointments within a thirty (30) consecutive day period,

5. The parent or legal guardian failed to complete the HCBS-CES waiver application within fifteen (15) calendar days of the authorized enrollment date as determined by the Operating Agency,

6. The parent or legal guardian fails to complete the service plan within thirty (30) calendar days of the authorized enrollment date as determined by the Operating Agency,

7. The parent or legal guardian refuses to use the home care allowance to pay for services, or uses the home care allowance payment for services not identified in the service agreement,

8. The parent or legal guardian refuses to sign the statement of agreement or other forms as required to receive services,

9. The client enrolls in a different long term care program,

10. The client moves out of state. The client shall be discontinued effective upon the day after the date of the move.

    a. A client who leaves the state on a temporary basis, with intent to return to Colorado, according to income maintenance staff manual 9 CCR 2503-1, Section 3.140.2, residence, shall not be discontinued unless one or more of the other client eligibility criteria are no longer met.

11. The parent or legal guardian voluntarily withdraws the client from HCBS-CES waiver. The client shall be discontinued from the program effective upon the day after the date on which the parent or legal guardian request is documented.

12. The CCB shall not send the LTC notice of action form when the basis for discontinuation is death of the client, but shall document the event in the client record and the date of action shall be the day after the date of death.

**8.503.170 QUALITY ASSURANCE**

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

1. The Operating Agency shall conduct reviews of each agency providing HCBS-CES waiver services or cause to have reviews to be performed in accordance with guidelines established by the Department or Operating Agency and Department. The review shall apply rules and standards developed for programs serving clients with developmental disabilities.

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

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

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

**8.503.210 POST ELIGIBILITY TREATMENT OF INCOME (PETI)**

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

**8.504 HOME AND COMMUNITY BASED SERVICES for CHILDREN WITH LIFE LIMITING ILLNESSWAIVER**

**8.504.1 DEFINITIONS**

Assessment means a comprehensive and uniform process using the Uniform Long Term Care (ULTC) Instrument to obtain information about a client including his/her condition, personal goals and preferences, functional abilities, including Activities of Daily Living (ADL) and Instrumental Activities of Daily Living, health status and other factors relevant to determine the client's level of functioning.

Assessment process includes collecting information from the client and appropriate collaterals pertaining to service needs, available resources, potential funding sources and includes supporting diagnostic information from a licensed medical professional.

Bereavement Counseling means counseling provided to the client and/or family members in order to guide and help them cope with the client's illness and the related stress that accompanies the continuous, daily care required by a child with a life-threatening condition. Enabling the client and family members to manage this stress improves the likelihood that the child with a life-threatening condition will continue to be cared for at home, thereby preventing premature and otherwise unnecessary institutionalization. Bereavement activities offer the family a mechanism for expressing emotion and asking questions about death and grieving in a safe environment thereby potentially decreasing complications for the family after the child dies