Appendix A

CDASS Rules and Regulations

8.500.90 SUPPORTED LIVING SERVICES WAIVER (SLS)

The section hereby incorporates the terms and provisions of the federally approved Home and Community Based Supported Living Services (HCBS-SLS) Waiver, CO.0293. To the extent that the terms of the federally approved waiver are inconsistent with the provisions of this section, the
waiver shall control.
HCBS-SLS services and supports which are available to assist persons with developmental disabilities to live in the person's own home, apartment, family home, or rental unit that qualifies as an HCBS-SLS setting. HCBS-SLS services are not intended to provide twenty four (24) hours of paid support or meet all identified client needs and are subject to the availability of appropriate services and supports within existing resources.

8.500.90 DEFINITIONS

ACTIVITIES OF DAILY LIVING (ADL) means basic self care activities including bathing, bowel and bladder control, dressing, eating, independent ambulation, and needing supervision to support behavior, medical needs and memory/cognition.
ADVERSE ACTION means a denial, reduction, termination or suspension from the HCBS-SLS waiver or a specific HCBS-SLS waiver service(s).

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

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

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

services and supports to such persons either directly or by purchasing such services and supports from service agencies.
CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES (CDASS) means the service delivery option set forth at section 8.510 et. Seq
COST CONTAINMENT means limiting the cost of providing care in the community to less than or equal to the cost of providing care in an institutional setting based on the average aggregate amount. The cost of providing care in the community shall include the cost of providing Home and Community Based Services, and Medicaid State Plan Benefits including Long Term Home Health services, and targeted case management.

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

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

DEVELOPMENTAL DISABILITY means a disability that is manifested before the person reaches twenty-two (22) years of age, which constitutes a substantial disability to the affected individual, and is attributable to mental retardation or related conditions which include cerebral palsy, epilepsy, autism or other neurological conditions when such conditions result in impairment of general intellectual functioning or adaptive behavior similar to that of a person with mental retardation. Unless otherwise specifically stated, the federal definition of "Developmental Disability" found in 42 U.S.C., Section 6000, *et seq.*, shall not apply.

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

Adaptive behavior similar to that of a person with mental retardation means that the person has overall adaptive behavior which is two or more

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

Substantial intellectual deficits means an intellectual quotient that is between seventy one (71) and seventy five (75) assuming a scale with a mean of one hundred100 and a standard deviation of fifteen (15), as measured by an instrument which is standardized, appropriate to the nature of the person's disability, and administered by a qualified professional. The standard error of measurement of the instrument should be considered when determining the intellectual quotient equivalent.

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

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

A mother, father, brother, sister or,
Extended blood relatives such as grandparent, aunt or uncle
Cousins or,
An adoptive parent; or,
One or more individuals to whom legal custody of a client with a developmental disability has been given by a court; or,
A spouse; or
The client’s children.

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

FUNCTIONAL NEEDS ASSESSMENT means a comprehensive face-to-face evaluation using the uniform long term care instrument and medical verification on the professional medical information page to determine if the applicant or client

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

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

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

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

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

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

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

OPERATING AGENCY means the Department of Health Care Policy and Financing, in the Division for Intellectual and Developmental Disabilities, which

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

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

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

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

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

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

RELATIVE means a person related to the client by virtue of blood, marriage, adoption or common law marriage.
RETROSPECTIVE REVIEW means the Department or the Operating Agency’s review after services and supports are provided to ensure the client received services according to the service plan and standards of economy, efficiency and quality of service

SERVICE DELIVERY OPTION means the method by which direct services are provided for a participant. Those options include: A) By and agency B) Participant Directed.

SERVICE PLAN means the written document that specifies identified and needed services to include Medicaid eligible and non-Medicaid eligible services, regardless of funding source, to assist a client to remain safely in the community and developed in accordance with the Department and the Operating Agency’s

rules set forth in 10 CCR 2505-10, Section 8.400.

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

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

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

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

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

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

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

8.500.94.A HCBS-SLS WAIVER SERVICES

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

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

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

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

b. Enhanced homemaker services includes basic homemaker services with the addition of either procedures for habilitation or procedures to perform extraordinary cleaning

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

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

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

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

a. Personal Care services include:

i) Assistance with basic self-care including hygiene, bathing, eating, dressing, grooming, bowel, bladder and menstrual care.
ii) Assistance with money management,
iii) Assistance with menu planning and grocery shopping, and
iv) Assistance with health related services including first aide, medication administration, assistance scheduling or reminders to attend routine or as needed medical, dental and therapy appointments, support that may include accompanying clients to routine or as needed medical, dental, or therapy appointments to ensure understanding of instructions, doctor's orders, follow up, diagnoses or testing required, or skilled care that takes place out of the home.

b. Personal Care services may be provided on an episodic, emergency or on a continuing basis. When personal care service is required, it shall be covered to the extent the Medicaid state plan or third party resource does not cover the service.

c. If the annual functional needs assessment identifies a possible need for skilled care: then the client shall obtain a home health assessment.

I. THE CLIENT SHALL OBTAIN A HOME HEALTH ASSESSMENT, OR

II. THE CLIENT SHALL BE INFORMED OF THE OPTION TO DIRECT HIS/HER HEALTH MAINTENANCE ACTIVITIES PURSUANT TO SECTION 8.510.12, ET SEQ.

17. HEALTH MAINTENANCE ACTIVITIES are available only as a Participant Directed Supported Living Service in accordance with 8.500.94.B. Health Maintenance activities means routine and repetitive health related tasks furnished to an eligible client in the community or in the client's home, which are necessary for health and normal bodily functioning that a person with a disability is unable to physically carry out. Services may include:

   a. Skin care provided when the skin is broken or a chronic skin condition is active and could potentially cause infection. Skin care may include: wound care, dressing changes, application of prescription medicine, and foot care for people with diabetes when prescribed by a licensed medical professional

   b. Nail care in the presence of medical conditions that may involve peripheral circulatory problems or loss of sensation

   c. Mouth care performed when:
      i. There is injury or disease of the face, mouth, head or neck
      ii. In the presence of communicable disease
      iii. The client is unconscious, or
      iv. Oral suctioning is required

   d. Dressing, including the application of anti-embolic or other prescription pressure stockings and orthopedic devices such as splints, braces, or artificial limbs if considerable manipulation is necessary

   e. Feeding
      i. When suctioning is needed on a stand-by or other basis
      ii. When there is high risk of choking that could result in the need for emergency measures such as CPR or the

Heimlich maneuver as demonstrated by a swallow study

iii. Syringe feeding, or
iv. Feeding using apparatus

f. Exercise prescribed by a license 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 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. Medial management required by a medical professional to monitor blood sugars, oxygen saturations, pain management, intravenous, or intramuscular injections

k. Respiratory Care:
   i. Postural drainage
   ii. Cupping
   iii. Adjusting oxygen flow within established parameters
   iv. Suctioning of mouth and nose
   v. Nebulizers
   vi. Ventilator and tracheostomy care
   vii. Prescribed respiratory equipment

8.500.94.B PARTICIPANT-DIRECTED SUPPORTED LIVING SERVICES

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

(2014).

1. Participants may choose to direct their own services through the Consumer Directed Attendant Support Services delivery option set forth at section 8.510, et seq.

2. Services that may be Participant-Directed under this option are as follows:
    i. Personal care as defined at section 10 CCR 2505-10 §8.500.94.A.10
    ii. Homemaker as defined at section 10 CCR 2505-10 §8.500.94.A.6
    iii. Health Maintenance activities as defined at section 10 CCR 2505-10 §8.500.94.A.17

3. The Case Manager shall conduct the case management functions set forth at section 8.510.14 et seq.

8.500.102 SERVICE PLAN AUTHORIZATION LIMITS (SPAL)

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

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

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

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

8.500.102.G Health Maintenance activities available under Consumer Directed

Attendant Support Services (CDAS) is not subject to the Service Plan Authorization Limit

8.510 CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES

DEFINITIONS

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

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

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

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

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

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

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

with the Department.

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

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

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

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

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

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

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

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

P. Financial Management Services (FMS) vendor means an entity

contracted with the Department and chosen by the client or Authorized Representative to complete employment-related functions for CDASS Attendants and to track and report on individual client CDASS Allocations.

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

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

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

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

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

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

W. Notification means a communication from the Department or its designee with information about CDASS. Notification methods include but are not limited to announcements via the Department's CDASS web

site, client account statements, Case Manager contact, or FMS vendor contact.

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

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

8.510.2 ELIGIBILITY

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

1. Choose the CDASS delivery option.
2. Meet HCBS waiver functional and financial eligibility requirements.
3. Demonstrate a current need for covered Attendant support services.
4. Document a pattern of stable client health indicating appropriateness for community-based services and a predictable pattern of CDASS Attendant support.
5. Provide a statement, at an interval determined by the Department, from the client's primary care physician, physician assistant, or advanced practice nurse, attesting to the client's ability to direct their care with sound judgment or a required AR with the ability to direct the care on the client's behalf.
6. Complete all aspects of the ASMP and training and demonstrate the ability to direct care or have care directed by an AR.

   a. Client training obligations

      i. Clients and ARs who have received training through the Training and Operations Vendor in the past two years and have utilized CDASS in the previous six months may receive a modified training to restart CDASS following an episode of closure.

The Case Manager will review the allocation and attendant management for the client's previous service utilization and consult with the Department to determine whether full retraining is required, or an abbreviated training based on history of managing allocation and services is needed.

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

8.510.3 COVERED SERVICES

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

8.510.3.B. Services include:

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

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

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

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

task, or:

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

ii) In the presence of communicable disease;

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

iv) Oral suctioning is required;

v) There is decreased oral sensitivity or hypersensitivity;

vi) Client is at risk for choking and aspiration.

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

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

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

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

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

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

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

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

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

v) Oral feeding when the client is unable to

communicate verbally, non-verbally or through other means.

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

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

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

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

iii) The use of a mechanical lift is needed.

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

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

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

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

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

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

ii) Care of external, indwelling and suprapubic catheters;

iii) Changing from a leg to a bed bag and cleaning of

tubing and bags as well as perineal care.

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

k. Respiratory care:

   i) Postural drainage;

   ii) Cupping;

   iii) Adjusting oxygen flow within established parameters;

   iv) Suctioning mouth and/or nose;

   v) Nebulizers;

   vi) Ventilator and tracheostomy care;

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

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

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

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

o. Mobility assistance is considered a health maintenance

task when health maintenance-level transfers are required in conjunction with the mobility assistance, or:

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

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

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

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

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

ii) The client is unable to complete task independently

EXCLUDED SERVICES

8.510.3.C. CDASS Attendants are not authorized to perform services and payment is prohibited:

1. While client is admitted to a nursing facility, hospital, a long-term care facility or incarcerated;
2. Following the death of client;
3. That are duplicative or overlapping. The Attendant cannot be reimbursed to perform tasks at the time a client is concurrently receiving a waiver service in which the provider is required to perform the tasks in conjunction with the service being rendered;

B. Companionship is not a covered CDASS service.

8.510.4 ATTENDANT SUPPORT MANAGEMENT PLAN

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

1. Needed Attendant support;
2. Plans for locating and hiring Attendants;
3. Plans for handling emergencies;
4. Assurances and plans regarding direction of CDASS Services, as described at

   8.510.3 and 8.510.6, if applicable.
5. Plans for budget management within the client's Allocation.
6. Designation of an AR, if applicable.
7. Designation of regular and back-up employees proposed or approved for hire.

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

8.510.5 CLIENT/AR RESPONSIBILITES

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

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

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

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

4. Determine the required qualifications for Attendants.

5. Recruit, hire and manage Attendants.

6. Complete employment reference checks on Attendants.

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

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

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

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

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

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

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

14. Budget for Attendant care within the established monthly and CDASS Certification Period Allocation. Services that exceed

the client's monthly CDASS Allocation by 30% or higher are not allowed and cannot be authorized by the client or AR for reimbursement through the FMS vendor.

15. Authorize Attendant to perform services allowed through CDASS.

16. Review all Attendant timesheets and statements for accuracy of time worked, completeness, and client/AR and Attendant signatures. Timesheets shall reflect actual time spent providing CDASS.

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

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

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

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

21. Select an FMS vendor upon enrollment into CDASS.

8.510.5.B. Client/AR responsibilities for Verification:

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

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

1. Right to receive training on managing CDASS.

2. Right to receive program materials in accessible format.

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

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

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

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

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

8.510.6 AUTHORIZED REPRESENTATIVES (AR)

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

1. Is least eighteen years of age;

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

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

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

8.510.6.B. CDASS clients who require an AR may not serve as an AR for another CDASS client.

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

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

8.510.7 ATTENDANTS

8.510.7.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.

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

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

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

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

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

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

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

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

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

8.510.8 FINANCIAL MANAGEMENT SERVICES (FMS)

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

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

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

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

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

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

6. Track and report utilization of client allocations.

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

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

8.510.9 SELECTION OF FMS VENDORS

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

Department.

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

8.510.10 START OF SERVICES

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

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

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

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

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

8.510.11 SERVICE SUBSTITUTION

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

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

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

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

8.510.12 FAILURE TO MEET CLIENT/AR RESPONSIBILITIES

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

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

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

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

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

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

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

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

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

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

8.510.13 IMMEDIATE INVOLUNTARY TERMINATION

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

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

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

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

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

client/AR in managing appropriate services through retraining.

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

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

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

8.510.14 ENDING THE CDASS DELIVERY OPTION

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

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

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

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

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

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

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

8.510.15 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 vendor shall make all payments from the client's Allocation under the direction of the client/AR. Attendant wages shall be commensurate with the level of skill required for the task and wages shall be justified in the ASMP.

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

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

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

8.510.16 REIMBURSEMENT TO FAMILY MEMBERS

8.510.16.A. Family Members/legal guardians may be employed by the

client/AR to provide CDASS, subject to the conditions below.

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

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

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

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

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

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

COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES (CDASS) PROTOCOL
CDASS Service Utilization Review & Allocation Management Protocol for Case Management Agencies Effective **8/1/2019 Revised 4/2/2021**

I. PURPOSE AND AUTHORITY

A. PURPOSE
The purpose of this protocol is to establish policies and procedures for Case Management Agencies (CMA) in the utilization review of services rendered through the Consumer Directed Attendant Support Services (CDASS) delivery option to ensure appropriate, timely and effective management of CDASS Member service and allocation utilization.

Previous over expenditure episodes expire three years from the date of the episode, except for episode five resulting in termination. This protocol is continuous and applies to the duration of the Member's participation in CDASS.

B. AUTHORITY
Consumer Directed Attendant Support Services, 10 CCR 2505-10 8.510.

Questions about the application or enforcement of this protocol can be directed to the Colorado CDASS Training and Operations vendor or the Department of Health Care Policy and Financing.

II. DEFINITIONS

A. Allocation - means the funds determined by the Case Manager in collaboration with the Member and made available by the Department through the Financial Management Services (FMS) vendor for attendant support services available in the CDASS delivery option.

B. Attendant Support Management Plan (ASMP) - means the documented plan at 8.510.5, detailing management of attendant support needs through CDASS.

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

D. 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.

E. Case Management Agency (CMA) - means a public or private entity that meets all applicable state and federal requirements and is certified by the Department to provide case management services for Home and Community Based Services

waivers pursuant to §§ 25.5-10-209.5 and 25.5-6-106, C.R.S., and has a current provider participation agreement with the Department.

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

G. Consumer Directed Attendant Support Services (CDASS) - means the service delivery option that empowers Members to direct their care and services to assist them in accomplishing activities of daily living when included as a waiver benefit. CDASS benefits may include health maintenance, personal care and homemaker services. In addition, if the Member is on the SLS waiver their services may include Enhanced Homemaker.

H. Continued Stay Review (CSR) - means a comprehensive evaluation with the individual seeking services and appropriate collaterals (such as family members, advocates, friends and/or caregivers) conducted by the Case Manager, with supporting diagnostic information from the Member's medical provider to determine the Member's level of functioning, service needs, available resources, and potential funding resources.

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

J. CDASS Training - means the required CDASS training and comprehensive assessment provided by the Training and Operations Vendor to a Member or Authorized Representative.

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

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

M. Long Term Care Certification Period - means the designated period of time in which a Member is functionally eligible to receive services not to exceed one year.

N. Monthly Member Expenditure Statement (MMES) - is a report that details all service utilization during the month. This statement is produced by the FMS vendor and includes all payments made to attendants during the month. The statement

summarizes expenditures for the month and the remaining yearly allocation amount. The statement reflects payment that has been processed through the date the statement is generated by the FMS. Late timesheets will not be reflected in the account statement until they are approved and processed by the FMS.

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

P. Allocation Reserves - are funds that remain unspent when a Member spends less than the average monthly allocation from the start date of the certification period to the current month of expenditure.

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

III. POLICY OVERVIEW

The purpose of this policy is to provide guidance to Case Managers on how to conduct utilization and allocation reviews of services provided through the CDASS delivery option. This policy overview does not provide guidance for every situation, but rather provides standards for use by Case Managers.

Allocation management is a key element of the CDASS delivery model, allowing for increased Member choice and control. Flexibility in how CDASS is utilized enables Members to manage the services they need to live independently and to more fully participate in their communities. CDASS covered service tasks as defined in 8.510.3 and 8.510.94.B are health maintenance, personal care and homemaker services; with Enhanced Homemaker being an additional service available through the SLS waiver The allocation shall only be used for covered CDASS tasks within the flexibility of the ASMP.

Upon enrollment, at the time of the CSR, or on request of the Member/Authorized Representative, the Case Manager assesses the Member's needs and identifies services to address those needs. CDASS allocations are authorized utilizing the CDASS Task Worksheet based on the Member's need for services and adhere to all service authorization requirements and limitations established by the Member's waiver program. If the Member experiences a change in condition the Case Manager may determine (as set forth in 8.510.16.E) during the service plan year that a reassessment is necessary. If a reassessment is completed and indicates that a change in Attendant support is necessary, the Case Manager shall follow Department guidelines to adjust the service plan. **Previous utilization should not determine an increase or a decrease to the Member's CDASS allocation.**

Each month, the FMS vendor shall notify each CMA when the MMES is available. The Case Manager shall review the MMES for appropriate utilization of services within the allocated amount. CDASS monthly utilization can fluctuate due to factors including but not limited to short term changes in individual needs and attendant turnover. A member is

not allowed to exceed their authorized monthly allocation by more than 29.99% even if reserves are present. Exceeding the monthly allocation by 30% or higher will result in denial of attendant payment. Amounts up to 129.99% of the monthly allocation will be paid out to the attendant if funds are present.

IV. PROTOCOL FOR OVER EXPENDITURE

The Member's assigned Case Manager will review the MMES provided by the Member's FMS vendor on a monthly basis to obtain the percentage of the monthly allocation that the Member/AR spent for the month. Members receiving CDASS through the Elderly, Blind and Disabled (EBD) waiver, Spinal Cord Injury (SCI) waiver, Brain Injury (BI) waiver, or Community Mental Health Supports (CMHS) waiver will have one budget to manage each month. However, Members receiving CDASS through the Supported Living Services (SLS) waiver may have two budgets they will manage each month. The SPAL budget is for personal care, homemaker and enhanced homemaker services while the HMA budget is for health maintenance activities. For these Members, overspending in either budget (or both) will result in one overspending episode.

The Case Manager is expected to discuss CDASS expenditures at each scheduled Member contact to discuss overall spending and budget management. Expenditures exceeding up to 9.99% percent of the Member's average monthly allocation are allowable and do not require the Case Manager to perform immediate follow up. Expenditures which exceed 10% to 29.99% of the average monthly allocation are allowed **if** the Member has allocation reserves that fully cover the expenditure or has received prior authorization from the Case Manager. If prior authorization is granted by the Case Manager, but the Member's remaining annual allocation does not cover the over expenditure, the Case Manager is not responsible as the Member, or their AR, is the legal Employer of Record it is their responsibility to ensure their annual allocation covers the attendants services provided. Prior authorization requires Case Management approval documented in the Service Plan, ASMP or BUS log notes. CDASS expenditures which exceed the Member's monthly CDASS Allocation by 30% or higher are not allowed, even with allocation reserves.

FORMAL ACTION STEPS FOR OVER-EXPENDITURE

If review of the MMES shows expenditures which exceed 10% to 29.99% of the average monthly allocation without reserves available or prior-authorization, the following formal action steps should be taken using the Member/AR preferred communication method:

1. First episode of over expenditure without reserves or prior-authorization:

    a. The Case Manager shall contact the Member/AR within five business days of receipt of the MMES to:

        1. Request information from the Member/AR on what caused the over expenditure and remind Member/AR to outreach Case Manager for prior-authorization in the future. Determine if the Member experienced a change in

condition (short-term or long-term) resulting in the need for additional services. Discuss with the Member/AR whether the current Task Worksheet is accurate based on change in condition. Evaluate whether additional care needs will continue and if they will be met through natural supports, CDASS, another state plan or waiver benefit; or a combination thereof without duplication of services rendered.

2. Discuss the over expenditure and develop a plan to reduce expenditures for a period of time within the certification period to support the Member to stay within their annual allocation.

3. Refer the Member/AR to review their ASMP and offer additional training through the Department contracted Training and Operations Vendor if the Member/AR reports difficulty with managing the allocation. Additional training at this point is advised but not a requirement to continue participation in CDASS.

b. The Case Manager shall document all activity in the BUS log notes including any training referral submission. The Case Manager will send the Member and AR, if applicable, a copy of this protocol and advise it is also available on the Training and Operations Vendor webpage. In addition, the Member and AR, if applicable, will receive a letter from the Case Manager summarizing the conversation within five business days of the discussion.

2. Second episode of over expenditure without reserves or prior-authorization:

a. The Case Manager shall contact the Member/AR within five business days of receipt of the MMES to:

1. Request information from the Member/AR on what caused the over expenditure and remind Member/AR to outreach Case Manager for prior-authorization in the future. Determine if the Member experienced a change in condition (short-term or long-term) resulting in the need for additional services. Discuss with the Member /AR whether the current Task Worksheet is accurate based on change in condition. Evaluate whether additional care needs will continue and if they will be met through natural supports, CDASS, another state plan or waiver benefit; or a combination thereof without duplication of services rendered.

2. Discuss the over expenditure and develop a plan to reduce expenditures for a period of time within the certification period to support the Member to stay within their annual

allocation.

3. Inform the Member/AR that mandatory retraining is required utilizing the Department contracted Training and Operations Vendor.

b. The Case Manager will send the Member and AR, if applicable, a letter summarizing the conversation and the referral for additional retraining within five business days of the discussion.

c. Refer the Member/AR for **mandatory** training through the Department contracted Training and Operations Vendor.

1. The Member/AR training shall be completed within 45 calendar days from the date of the referral to the Training and Operations Vendor.

2. At completion of training the Member/AR must complete an ASMP Update for Case Manager approval to document a plan for service utilization and allocation management, and sign an acknowledgement of this allocation management protocol during the training session.

3. Failure to complete Member/AR training within designated timelines requires case management action. The Case Manager will issue a Notice of Action (803) to the Member stating CDASS participation is being terminated.

4. The Case Manager will document in the BUS log notes the discussion and date of training referral submission.

3. Third episode of over expenditure without reserves or prior-authorization:

a. The Case Manager shall contact the Client/AR within five business days of receipt of the MMES to:

1. Request information from the Member/AR on what caused the over expenditure and remind Member/AR to outreach Case Manager for prior-authorization in the future. Determine if the Member experienced a change in condition (short-term or long-term) resulting in the need for additional services. Discuss with the Member/AR whether the current Task Worksheet is accurate based on change in condition. Evaluate whether additional care needs will continue and if they will be met through natural supports, CDASS, another state plan or waiver benefit; or a combination thereof without duplication of services rendered.

2. Discuss the over expenditure and develop a plan to reduce expenditures for a period of time within the certification period to support the Member to stay within their annual allocation.

3. Inform the Member/AR that a **mandatory** change in AR or use of an AR is required. The AR shall be identified and scheduled for training with the Department contracted Training and Operations Vendor within 15 calendar days.

b. Mail Member a Notice of Action (803) for requirement to change or appoint an AR.

c. Mail Member a copy of the spending modification plan in a letter sent to the Member and AR within five business days of the discussion.

d. Refer the new Member/AR for **mandatory** training through the Department contracted Training and Operations Vendor within 15 calendar days.

1. The Member/AR training shall be completed within 45 calendar days from the date of the referral to the Training and Operations Vendor.
2. At completion of training the Member/AR must complete an ASMP for Case Manager approval to document a plan for service utilization and allocation management, and sign an acknowledgement of this allocation management protocol during the training session.
3. Failure to complete Member/AR training within designated timelines requires case management action. The Case Manager will issue a Notice of Action (803) to the Member stating CDASS participation is being terminated.

e. The Case Manager will document in the BUS log notes the discussion and date of training referral submission.

4. Fourth episode of over expenditure without reserves or prior-authorization:

a. The Case Manager shall contact the Member/AR within five business days of receipt of the MMES to:

1. Request information from the Member/AR on what caused the over expenditure and remind Member/AR to outreach Case Manager for prior-authorization in the future. Determine if the Member experienced a change in condition (short-term or long-term) resulting in the need

for additional services. Discuss with the Member/AR whether the current Task Worksheet is accurate based on change in condition. Evaluate whether additional care needs will continue and if they will be met through natural supports, CDASS, another state plan or waiver benefit; or a combination thereof without duplication of services rendered.

2. Discuss the over expenditure and develop a plan to reduce expenditures for a period of time within the certification period to support the Member to stay within their annual allocation.

3. Inform the Member/AR that mandatory retraining is required utilizing the Department contracted Training and Operations Vendor.

b. Refer the Member/AR for **mandatory** retraining through the Department contracted Training and Operations Vendor.

1. The Member/AR training shall be completed within 45 calendar days from the date of the referral to the Training and Operations Vendor.

2. At completion of training the Member/AR must complete an ASMP Update for Case Manager approval to document a plan for service utilization and allocation management, and sign an acknowledgement of this allocation management protocol during the training session.

3. Failure to complete Member/AR training within designated timelines requires case management action. The Case Manager will issue a Notice of Action (803) to the Member stating CDASS participation is being terminated.

c. The Case Manager will send the Member and AR, if applicable, a letter summarizing the conversation and the referral for additional training within five business days of the discussion.

d. The Case Manager will document in the BUS log notes the discussion and date of training referral submission.

5. Fifth episode of over expenditure without reserves or prior-authorization:

a. The Case Manager shall contact the Member/AR within five business days of receipt of the MMES to inform the Member/AR that the

Member will be terminated from the CDASS service delivery option in accordance with 8.510.12 within 30 calendar days.

b. Case Manager will mail Notice of Action (803) to Member for CDASS termination. Member is not eligible for re-enrollment in the service delivery option.

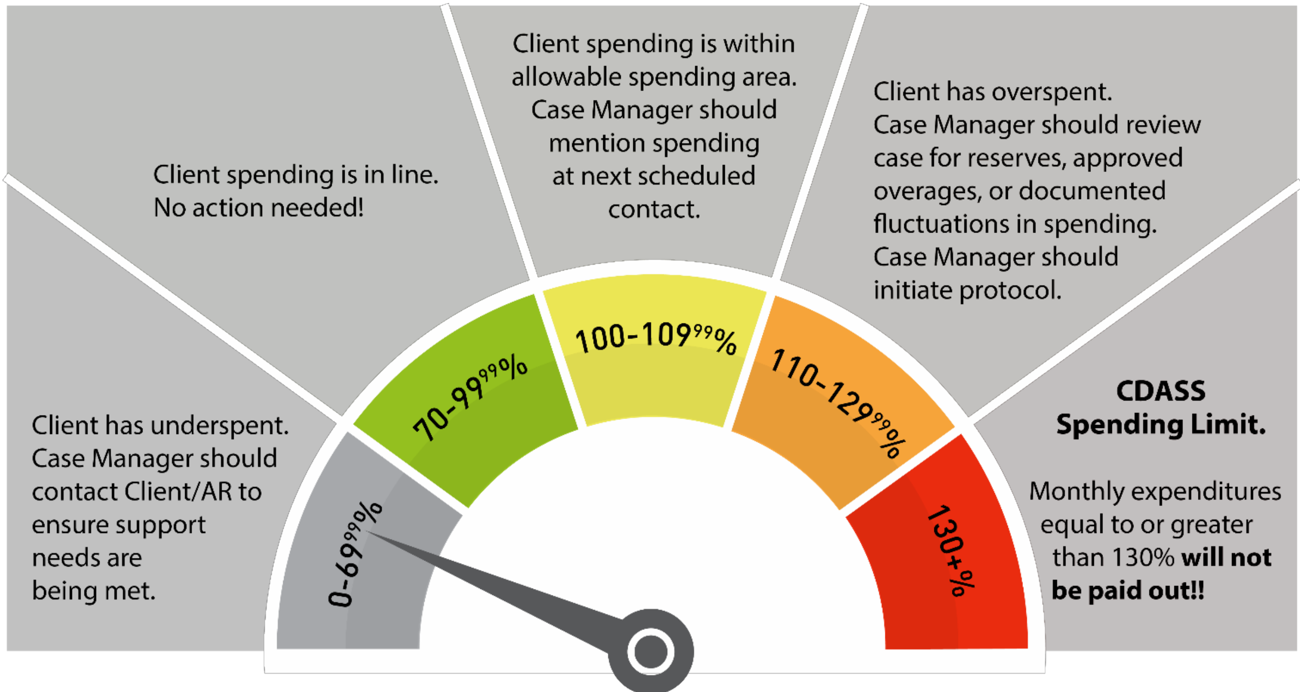
c. The Case Manager will work collaboratively with the Member and their support system to secure agency-based waiver and/or state plan services. If the Case Manager determines that the Member cannot be safely served given the type or amount of services available, the Case Manager shall comply with all provisions of 8.393.25. A.2. The Case Manager shall provide the Member with a Notice of Action (803), in accordance with 8.510.13.A.2

d. The Case Manager shall notify the FMS vendor of the date on which the Member is being terminated from CDASS.

e. The Case Manager shall document all activities in the BUS log notes and close the Member's service authorization in the FMS portal.

C. PROTOCOL FOR UNDER EXPENDITURE

If the MMES indicates that expenditures are 30% below the Member's average monthly allocation the Case Manager will contact the Member/AR to review service utilization reasons such as; health and safety supports are being met, experienced a change in condition or support needs, or hospitalization. Case Manager shall offer support through the Departments contracted Training and Operations Vendor for hiring and/or budgeting assistance, if needed, and document all activities in the BUS log notes. **Underutilization should not determine a decrease to a CDASS allocation for current certification period or future certification period.**


Client spending is in line.
No action needed!
Client spending is within allowable spending area. Case Manager should mention spending at next scheduled contact.
Client has overspent. Case Manager should review case for reserves, approved overages, or documented fluctuations in spending. Case Manager should initiate protocol.
Client has underspent. Case Manager should contact Client/AR to ensure support needs are being met.
0-69.99%
70-99.99%
100-109.99%
110-129.99%
130+%
CDASS Spending Limit.
Monthly expenditures equal to or greater than 130% will not be paid out!!

.

COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES (CDASS) PROTOCOL

CDASS Two Attendant Requirement Protocol for FMS Vendors & Case Management Agencies

Effective 1.1.2016

I. PURPOSE AND AUTHORITY

A. PURPOSE

The purpose of this protocol is to establish policy and procedures for Financial Management Service (FMS) vendors and Case Management Agencies (CMA) in meeting the requirement for a CDASS client to have two attendants employed with the client selected FMS vendor. Because CDASS clients are responsible for managing their homemaker, health maintenance and personal care services, it is imperative that clients have at least two employees. Two employees provide backup services in the event that the primary attendant is unavailable.

B. AUTHORITY

Consumer Directed Attendant Support Services, 10 CCR 2505-10 8.510.

II. DEFINITIONS

A. Attendant means the individual who meets qualifications in §8.510.8 who provides CDASS as determined by § 8.510.3 and is hired by the client or client authorized representative.

B. 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.

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

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

E. Consumer Directed Attendant Support Services (CDASS) means the

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.

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

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

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

III. POLICY OVERVIEW

The purpose of this protocol is to provide guidance to FMS vendors and case management agencies on how to monitor and report CDASS client employment contracts in the CDASS service delivery option. Attendant management is a key element of the CDASS service delivery model as it gives
clients the choice and control to select and manage their CDASS attendants. Clients or their CDASS authorized representative are responsible for hiring, training, scheduling and managing attendants. Assuring back up coverage is an essential part of management of attendant services in any model. CDASS clients take responsibility for arranging their own backup care and therefore must always have a backup attendant available. Prior to the case manager and the FMS vendor determining a start date for CDASS, the client or authorized representative is required to establish the employment of two attendants through the client's selected FMS vendor. Maintaining employment of a minimum of two CDASS attendants is essential for the health and welfare of CDASS participants to ensure they are able to access attendant services timely and have their personal care, homemaker, and health maintenance service needs met. **While the client or authorized representative must have established employment with two CDASS attendants, it is the determination of the client or authorized representative whether to utilize one or more attendants to perform services during any pay period. This policy overview does not provide guidance for every situation, but**

rather provides standards for use by FMS vendors and case management agencies.

IV. PROTOCOL

A. Each FMS vendor is responsible for running a monthly report to identify any clients who do not have an employment relationship with at least two CDASS attendants. When the FMS vendor identifies a client who does not have two CDASS attendants, the client's FMS vendor shall:

1. Contact the client or client's authorized representative to inform them that the two attendant employment requirement is not being met.
    a. This contact will be initiated by the client's FMS vendor within five business days of the identification of the client not meeting the requirement. The FMS vendor will mail or email (based on client communication preferences) the client or the client's authorized representative notification regarding noncompliance with the two attendant protocol. The notification will include the CDASS Two Attendant Requirement Protocol for FMS Vendors & Case Management Agencies and FMS employment applications for completion. Client will also be advised of the opportunity for voluntary training through the Department's contracted training and operations vendor regarding locating, interviewing and hiring new attendants. Upon request, the client's FMS vendor will provide the client or client authorized representative with a list of available attendants that are seeking employment.
    b. The client's FMS vendor will notify the client's case manager regarding the two attendant protocol violation.

2. The client, or client authorized representative is required to submit a completed employee application to hire at least one additional attendant in order to be in compliance with the two attendant requirement.
    a. The completed employee application must be submitted to the client's FMS vendor within 30 calendar days of FMS notification.
    b. The client's FMS vendor has five business days to process the employee application and inform the client, or client authorized representative of the employment eligibility determination. The FMS vendor must identify all errors in the employment application within the first three business days and report any errors to the client or AR.
    c. The client, or client authorized representative will be required to

submit additional employment applications within 30 calendar days of notification of selected employee being ineligible for hire.
d. The FMS vendor will notify the client's case manager upon receipt of the employment application and also upon determination of employment eligibility.
e. If a client submits incomplete applications and fails to correct them or continuously submits applications for ineligible employees resulting in no additional hires over a three month period, the client or AR will be required to attend mandatory retraining with the Department's contracted training and operations vendor.

3. If the client, or client authorized representative does not submit an employee application within the first 30 calendar days following FMS identification and notification of the client not meeting the two attendant requirement:
a. The FMS vendor will notify the client's case manager within five business days of the requirement not being met.
b. Within five business days after notification from the client's FMS vendor, the case manager will refer the client or client authorized representative to the Department's contracted training and operations vendor for mandatory retraining. The case manager shall inform the client, or client authorized representative if applicable, that retraining must be completed within 45 days from the date the case manager contacts, and submits the retraining referral to the training and operations vendor. The case manager will send written notification to the client, or client authorized representative informing them of the mandatory training and the time frame for training to be completed.
c. The client, or client authorized representative will no longer be required to complete training if an eligible employee is hired before the established 45-day timeframe.
d. If the client or AR notifies the FMS with good cause for not complying and has made reasonable efforts to secure a second attendant the FMS will contact the Department to request an extension. The maximum extension is an additional 20 days.

4. If the client, or client authorized representative does not complete the required training through the training and operations vendor by the established 45-day timeframe and does not have two attendants approved for employment through the FMS vendor:
a. The training and operations vendor will notify the client's case

manager within five business days of the timeframe for retraining not being met.

b. The case manager will notify the client within five business days of notification from the training and operations vendor that the client is required to designate an authorized representative; or a new authorized representative will need to be designated if one is being utilized. The case manager will provide the client with written notification of the requirement and timeframe to designate an authorized representative or a new authorized representative. The authorized representative shall be identified and scheduled for training with the Department's contracted training and operations vendor within 15 calendar days. The authorized representative's training and paperwork with the CDASS training and operations vendor and the client selected FMS vendor shall be completed within 60 calendar days.

c. The client authorized representative will be required to submit a complete employment application within 30 calendar days of completing the required CDASS training and paperwork.

d. The client's FMS vendor has five business days to process the employee application and inform the client, or client authorized representative of the employment eligibility determination. The FMS vendor must identify all errors in the employment application within the first three business days. The authorized representative will be required to submit at least one additional employment applications within 30 calendar days of notification of the selected employee being ineligible for hire.

5. If the client does not designate an authorized representative or a new authorized representative, or the client authorized representative does not complete all required CDASS training and paperwork within 60 calendar days, the case manager shall:

a. Inform the client and AR that the client will be terminated from the CDASS service delivery option in accordance with §8.510.12 and 8.510.9.C within 30 calendar days.

b. The case manager will work collaboratively with the client to secure IHSS or agency based waiver services.

c. The case manager shall provide the client with a Notice of Action, in accordance with §8.510.12.A.1 and §8.510.12.A.2. This notice provides the client with their appeal rights.

d. The case manager shall notify the client FMS organization of the

date on which the client is being terminated from CDASS.

6. If the client's authorized representative does not submit an employee application within 30 calendar days following training or does not have two attendants approved for employment through the FMS vendor within 60 calendar days following training, the case manager shall:

a. Inform the client and AR that the client will be terminated from the CDASS service delivery option in accordance with §8.510.12 and 8.510.9.C within 30 calendar days.
b. The case manager will work collaboratively with the client to secure IHSS or agency based waiver services.
c. The case manager shall provide the client with a Notice of Action, in accordance with §8.510.12.A.1 and §8.510.12.A.2. This notice provides the client with their appeal rights.
d. The case manager shall notify the client FMS organization of the date on which the client is being terminated from CDASS.

Appendix B

Preventing Abuse, Neglect, and Exploitation

Adult Protective Service Contact Information