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8.7400 HCBS Benefits and Services Rule Revisions

8.7401 Definitions

Acupuncture {- CIH} means the insertion of needles and/or manual, mechanical, thermal, electrical, and electromagnetic treatment to stimulate specific anatomical tissues for the promotion, maintenance and restoration of health and prevention of disease both physiological and psychological. During an acupuncture treatment, dietary advice and therapeutic exercises may be recommended in support of the treatment.

~~[Acupuncture - CIH (CIH) formerly in Complementary and Integrative Health Services (CIHS) at 8.517.B.E.]~~

~~[B. Complementary and Integrative Health Care Plan means the plan developed prior to the delivery of Complementary and Integrative Health Services in accordance with Section 8.517.11.D.~~

~~C. Complementary and Integrative Health Provider means an individual or agency certified annually by the Department to have met the certification standards listed at Section 8.517.11.~~

~~D. Complementary and Integrative Health Services (CIHS) means Acupuncture, Chiropractic, and Massage Therapy.]~~

8.7402 Acupuncture

8.7402.01 Acupuncture Inclusions

A. Acupuncture is used for treating conditions or symptoms related to the member's qualifying condition and inability to independently ambulate.
B. Members receiving acupuncture and other complementary and integrative health services shall be asked to participate in an independent evaluation to determine the effectiveness of the services.
C. Acupuncture ~~[and other Complementary and Integrative Health Services]~~ shall be provided {in the clinic of a licensed acupuncturist,} an approved outpatient setting, ~~[in accordance with 8.517.11.C.2]~~ or in the member's residence.
D. ~~[Complementary and Integrative Health Services shall be provided only by a Complementary and Integrative Health Provider certified by the Department of Health Care Policy and Financing to have met the certification standards listed at Section 8.517.11.C.]~~

8.7402.02 Acupuncture Exclusions and Limitations

A. ~~[Complementary and Integrative Health Services]~~ {Acupuncture} shall be limited to the member's assessed need for services {as identified and documented in the person centered support plan}. ~~[documented in the Complementary and Integrative Health Care Plan.]~~
B. ~~[Complementary and Integrative Health Services shall be provided only by a Complementary and Integrative Health Provider certified by the Department of Health Care Policy and Financing to have met the certification standards listed at Section 8.517.11.C.]~~
C. ~~[The Complementary and Integrative Health Services benefit is limited as follows:~~

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1. ~~A Client may receive each of the three individual Complementary and Integrative Health Services on a single date of service.~~
2. ~~A Client shall not receive more than four (4) units of each individual Complementary and Integrative Health Service on a single date of service.~~
3. ~~A Client shall not receive more than 204 units of a single Complementary and Integrative Health service during a 365-day certification period.]~~
4. A member shall not receive more than 408 combined units of all Complementary and Integrative Health Services during {the support plan year.} [~~a 365-day certification period.]~~

8.7402.03 Acupuncture Service Provider Agency Requirements

A. ~~[Complementary and Integrative Health Services must be provided by licensed, certified, and/or registered individuals operating within the applicable scope of practice.]~~

B. Acupuncturists shall be licensed by the Department of Regulatory Agencies, Division of Registrations as required by the Acupuncturists Practice Act (C.R.S § 12-200-101 et seq) and have at least (1) year of experience practicing Acupuncture at a rate of 520 hours per year; OR (1) year of experience working with individuals with paralysis or other long term physical disabilities.

C. ~~[Environmental Standards for Complementary and Integrative Health Services provided in an outpatient setting.~~

D. ~~Complementary and Integrative Health Providers shall develop a plan for infection control that is adequate to avoid the sources of and prevent the transmission of infections and communicable diseases. They shall also develop a system for identifying, reporting, investigating and controlling infections and communicable diseases of patients and personnel. Sterilization procedures shall be developed and implemented in necessary service areas~~

E. ~~Policies shall be developed, and procedures implemented for the effective control of insects, rodents, and other pests.~~

F. ~~All wastes shall be disposed of in compliance with local, state and federal laws.~~

G. ~~A preventive maintenance program to ensure that all essential mechanical, electrical and patient care equipment is maintained in safe and sanitary operating condition shall be provided. Emergency Systems, and all essential equipment and supplies shall be inspected and maintained on a frequent or as needed basis.~~

H. ~~Housekeeping services to ensure that the premises are clean and orderly at all times shall be provided and maintained. Appropriate janitorial storage shall be maintained.~~

I. ~~Outpatient settings shall be constructed and maintained to ensure access and safety.~~

J. ~~Outpatient settings shall demonstrate compliance with the building and fire safety requirements of local governments and other state agencies.~~

K. ~~Failure to comply with the requirements of this rule may result in the revocation of the Complementary and Integrative Health Provider certification.~~

L. ~~Complementary and Integrative Health Services Care Plan]~~

M. {Acupuncture} [~~Complementary and Integrative Health~~] Providers shall:

1. ~~[Guide the development of the Complementary and Integrative Health Care Plan in coordination with the member and/or member's representative].~~
2. Recommend the appropriate modality, amount, scope, and duration of {acupuncture} [the Complementary and Integrative Health Service(s)] within the established limits as listed at [8.517.11.B].
3. Recommend only services that are necessary and appropriate and will be rendered by the recommending {acupuncturist.} [Complementary and Integrative Health Provider.

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4. ~~Maintain member records as established at Section 8.487.16. Member records shall be made available to the Department or designated entity upon request and demonstrate the completion of Complementary and Integrative Health Providers requirements above.~~

N. ~~The Complementary and Integrative Health Provider shall reassess the Complementary and Integrative Health Care Plan annually or more frequently as necessary. The reassessment shall include a visit with the member.~~

O. ~~The Complementary and Integrative Health Care Plan shall be developed using Department prescribed form(s) or template(s).~~

P. ~~The Complementary and Integrative Health Care Plan shall include the amount, scope, and duration of recommended Complementary and Integrative Health Services (CIHS).~~

Q. ~~Recommendations for CIHS on the Complementary and Integrative Health Care Plan will guide case managers in completing the Prior Authorization Request (PAR).~~

R. ~~CIHS will be added to the PAR only if recommended in the Complementary and Integrative Health Care Plan and agreed to by the member.]~~

8.7403 Adaptive Therapeutic Recreational Equipment and Fees (CES) ~~[formerly at 8.503.40.A.1]~~

A. Adaptive therapeutic recreational equipment and fees [~~are services that~~] assist a member in recreating within the member's community. These services include recreational equipment that is adapted specific to the member's disability and not [~~those~~] items that a typical age peer would commonly need as a recreation item.

B. Adaptive Therapeutic Recreational Equipment and Fees Inclusions
   1. The cost of {an} item shall be above and beyond what is typically expected for recreation and recommended by a doctor or therapist.
   2. Adaptive therapeutic recreational equipment may include an 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 member with a Developmental Disability.
   3. A pass for admission to recreation centers for the member 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.
   4. Adaptive therapeutic recreation fees include those for water safety training.

C. Adaptive Therapeutic Recreational Equipment and Fees Exclusions {and Limitations}
   1. The following items are specifically excluded [~~under HCBS-CES waiver]~~ and not eligible for reimbursement:
      i. \Entrance fees for:
         a. Zoos;
         b. Museums;
         c. Butterfly Pavilion;
         d. Movie, theater, concerts; and
         e. Professional and minor league sporting events.
      ii. Outdoors play structures;
      iii. Batteries for recreational items\[; and]
      iv. Outdoors play structures.
      v. ~~[Passes for Family admission to recreation centers]~~

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D. Adaptive Therapeutic Recreational Equipment and Fees Reimbursement
   1. The maximum annual allowance for adaptive therapeutic recreational equipment and fees is one thousand (1,000.00) dollars per ~~[Service Plan]~~ {support plan} year.

8.7404 Adult Day Services (EBD, CMHS, CIH; BI) ~~[formerly at 8.491; 8.515.70]~~

8.7404.01 Adult Day Services Definitions

A. Adult Day Services (ADS) Centers are certified centers that provide Basic Adult Day Services and Specialized Adult Day Services to members.
B. Adult Day Services (ADS) are provided in an Adult Day Services Center or through Non-Center-Based means including Telehealth, on a regularly scheduled basis, as specified in the Person-Centered Support Plan, promoting social, recreational, physical, and emotional well-being that encompasses the supportive services needed to ensure the optimal wellness of the member.
C. BI - Adult Day Services means services provided in an Adult Day Services Center two or more hours per day, one or more days per week.
D. Basic Adult Day Services (ADS) Center means a community-based entity that provides basic Adult Day Services in conformance with all state established requirements as described in 10 CCR 2505-10 section 8.130 and 10 CCR 2505-10 section 8.491..
E. Center-Based Adult Day Services are services provided in a certified ADS Center.
F. Non-Center-Based Adult Day Services are services that may be provided outside of the certified ADS Center, where members can engage in activities and community life, either in-person or through virtual means.
G. Specialized Adult Day Services (SADS) Center means a community-based entity providing Adult Day Services for members with a primary diagnosis of dementia related diseases, Multiple Sclerosis, Brain Injury, chronic mental illness, Intellectual and Developmental Disabilities, Huntington's Disease, Parkinson's, or post-stroke members, who require extensive rehabilitative therapies. To be designated as specialized, two-thirds of an ADS Center's population must have a diagnosis which is one of any of the above diagnoses. Each diagnosis must be verified by a Licensed Medical Professional, either directly or through Case Management Agency documentation, in accordance with Section 8.491.14.A.
H. Telehealth Adult Day Services are provided through virtual means in a group or on an individual basis. Telehealth ADS are ways for members to engage in activities with their community and connect to staff and other ADS members virtually or over the phone, only if a member does not have access or the ability to use video chat technology. Services provided through Telehealth are not required to provide nutrition services.

8.7404.02 Adult Day Services Inclusions

A. Only members whose needs can be met by the ADS provider within its certification category and populations served may be admitted by the ADS provider.
B. A member can receive either Center-Based ADS, Non-Center-Based ADS, or a combination of Center-Based ADS and Non-Center-Based ADS within the same week.
C. ADS for all waivers shall include, but are not limited to, the following:
   1. Assistance with activities of daily living (ADL), as needed when ADS is provided in-person; monitoring of the member's health status and personal hygiene; assistance with administering medication and medication management (administration of medication only during the in-person delivery

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of services); and carrying out physicians' orders as set forth in member's individual Person-Centered Support Plan.

2. Activities that assist in the development of self-care capabilities, personal hygiene, and social support services.

D. Nutrition services including therapeutic diets and snacks in accordance with the member's individual Person-Centered Support Plan and hours of attendance. Nutrition services are not required during the delivery of Non-Center-Based ADS.

E. Age-appropriate social and recreational supportive services as appropriate for each member and their needs, as documented in the member's Person-Centered Support Plan. Activities shall take into consideration individual differences in age, health status, sensory deficits, religious affiliation, interests, abilities, and skills by providing opportunities for a variety of types and levels of involvement.

F. Members have the right to choose not to participate in social and recreational activities.

8.7404.03 Specialized Adult Day Services

A. The member's Person-Centered Support Plan must include documentation of their diagnosis(es) and service goals.

B. A Specialized Adult Day Services (SADS) provider must verify all Medicaid member's diagnosis(es) using the Professional Medical Information Page (PMIP) which shall be supplied by the case manager or documentation from the member's Licensed Medical Professional (LMP). Documentation must be verified at the time of admission and whenever there is a significant change in the member's condition. Any significant change must be recorded in the member's record or Person-Centered Support Plans.

C. For members from other payment sources, diagnosis(es) must be documented in a Person-Centered Support Plans, or other admission form, and verified by the member's physician or LMP. This documentation must be verified at the time of admission, and whenever there is a significant change in the member's condition.

D. Adult Day Services Exclusions and Limitations

1. The delivery of a meal, workbook, activity packet, etc. does not constitute rendered ADS and therefore are not reimbursable, unless in-person ADS service was provided in addition to the delivery of food or item.

8.7404.04 Adult Day Services Provider Agency Requirements

A. General

a. ADS providers shall be Medicaid certified by the Department as an ADS provider, in accordance with 10 CCR, 2505-10 Section 8.487.20. Proof of Medicaid certification consists of a completed Provider Agreement approved by the Department and the Department's fiscal agent, and recommendation for certification by CDPHE.

i. The Department or its designee will review an ADS Center's designation as a Specialized Adult Day Services (SADS) Center at the time of initial approval and during the recertification survey.

B. Environment

a. Center-Based ADS must be provided in an integrated, community-based setting, which supports participation and engagement in community life and gaining access to the greater community; members may engage in meaningful activities in integrated and community settings.

b. ADS Centers shall provide a clean and sanitary environment that is physically accessible to the members, including those members with supportive devices for ambulation or who are in wheelchairs.

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c. ADS Centers shall provide lockers or a safe and secure place for members' personal items.
d. ADS Centers shall provide recreational areas and activities appropriate to the number and needs of the members, at the times desired by the members.
e. ADS Centers must provide for a private shower and/or bathing area located on site to address the emergency hygiene needs of members as needed.
f. To accommodate the activities and program needs of the ADS Center, the center must provide eating and activity areas that are consistent with the number and needs of the members being served, which is at a minimum of 40 square feet per member.
g. ADS Centers shall maintain a comfortable temperature throughout the center. At no time shall the temperature fall outside the range of 68 degrees to 76 degrees Fahrenheit.
h. ADS Centers must provide an environment free from restraints.
i. ADS Centers, in accordance with 10 CCR 2505-10 section 8.491.4.A above, must provide a safe environment for all members, including members exhibiting behavioral problems, wandering behavior, or limitations in mental/cognitive functioning.

C. Food Safety Requirements
   a. ADS providers shall comply with all applicable local food safety regulations. In addition, all ADS Centers must ensure:
      i. Access to a handwashing sink, soap, and disposable paper towels;
      ii. Food handlers, cooks, and servers, including members engaged in food preparation, properly wash their hands using proper hand-washing guidelines;
      iii. The ADS Centers do not allow any staff or members who are not in good health and free of communicable disease to handle, prepare or serve food or handle utensils;
      iv. Refrigerated foods opened or prepared and not used within 24 hours are marked with a “use by” or “discard by” date. The “use by” or “discard by” date may not exceed 7 days following opening or preparation, or exceed or surpass the manufacturer’s expiration date for the product or its ingredients;
      v. For food service, foods are maintained at the proper temperatures at all times. Foods that are stored cold must be held at or below 41 degrees Fahrenheit and foods that are stored hot must be held at or above 135 degrees Fahrenheit in order to control the growth of harmful bacteria;
         1. Kitchen and food preparation equipment are maintained in working order and cleanable; and
         2. Any equipment or surfaces used in the preparation and service of food are washed, rinsed, and sanitized before use or at least every 4 hours of continual use. Dish detergent must be labeled for its intended purpose. Sanitizer must be approved for use as a no-rinse food contact sanitizer. Sanitizers must be registered with the Environmental Protection Agency (EPA) and used in accordance with labeled instructions.

D. Medication Administration and Monitoring
   a. ADS providers must comply with Medication Administration regulations in Section 8.7XXX.

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E. Records and Information
   a. All ADS providers shall keep records and information necessary to document the services provided to members receiving Adult Day Services, as outlined in XXX. In addition to the requirements at XXX, ADS records must also include:
      i. Name, address, and telephone number of primary physician;
      ii. Documentation of the supervision and monitoring of services provided;
      iii. Documentation that all members and their guardian or other legally authorized representative, if authorized/if within the scope of their authority (if any) were oriented to the ADS Center, their policies and procedures, to the services provided by the ADS provider, and delivery methods offered.;
      iv. A service agreement signed by the member and/or the guardian or other legally authorized representative, if authorized/if within the scope of their authority and appropriate staff; and
      v. For SADS providers only, a copy of the PMIP, or diagnosis documentation from the member's LMP;
      vi. Documentation specifically stating the types of services and monitoring that are provided when rendered via Telehealth, ensuring the integrity of the service provided and the benefit the service provides the member.

F. Person-Centered Support Plan
   a. The following information must be documented in the Person-Centered Support Plan and used to direct the member's care and must be reviewed annually.
      i. Medical Information:
         1. All medications the member is taking, including those while receiving Center-Based or Non-Center-Based ADS, and whether they are being self-administered;
         2. Special dietary considerations, instructions, or restrictions;
         3. Services that are administered to the member while receiving Center-Based and/or Non-Center-Based ADS (may include nursing or medical interventions, speech therapy, physical therapy, or occupational therapy);
            a. Any restrictions on social and/or recreational activities identified by member's LMP; and
            b. Any other special health or behavioral management services or supports recommended to assist the member by the member's LMP.
      ii. Person-Centered Support Planning Documentation:
         1. Documentation that the provider was selected by the individual and/or guardian or other legally authorized representative, if authorized/if within the scope of their authority;
         2. Individual choices, including location and delivery method for ADS, preferences, and needs shall be incorporated into the goals and services outlined in the Person-Centered Support Plan;
         3. All member information and the Person-Centered Support Plan are considered protected health information and shall be kept confidential; and

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4. The member and/or guardian or other legally authorized representative, must review and sign the Person-Centered Support Plan.
5. Any modifications to the Person-Centered Support Plan must comply with XXX.
6. Documentation as to whether the member has executed an advance directive or other declaration regarding medical decisions.

G. Staff Requirements

a. In determining appropriate staffing levels, the ADS provider shall adjust staffing ratios based on the individual acuity and needs of the members being served. At a minimum, staffing must be sufficient in number to provide the services outlined in the Person-Centered Support Plans, considering the individual needs, level of assistance, and risks of accidents. A staff person can have multiple functions, as long as they meet the definition of Direct Care Staff defined at 10 CCR 2505-10, Sections 8.491.1. Staff counted in the staff-member ratio are those who are trained and able to provide direct services to members.

i. Staffing for Center-Based and in person Non-Center-Based ADS shall be no less than the following standard:
   1. A minimum of 1 staff to 8 members with continuous supervision of members during program operation.

ii. Staffing for Telehealth ADS shall be no less than the following standard:
   1. A minimum of 1 staff to 15 virtual members with continuous virtual supervision of members during Telehealth program operation.

iii. Staff shall provide the following:
   1. Immediate response to emergency situations to assure the safety, health, and welfare of members;
   2. Activities that are planned to support the Person-Centered Support Plans for the members; and
   3. Administrative, recreational, social, and supportive functions and duties.

iv. Nursing services for regular monitoring of the on-going medical needs of members and the supervision of medications. These services must be available a minimum of two hours daily during Center-Based ADS and as needed for Non-Center-Based ADS and must be provided by a Registered Nurse (RN) or Licensed Practical Nurse (LPN). Certified Nursing Assistants (CNA) may provide nursing services under the direction of a RN or an LPN, in conformance with nurse delegation provisions outlined in CRS 12-38-132. Supervision of CNAs must include documented consultation and oversight on a weekly basis or more according to the member's needs. If the supervising RN or LPN is an ADS provider staff member, with consultation and oversight of CNAs included in the member's job description, the supervising nurse's documented attendance shall be sufficient to document consultation and oversight.

v. In addition to the above services, Specialized Adult Day Services (SADS) Centers shall have sufficient staff to provide nursing services during all hours of operation.

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1. Nursing services must be provided by a licensed RN or LPN or by a CNA under the supervision of an RN or LPN, as per 10 CCR 2505-10 section 8.491.4.G.1.e above and employed or contracted by the SADS Center.

H. Director Qualifications
   a. All Directors shall meet one of the following qualifications:
      i. At least a bachelor's degree from an accredited college or university and a minimum of two years of social services or health services experience and shall have demonstrated ability to perform all aspects of the position; or
      ii. A licensure by the state of Colorado as a Licensed Practical Nurse or Registered Nurse and completion of two years of paid or volunteer experience in planning or delivering health or social services including experience in supervision and administration; or
      iii. A high school diploma or GED equivalent, a minimum of four years of experience in a social services or health services setting, skills to work with aging adults or adults with functional impairment, and skills to supervise ADS Center staff persons.

I. Training Requirements
   a. All staff and volunteers must be trained in accordance with XXX and in the use of universal precautions and infection control, as defined at 10 CCR 2505-10 section 8.491.1.

J. Dementia Training Requirements (on consent in MSB process)
   a. As of October 1, 2023, each Adult Day Services provider shall ensure that its Direct-Care Staff Members complete dementia training as required by Section 25.5-6-314, C.R.S.
   b. Definitions: applicable to Dementia Training Requirements: as required by Section 25.5-6-314, C.R.S.
      i. "Covered Facility" means an Assisted Living Residences, Nursing Care Facilities, and Adult Day Care Facilities as defined in Section 25.5-6-303(1), C.R.S.
      ii. "Dementia diseases and related disabilities" is a condition where mental ability declines and is severe enough to interfere with an individual's ability to perform everyday tasks. Dementia diseases and related disabilities include Alzheimer's disease, mixed dementia, Lewy Body Dementia, vascular dementia, frontotemporal dementia, and other types of dementia.
      iii. "Direct-Care Staff Member" means a staff member caring for the physical, emotional, or mental health needs of participants of an Adult Day Services provider and whose work involves regular contact with participants who are living with Dementia Diseases and related disabilities.
      iv. "Staff member" means an individual, other than a volunteer, who is employed by an Adult Day Services provider.
      v. "Equivalent training" means any initial training provided by a Covered Facility that meets the requirements in Section 8.491.4.J.3.
   c. Initial training: Each Adult Day Services provider is responsible for ensuring that all Direct-Care Staff Members are trained in dementia diseases and related disabilities.

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i. Initial training shall be available to Direct-Care Staff Members at no cost to them.
ii. The training shall be competency-based and culturally competent and shall include a minimum of four hours of training in dementia topics including the following content:
    1. Dementia diseases and related disabilities;
    2. Person-centered care;
    3. Care planning;
    4. Activities of daily living; and
    5. Dementia-related behaviors and communication.
iii. For Direct-Care Staff Members already employed prior to October 1, 2023, the initial training must be completed as soon as practical, but no later than 120 days after October 1, 2023, unless an exception, as described in Section 8.491.4.J.4.a., applies.
iv. For Direct-Care Staff Members hired or providing care on or after October 1, 32 2023, the initial training must be completed as soon as practical, but no later than 120 days after the start of employment or the provision of direct-care services, unless an exception, as described in Section 8.491.4.J.4.b., applies.

d. Exception to initial dementia training requirement
    i. Any Direct-Care Staff Member who is employed by or providing direct-care services prior to the October 1, 2023, may be exempted from the provider's initial training requirement if all of the following conditions are met:
        1. The Direct-Care Staff Member has completed Equivalent Training program, as defined in these rules, within the 24 months immediately preceding October 1, 2023; and
        2. The Direct-Care Staff Member can provide documentation of the satisfactory completion of the Equivalent Training program.
        3. If the Equivalent Training was provided more than 24 months prior to the date of hire, the individual must document participation in both the Equivalent Training, and all required continuing education subsequent to the initial training.
    ii. Any Direct-Care Staff Member who is hired or begins providing direct-care services on or after October 1 ,2023, may be exempted from the provider's initial training requirement if the Direct-Care Staff Member:
        1. Has completed an equivalent initial dementia training program, as defined in these rules, either:
            a. Within the 24 months immediately preceding October 1, 2023; or
            b. Within the 24 months immediately preceding the date of hire or the first date the Direct-Care Staff Member provides direct care services; and
        2. Provides documentation of the satisfactory completion of the initial training program; and
        3. Provides documentation of all required continuing education subsequent to the initial training.
    iii. Such exceptions shall not exempt a Direct-Care Staff Member from the requirement for dementia training continuing education as described in Section 8.491.4.J.5.

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e. Dementia Training: Continuing Education
   i. After completing the required initial training, all Direct-Care Staff Members shall have completed and documented a minimum of two hours of continuing education on dementia topics every two years.
   ii. Continuing education on this topic must be available to Direct-Care Staff Members at no cost to them.
   iii. This continuing education shall be culturally competent, include current information provided by recognized experts, agencies, or academic institutions, and include best practices in the treatment and care of persons living with dementia diseases and related disabilities.

f. Individuals conducting dementia training must meet the following minimum requirements:
   i. Specialized training from recognized experts, agencies, or academic institutions in dementia disease., or
   ii. Successful completion training which meets the minimum standards described herein; and
   iii. Two or more years of experience working with persons living with dementia diseases and related disabilities.

g. Documentation of initial dementia training and continuing education for Direct-Care Staff Members:
   i. The provider shall maintain documentation that each Direct-Care Staff Member has completed initial dementia training and continuing education. Such records shall be made available upon request.
   ii. Completion shall be demonstrated by a certificate, attendance roster, or other documentation.
   iii. Documentation shall include the number of hours of training, the date on which it was received, and the name of the instructor and/or training entity.
   iv. Documentation of the satisfactory completion of an equivalent initial training program as defined in Section 8.491.4.J.2.e. shall include the information required in this Section 8.491.4.J.7.b. & c.
   v. After the completion of training and upon request, such documentation shall be provided to the staff member for the purpose of employment at another Covered Facility.

K. Written Policies
   a. In addition to the policies and procedures outlined in XXX, the ADS provider shall have written policies and procedures relevant to the operation of the Adult Day Services. Such policies shall include, but not be limited to, statements describing:
      i. Admission criteria for members who can be appropriately served by the ADS provider;
      ii. Intake procedures conducted for members and/or guardian or other legally authorized representative, if authorized/if within the scope of their authority prior to admission with the ADS provider;
      iii. The meals and nourishments, including special diets, that are provided at Center-Based ADS;
      iv. The hours and days that Center-Based ADS are open and available, and the days and times that Non-Center-Based ADS are available to members, including the availability of nursing services;

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v. The personal items that the members may bring with them to the ADS Center; and

vi. The administration of Telehealth Adult Day Services, if provided. This includes telehealth options, provision of services, and examples of virtually offered services.

b. There shall be a written, signed agreement between the member and/or guardian or other legally authorized representative, if authorized/if within the scope of their authority and the ADS provider outlining the rules and responsibilities of the ADS provider and the member. Each party in the agreement shall be provided a copy.

8.7404.05 Adult Day Services Provider Reimbursement Requirements

A. Reimbursement for ADS for members in the HCBS Elderly, Blind and Disabled (EBD) waiver, Community Mental Health Supports waiver (CMHS), and the Complementary and Integrative Health (CIH) waiver is to be billed in accordance with the current rate schedule:

a. Providers may bill in 15-minute units or for 1-2 units of 3-5-hours depending on the member's needs and how the service is delivered. When billing 15-minute units, which can be delivered either in-person or via Telehealth, the total number of units may not exceed 12 units or three (3) hours per day of Basic Adult Day Services. A provider may bill the maximum of 15-minute units for ADS in combination with no more than 1 unit of 3-5 hour ADS on the same day, as long as services were rendered at separate times.

B. For persons in the HCBS waiver for Persons with a Brain Injury (BI), reimbursement for BI-ADS is to be billed in accordance with the current rate schedule.

a. A unit is defined as the following:

i. Providers may bill in units of 15 minutes or a unit of 2 or more hours depending on the member's needs and how the service is delivered. When billing 15-minute units, which can be delivered either in-person or via Telehealth, the total number of units may not exceed 8 units or two (2) hours per day of services. Units of 2 hours or more can only be delivered in-person. A provider cannot bill for 15-minute units of ADS if a unit of 2-hour BI ADS was provided on the same day.

C. ADS Centers are permitted to utilize funding from other Federal sources, such as the Child and Adult Care Food Program (CACFP), in addition to the Medicaid per diem. If such funding is utilized, a Center must acknowledge the use of multiple funding sources and demonstrate that Federal funds are not used in a duplicative manner to Medicaid-funded services.

D. Only providers certified as a Specialized Adult Day Services Center are permitted to receive the SADS reimbursement rate, for members needing SADS. The SADS reimbursement rate applies to every member at a SADS Center, even if the member does not have a specialized diagnosis.

E. Certified SADS providers may provide Non-Center-Based Adult Day Services, including Telehealth ADS, billing only for Basic Adult Day Services using the 15-minute unit, up to 3 hours per day. The SADS provider may bill the maximum of 15-minute units for Basic ADS in combination with no more than 1 unit of 3-5 hour SADS on the same day, as long as services were rendered at separate times.

F. Providers shall not bill for services on the same day of service for a member in an HCBS residential program, unless the following criteria have been met:

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a. ADS and residential services have been authorized by the Department and are included on the prior authorization request (PAR);
b. Documentation from the member's physician demonstrating the required specialized services in the ADS Center are necessary because of the member's diagnosis(es), are essential to the care of the member, and are not included in the residential per diem;
c. Documentation that the extensive rehabilitative therapies and therapeutic needs of the member are not being met by the residential program and are not included in the residential per diem; and
d. Documentation from the member's physician recommending ADS and how it will meet the previously mentioned needs.

8.7405 Alternative Care Facility (EBD, CMHS) [~~formerly at 8.495~~]

8.7405.01 Alternate Care Facility Definitions

A. Alternative Care Facility (ACF) authorized in 25.5-6-303(3), C.R.S., means an Assisted Living Residence as defined at 6 CCR 1011-1, Chapter VII, Section 2, which has been licensed by the Colorado Department of Public Health and Environment (CDPHE) and has been certified by the Department to provide Alternative Care Services to Medicaid members.
   i. Alternative Care Services as described in 25.5-6-303(4), C.R.S., means, but is not limited to, a package of personal care and homemaker services provided in a state licensed and certified alternative care facility including: assistance with bathing, skin, hair, nail and mouth care, shaving, dressing, feeding, ambulation, transfers, positioning, bladder & bowel care, medication reminding and monitoring, accompanying, routine house cleaning, meal preparation, bed making, laundry, and shopping. Alternative Care Services also includes medication administration and protective oversight.

8.7405.02 Alternate Care Facility Inclusions

A. Member Eligibility
   i. Members in the Home and Community Based Services (HCBS) Elderly, Blind and Disabled waiver pursuant to, Section 8.485 and the HCBS Community Mental Health Supports waiver pursuant to, Section 8.509 are eligible to receive services in an Alternative Care Facility.
      1. Potential members shall be assessed, at a minimum, by a team that includes the member and/or guardian or other legal representative, the ACF administrator or appointed representative, and Case Management Agency (CMA) case manager. If one of the parties listed above is not available, input or information must be obtained from each party prior to making an admission determination. It may also include family members, Accountable Care Collaborative or Mental Health Center case managers, and any other interested parties as approved by the member, to determine that the ACF is an appropriate community setting that will meet the individual's choice and need for independence and community integration.
         a. An assessment will be conducted prior to admission, annually, and whenever there is a significant change in physical, cognitive, or behavioral needs, or as requested by the member. The annual assessment must be completed by the team outlined in Sections 8.495.2.B.

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b. The assessment will document that the setting is able to support the member and their needs. The assessment will also document the member's physical, behavioral and social needs, so that supports can be identified to enable them to lead as independent a life as possible. The assessment will be used to develop the member's support plan.

8.7405.03 Member Benefits

A. Alternative Care Services which include, but are not limited to, personal care and homemaker services pursuant to, Sections 8.489 and 8.490, are benefits to members residing in an ACF.
   i. Medication Administration is included in the reimbursement rate for Alternative Care Services and shall not be additionally reimbursed or billed in any other manner.

B. Additional services which are available as a State Plan benefit or other CMHS or EBD waiver service cannot be provided under the ACF service.

C. Participant engagement opportunities shall be provided by the ACF, as outlined in 6 CCR 1011-1, Chapter VII, Section 12.19-26.

8.7405.04 Member Rights

A. Members shall be informed of their rights, according to 6 CCR 1011-1, Chapter VII, Section 13 and 10 CCR 2505-10 8.484. Any modification of those rights shall be in accordance with 8.484.5. Pursuant to 6 CCR 1011-1, Chapter VII, Section 13.1, the policy on resident rights shall be in a visible location so that they are always available to members and visitors.

B. Members shall be informed of all ACF policies upon admission to the setting, and when changes to policies are made, rules and/or policies shall apply consistently to the administrator, staff, volunteers, and members residing in the facility and their family or friends who visit. Member acknowledgement of rules and policies must be documented in the support plan or a resident agreement.

C. If requested by the member, the ACF shall provide bedroom furnishings, including but not limited to a bed, bed and bath linens, a lamp, chair and dresser and a way to secure personal possessions.

D. Providers shall not discontinue services to a member unless documented efforts have been ineffective to resolve the conflict leading to the discontinuance of services in accordance with 6 CCR 1011-1, Ch. VII Section 11.

8.7405.05 Alternate Care Facility Provider Agency Requirements

A. The Provider shall be licensed in accordance with 6 CCR 1011-1, Chapters II and VII and receive ACF certification prior to enrollment with the Department.

B. Participant Engagement
   i. Providers shall, in consultation with the members, provide social and recreational engagement opportunities both within and outside the setting.
      1. Opportunities for social and recreational engagement shall take into consideration the individual interests and wishes of the members.
      2. In determining the types of opportunities and activities offered, the provider shall consider the physical, social, and mental stimulation needs of the members.

C. Participant Leave
   i. Providers shall notify the member's case manager of any member planned or unplanned non-medical and/or programmatic leave for greater than 24 hours.
   ii. The therapeutic and/or rehabilitative purpose of leave shall be documented in the member's support plan.

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D. Support Plan
   i. The following information must be documented in the support plan:
      1. Medical Information:
         a. Medications the member takes and how they are administered, with reference to the Medication Administration Record (MAR);
         b. Special dietary needs, if any; and
         c. Reference to any documented physician orders.
      2. Social and recreational engagement:
         a. The member's preferences and current relationships; and
         b. Any restrictions on social and/or recreational activities identified by a physician.
   ii. Any other special health or behavioral management needs that support the member's individual needs.
   iii. Additional Support Planning Documentation:
      1. Documentation from the admission process which demonstrates that the setting was selected by the member;
      2. Identification of the individual's goals, choices, preferences, and needs and incorporation of these elements into the supports and services outlined in the support plan;
      3. Any modifications to the members rights, with the required supporting documentation; and
      4. Evidence the member and/or their guardian, designated representative, or legal representative has had the opportunity to participate in the development of the support plan, has reviewed it, and has signed in agreement with the plan.

E. Environmental Standards
   i. The Alternative Care Facility is an environment that supports individual comfort, independence, and preference, maintains a home-like quality and feel for members at all times, and provides members with unrestricted access to the ACF in accordance with the residency agreement or modifications as agreed to and documented in the member's support plan.
   ii. ACFs shall provide an outdoor area accessible to members without staff assistance that is well maintained, facilitates community gatherings, and is appropriately equipped for the population served.
   iii. ACFs shall provide access for members to make private phone calls at their preference and convenience.
   iv. ACFs shall provide comfortable places for private visits with family, friends and other visitors.
   v. ACFs shall provide easily accessible common areas and a physical environment that meets the needs of any member needing support.
   vi. ACFs shall maintain a comfortable temperature throughout the ACF and member rooms, sufficient to accommodate the use and needs of the members, never to exceed 80 degrees.
   vii. The ACF shall develop and follow written policies and procedures to ensure the continuation of necessary care to all residents for at least 72 hours immediately following any emergency including, but not limited to, a long-term power failure.
   viii. The monthly schedule of daily recreational and social engagement opportunities shall be in a visible location so that they are always available to

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members and visitors, and developed in accordance with 6 CCR 1011-1, Chapter VII, Section 12.26, pertaining to Resident Engagement.

1. Staff shall be responsible for ensuring that the daily schedule of recreational and social engagement opportunities is implemented and offered to all members.

ix. Reading material shall be available in the common areas at all times, reflecting the interests, hobbies, and requests of the members.

x. ACFs shall provide nutritious food and beverages that members have access to at all times. Access to food and cooking of food shall be in accordance with 6 CCR 1011-1, Chapter VII, Section 17.1-3. The access to food shall be provided in at least one of the following ways:

1. Access to the ACF kitchen.
2. Access to an area separate from the ACF kitchen stocked with nutritious food and beverages.
3. A kitchenette with a refrigerator, sink, and stove or microwave, separate from the member's bedroom.
4. A safe, sanitary way to store food in the member's room.

xi. Each member's cooking capacity shall be assessed as part of the pre-admission process and updated in the support Plan as necessary.

F. Staffing Requirements

i. Each ACF will divide the 24-hour day into two 12-hour blocks which will be considered daytime and nighttime. The designation of daytime and nighttime hours shall be permanently documented in ACF policy and disclosed in the written resident agreements. In determining appropriate staffing levels, the ACF shall adjust staffing ratios based on the individual acuity and needs of the members in the ACF. At a minimum, staffing must be sufficient in number to provide the services outlined in the support plans, considering the individual needs, level of assistance, and risks of accidents. A staff person can have multiple functions, as long as they meet the definition Direct Care Staff defined at Sections 8.495.1. Staff counted in the staff-member ratio are those who are trained and able to provide direct services to members.

ii. Staffing at an ACF shall be no less than the following standards

1. A minimum of 1 staff to 10 members during the daytime.
2. A minimum of 1 staff to 16 members during the nighttime.
3. A minimum of 1 staff to 6 members in a Secured Environment at all times.
    a. There shall be a minimum of one awake staff member that is on duty during all hours of operation in a Secured Environment

iii. Staffing Ratio Waiver

1. Staffing waiver requests shall be submitted to the Department's ACF Benefit Administrator. They will be evaluated and granted based on several criteria. This includes, but is not limited to:
    a. Years ACF has been in operation;
    b. Past Incidents at the ACF;
    c. The Provider has adequately documented how a staffing waiver would not jeopardize the health, safety or quality of life of the members;
    d. Provider availability and member access; and

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e. Free of deficiencies impacting member health and safety in both the CDPHE and Life Safety Code survey and inspections.

2. An approved staffing waiver is only applicable for nighttime hours, with the exception for Secured Environments.
3. A staffing waiver expires five years from the date of approval. Continuance of staffing waiver requires Department approval.
4. Any existing staffing waiver may be subject to revocation if an ACF does not comply with any applicable regulations, is cited with deficiencies impacting member health and safety by CDPHE or the Division of Fire Protection Control, has substantiated patient care complaints, or the staffing waiver has jeopardized the health, safety or quality of life of the members.
    a. In the event of a staffing waiver denial or revocation, an ACF may reapply for a staffing waiver only after the ACF receives a CDPHE and Life Safety survey with no deficiencies impacting member health and safety
    b. Existing staffing waivers shall be null and void upon a change in the total number of licensed beds or a change of ownership in an ACF.
5. The ACF shall ensure that all staff and volunteer training be completed within the first 30 days of employment. Training shall include, but is not limited to, the training topics outlined in 6 CCR 1011-1, Chapter VII, Section 7.9.
6. The Provider shall ensure the Administrator and all staff meet the qualifications and employment standards set forth in 6 CCR 1011-1, Chapter VII, Section 7.4-

8.7405.06 Standards for Secured Environment ACFs

A. ACFs providing a secured environment may be licensed for a maximum of 30 secured beds.
    i. A waiver may be granted by the Department when adequate documentation of the need for additional beds has been proven and the number of beds would not jeopardize the health, safety and quality of care of members.
B. The ACF shall establish an environment that promotes independence and minimizes agitation and unsafe wandering through the use of visual cues and signs.
C. Provide a secured outdoor area accessible without staff assistance, which shall be level, well maintained, and appropriately equipped for the population served.

8.7405.07 Appropriateness of Medicaid Participant Placement

A. An ACF shall not admit, or shall discharge within 30 days, any member according to Colorado Code of Regulations 6 CCR 1011-1 Chapter 7, Part 11.

8.7405.08 Alternate Care Facility Provider Reimbursement Requirements

A. Room and board shall not be a benefit of ACF services, per 10 CCR 2505-10 8.75014.
B. ACF services shall be reimbursed according to a per diem rate, using a methodology determined by the Department.
    i. ACF services are subject to Post Eligibility Treatment of Income (PETI), as outlined in XXX.
C. Non-Medical/Programmatic Leave Reimbursement

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i. The ACF may receive reimbursement for a maximum of 42 days in a calendar year for Non-Medical/Programmatic Leave Days combined.
ii. The ACF cannot bill for services during Leave Days if the member is receiving Medicaid services over 24 hours in another approved Medicaid Facility, such as a nursing facility or hospital.

8.7406 Assistive Technology (CES; SLS) [~~formerly at 8.503.40.A.2; 8.500.94.B.1~~]

8.7406.01 Assistive Technology Definitions:

A. Assistive Technology Device means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of members.
B. Assistive technology service means a service that directly assists a member in the selection, acquisition, or use of an assistive technology device.

8.7406.02 Assistive Technology Inclusions

A. The evaluation of the assistive technology needs of a member, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the member in the customary environment of the member.
B. Assistive technology recommendations shall be based on an assessment provided by a qualified provider within the provider's scope of practice.
C. Training and technical assistance shall be time limited, goal specific and outcome focused.
D. Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices,
E. Training or technical assistance for the member, or where appropriate, the family members, guardians, caregivers, advocates, or authorized representatives of the member.
F. Warranties, repairs or maintenance on assistive technology devices purchased through the waiver.
G. Adaptations to computers, or computer software related to the member's identified needs in their person-centered support plan. [~~This specifically excludes cell phones, pagers, and internet access unless prior authorized in accordance with the procedure.~~]

8.7406.03 Assistive Technology Exclusions and Limitations

A. 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.
B. When the expected cost is to exceed $2,500 per device, three estimates shall be obtained and maintained in the case record and the most cost-effective option shall be selected. When it is not possible to three estimates, documentation shall be maintained in the case record the reason for less than three estimates.

C. \Items or devices that are generally considered to be experimental or do not meet the identified needs of the member identified in the person-centered support plan.\
D. The following items and services are specifically excluded under HCBS waivers and not eligible for reimbursement:
i. Purchase, training, or maintenance of service animals,
ii. Computers {or similar devices like mobile phones or tablets}.
iii. Items or devices that are generally considered to be entertainment in nature,
iv. including but not limited to CDs, DVDs, iTunes®, any type of game.
v. Training or adaptation directly related to a school or home educational goal or curriculum.

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vi. \Internet or broadband access.\

E. The following items and services are specifically excluded and not eligible for reimbursement:
   i. In-home installed video monitoring equipment.
   ii. Medication reminders.
   iii. Hearing aids.
   iv. Items considered as typical toys for children.

8.7406.04 Assistive Technology Reimbursement Requirements

A. The total cost of home accessibility adaptations, vehicle modifications, and assistive technology shall not exceed $10,000 over the five-year life of the waiver [~~unless an exception is applied for and approved.~~] \without an exception granted by the Department.\

B. Costs that exceed this limitation may be approved by the {Department} for devices to ensure the health and safety of the member or that enable the member to function with greater independence in the home, or if it decreases the need for paid assistance in another waiver service on a long-term basis.

C. Requests for an exception shall be prior authorized in accordance with the {Department's} procedures within thirty (30) days of the request.

8.7407 Behavioral Programing/Behavioral Management and Education (BI) 8.516.40

A. Behavioral programming and education are individually developed **interventions designed to decrease/control the member's severe maladaptive behaviors which, if not modified, will interfere with the members ability to remain integrated in the community.**

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8.7407.01 Behavioral Programming/Behavioral Management and Education Inclusions

A. Programs should consist of a comprehensive assessment of behaviors, development of a structured behavioral intervention plan, and ongoing training of family and caregivers for feedback about plan effectiveness and revision. Consultation with other providers may be necessary to ensure comprehensive application of the program in all facets of the members environment.

B. Behavioral programs may be provided in the community, or in the member's residence unless the residence is a Transitional Living Program which provides behavioral intervention as a treatment component.

C. All behavioral programming must be documented in the support plan and [~~reauthorized after~~] {may not exceed} 30 units of service. [~~with the Brain Injury Program Coordinator.~~] {The Department may authorize additional units based on needs identified in the support plan.}

8.7407.02 Behavioral Programming/Behavioral Management and Education Provider Agency Requirements

A. The program should have as its director a Licensed Psychologist who has one year of experience in providing neurobehavioral services or services to persons with brain injury or a healthcare ~~[health care]~~ professional such as a Licensed Clinical Social Worker, Registered Occupational Therapist, Registered Physical Therapist, Speech Language Pathologist, Registered Nurse or Masters level Psychologist with three years of experience in caring for persons with neurobehavioral difficulties. Behavioral specialists who directly implement the program shall have two years of related experience in the implementation of behavioral management concepts.

B. Behavioral specialists will complete a 24-hour training program dealing with unique aspects of caring for and working with individuals with brain injury if their work experience does not include at least one year of the ~~[same of]~~ same.

8.7407.03 Behavioral Programming/Behavioral Management and Education Reimbursement

A. The {case manager must document the} behavioral programming service [on] the member's support plan and include {service units} in the member's prior authorization request (PAR). [~~care plan and prior authorized through the State Brain Injury Program Coordinator.~~]

B. Behavioral programming services will be paid on an hourly basis as established by the Department.

8.7408 Behavioral Therapies (SLS; DD) [~~formerly at 8.500.94.B.2; 8.500.5.B.1~~]

A. "Behavioral services" means services related to the member's intellectual or developmental disability which assist a member to acquire or maintain appropriate interactions with others.

8.7408.01 Behavioral Therapies Inclusions

A. Behavioral services shall address specific challenging behaviors of the member and identify specific criteria for remediation of the behaviors.

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

C. Behavioral Services include:

i. Behavioral consultations and recommendations for behavioral interventions and development of behavioral support plans that are related to the member's developmental disability and are necessary for the member to acquire or

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maintain appropriate adaptive behaviors, interactions with others and behavioral self-management.

ii. Intervention ~~[modalities]~~ [strategies] related to an identified challenging behavioral need of the member. Specific goals and procedures for the behavioral service shall be established.

iii. Behavioral plan assessment services include observations, interviews of direct care staff, functional behavioral analysis and assessment, evaluations, and completion of a written assessment document.

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

1. Is related to the developmental disability in order for the member to acquire or maintain appropriate adaptive behaviors, interactions with others and behavioral self-management, and
2. Positively impacts the member's behavior or functioning and may include cognitive behavior therapy, systematic desensitization, anger management, biofeedback, and relaxation therapy.

v. Behavioral line services include direct one on one (1:1) implementation of the behavioral support plan and are:

1. Under the supervision and oversight of a behavioral consultant.
2. Inclusive of acute, short-term interventions at the time of enrollment from an institutional setting.
    a. To address an identified challenging behavior of a member at risk of institutional placement, and that places the member's health and safety or the safety of others at risk.

8.7408.02 Behavioral Therapies Exclusions and Limitations

A. Services covered under Medicaid {Early and Periodic Screening, Diagnostic and Treatment} 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.

B. Behavioral consultation services are limited to eighty (80) units per support plan year. One (1) unit is equal to fifteen (15) minutes of service.

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

D. Behavioral line services are limited to nine hundred and sixty (960) units per service plan year. One (1) unit is equal to fifteen (15) minutes of service.

E. Counseling services are limited to two hundred and eight (208) units per ~~[service plan]~~ {person-centered support plan} year. One (1) unit is equal to fifteen (15) minutes of service.

F. Services for the sole purpose of training basic life skills, such as activities of daily living, social skills and adaptive responding are excluded and not reimbursed under behavioral services.

8.7409 Benefits Planning Service (SLS, DD)

A. Benefits Planning is the analysis and guidance provided to a member and their family/support network to improve their understanding of the potential impact of employment-related income on the member's public benefits. Public benefits include, but are not limited to: Social Security, Medicaid, Medicare, food/nutrition programs, housing assistance, and other federal, state, and local benefits. Benefits Planning gives the member an opportunity to make an informed choice regarding employment opportunities or career advancement.

8.7409.01 Benefits Planning Service Inclusions

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A. {Benefits Planning is available in the [Supported Living Services (SLS) Waiver and the Developmental Disabilities (DD) Waiver.}
B. Benefits Planning is available regardless of employment history or lack thereof and can be accessed throughout the phases of a member's career such as: when considering employment, changing jobs, or for career advancement/exploration.
C. Certified Benefits Planners support members by providing any of these core activities:
    i. Intensive individualized benefits counseling;
    ii. Benefits verification;
    iii. Benefit summary & analysis (BS&A);
    iv. Identifying applicable work incentives, and if needed, developing a work incentive plan for the member and team;
D. In addition to the core activities, Benefits Planning may also be utilized to:
    i. Conduct an informational meeting with the member, alone or with their support network.
    ii. Assist with evaluating job offers, promotional opportunities (increase in hours/wage), or other job changes that the member is considering which changes income levels; and outlining the impact that change may have on public benefits.
    iii. Provide information on waiver benefits (including Buy-In options), federal/state/local programs, and other resources that may support the member in maintaining benefits while pursuing employment.
    iv. Assist with referrals and connecting the member with identified resources, as needed; as well as coordinating with member, case manager, family, and other team members to promote accessing services/resources that will advance the member's desired employment goals.
    v. Navigate complicated benefit scenarios and offer problem-solving strategies, so that the member may begin or continue working while maintaining eligibility for needed services.
    vi. Offer suggestions to the member and their family/support network regarding how to create and maintain a recordkeeping structure and reporting strategy related to benefit eligibility and requirements.
        1. If the member needs assistance with the collection and submission of income statements and/or documentation related to the Social Security Administration (SSA), or other benefits managing organizations, and the member does not have other supports to do so, the Benefits Planner may assist on a temporary basis.
    vii. In collaboration with the member's case manager and support team, a Benefits Planner can assist in accessing federal/state/local resources, evaluate the potential impact on benefits due to changes in income, and if there is a negative impact identified the Benefits Planner can help brainstorm alternatives to meet existing needs.

8.7409.02 Benefits Planning Service Requirements

A. The Benefits Planning provider must maintain records which reflect the Benefits Planning activities that were completed for the member, including copies of any reports provided to the member.

8.7409.03 Benefits Planning Service Exclusions and Limitations

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A. Benefits Planning shall not take the place of nor shall it duplicate services received through the Division of Vocational Rehabilitation.

8.7409.04 Benefits Planning Service Provider Agency Requirements

A. Benefits Planning may only be provided by Certified Benefits Planners. A Certified Benefits Planner holds at least one of the following credentials:
   i. Community Work Incentives Coordinator (CWIC);
   ii. Community Partner Work Incentives Counselor (CPWIC);
   iii. Credentialed Work Incentives Practitioner (WIP-C™).

B. Documentation of the Benefits Planner's certification and additional trainings shall be maintained and provided upon request by a surveyor or the Department.

C. Certified Benefits Planners must obtain and sustain a working knowledge of Colorado's Medicaid Waiver system as well as federal, state, and local benefits. If the Certified Benefits Planner encounters a benefit situation that is beyond their expertise, consultation with technical assistance liaisons is expected.

8.7409.05 Benefits Planning Reimbursement

A. Benefits Planning services are limited to forty (40) units per service plan year. One (1) unit is equal to fifteen (15) minutes of service.

8.7410 Bereavement Counseling (CLLI) [~~formerly at 8.504.1.D.B~~]

A. Bereavement Counseling means counseling provided to the member and/or family members to guide and help them cope with the member's illness and the related stress that accompanies the continuous, daily care required by a child with a life-threatening condition. Enabling the member and family members to manage this stress improves the likelihood that the member 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 member dies.

8.7410.01 Bereavement Counseling Exclusions and Limitations

A. Bereavement Counseling shall only be a benefit if it is not available under Medicaid {Early and Periodic Screening, Diagnostic and Treatment} EPSDT coverage, Medicaid State Plan benefits, third party liability coverage or by other means.

B. ~~[Bereavement Counseling is limited to the member's assessed need and is only billable one time.]~~

8.7410.02 Bereavement Counseling Reimbursement

A. Bereavement Counseling is initiated and billed while the ~~[child]~~ [member] is on the waiver but may continue after the death of the ~~[child]~~ [member] for a period of up to one year.

8.7411 Chiropractic - CIH (CIH) ~~[formerly at Complementary and Integrative Health Services (CIHS) 8.517.B.E.]~~

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\major revision\	{combined/moved similar language}
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A. Chiropractic - CIH means the use of manual adjustments (manipulation or mobilization) of the spine or other parts of the body with the goal of correcting and/or improving alignment, neurological function, and other musculoskeletal problems. During chiropractic treatment, nutrition, exercise, and rehabilitative therapies may be recommended in support of the adjustment.

~~B. [Complementary and Integrative Health Care Plan means the plan developed prior to the delivery of Complementary and Integrative Health Services in accordance with Section 8.517.11.D.~~

~~C. Complementary and Integrative Health Provider means an individual or agency certified annually by the Department to have met the certification standards listed at Section 8.517.11.~~

~~D. Complementary and Integrative Health Services (CIHS) means Acupuncture, Chiropractic, and Massage Therapy.]~~

8.7411.01 Chiropractic - CIH Inclusions

A. Chiropractic is used for treating conditions or symptoms related to the member's qualifying condition and inability to independently ambulate.

B. Members receiving chiropractic services or other Complementary and Integrative Health Services shall be asked to participate in an independent evaluation to determine the effectiveness of the services.

C. Chiropractic shall be provided {in a licensed chiropractor's clinic}, an approved outpatient setting, or in the member's residence.

~~D. [Complementary and Integrative Health Services shall be provided only by a Complementary and Integrative Health Provider certified by the Department of Health Care Policy and Financing to have met the certification standards listed at Section 8.517.11.C.]~~

8.7411.02 Acupuncture Exclusions and Limitations

A. ~~[Complementary and Integrative Health Services]~~ {Chiropractic} shall be limited to the member's assessed need for services {as identified and documented in the person centered support plan.}

B. ~~[Complementary and Integrative Health Services shall be provided only by a Complementary and Integrative Health Provider certified by the Department of Health Care Policy and Financing to have met the certification standards listed at Section 8.517.11.C.~~

C. ~~The Complementary and Integrative Health Services benefit is limited as follows:~~

i. ~~A Client may receive each of the three individual Complementary and Integrative Health Services on a single date of service.~~

ii. ~~A Client shall not receive more than four (4) units of each individual Complementary and Integrative Health Service on a single date of service.~~

iii. ~~A Client shall not receive more than 204 units of a single Complementary and Integrative Health service during a 365-day certification period.]~~

D. A member shall not receive more than 408 combined units of all Complementary and Integrative Health Services during the support plan year.

8.7411.03 Chiropractic Service Provider Agency Requirements

A. ~~[Complementary and Integrative Health Services must be provided by licensed, certified, and/or registered individuals operating within the applicable scope of practice.]~~

B. Chiropractors shall be licensed by the State Board of Chiropractic Examiners as required by the Chiropractors Practice Act (C.R.S. § 12-215-101 et seq) and have at least (1) year experience practicing Chiropractic at a rate of 520 hours per year; OR (1) year of experience working with individuals with paralysis or other long term physical disabilities.

C. ~~[Environmental Standards for Complementary and Integrative Health Services provided in an outpatient setting.~~

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i. ~~Complementary and Integrative Health Providers shall develop a plan for infection control that is adequate to avoid the sources of and prevent the transmission of infections and communicable diseases. They shall also develop a system for identifying, reporting, investigating and controlling infections and communicable diseases of patients and personnel. Sterilization procedures shall be developed and implemented in necessary service areas.~~

ii. ~~Policies shall be developed, and procedures implemented for the effective control of insects, rodents, and other pests.~~

iii. ~~All wastes shall be disposed of in compliance with local, state and federal laws.~~

iv. ~~A preventive maintenance program to ensure that all essential mechanical, electrical and patient care equipment is maintained in safe and sanitary operating condition shall be provided. Emergency Systems, and all essential equipment and supplies shall be inspected and maintained on a frequent or as needed basis.~~

v. ~~Housekeeping services to ensure that the premises are clean and orderly at all times shall be provided and maintained. Appropriate janitorial storage shall be maintained.~~

vi. ~~Outpatient settings shall be constructed and maintained to ensure access and safety.~~

vii. ~~Outpatient settings shall demonstrate compliance with the building and fire safety requirements of local governments and other state agencies.~~

~~D. Failure to comply with the requirements of this rule may result in the revocation of the Complementary and Integrative Health Provider certification.]~~

8.7411.04 ~~[Complementary and Integrative Health Services Care Plan]~~

~~A.~~ {Chiropractor} ~~[Complementary and Integrative Health]~~ Providers shall:

~~i. [Guide the development of the Complementary and Integrative Health Care Plan in coordination with the member and/or member's representative.]~~

~~ii.~~ Recommend the appropriate modality, amount, scope, and duration of ~~[the Complementary and Integrative Health]~~ {chiropractic service}~~[(s)]~~ within the established limits. ~~[as listed at 8.517.11.B].~~

~~iii.~~ Recommend only services that are necessary and appropriate and that will be rendered by the recommending {chiropractic} provider. ~~[Complementary and Integrative Health Provider.]~~

~~iv. [Maintain member records as established at Section 8.487.16. Member records shall be made available to the Department or designated entity upon request and demonstrate the completion of Complementary and Integrative Health Providers requirements above.~~

~~B. The Complementary and Integrative Health Provider shall reassess the Complementary and Integrative Health Care Plan annually or more frequently as necessary. The reassessment shall include a visit with the member.~~

~~C. The Complementary and Integrative Health Care Plan shall be developed using Department prescribed form(s) or template(s).~~

~~D. The Complementary and Integrative Health Care Plan shall include the amount, scope, and duration of recommended Complementary and Integrative Health Services (CIHS).~~

~~E. Recommendations for CIHS on the Complementary and Integrative Health Care Plan will guide case managers in completing the Prior Authorization Request (PAR).~~

~~F. CIHS will be added to the PAR only if recommended in the Complementary and Integrative Health Care Plan and agreed to by the member.]~~

8.7412 Community Connector Services (CES; CHRP) formerly at 8.503.40.A.3; 8.508.100.L

8.7412.01 Community Connector Service Inclusions

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A. Community Connector services are intended to aid the member in integrating into the member's community and access naturally occurring resources. Community Connector services shall:
   i. Support the abilities and skills necessary to enable the member to access typical activities and functions of community life such as those chosen by the general population.
   ii. Utilize the community as a learning environment to assist the member to build relationships and natural supports in the member's residential community.
   iii. Be provided one-on-one, to a single member, in a variety of settings within the community in which members interact with individuals without disabilities (other than the individual who is providing the service to the member).
   iv. The targeted behaviors, measurable goal(s), and plan to address those behaviors must be clearly articulated in the Person-Centered Support Plan.

8.7412.02 Community Connector Service Exclusions and Limitations

A. 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 and HCBS-CHRP waivers and shall not be reimbursed.
B. HCBS-CHRP
   a. This service is limited to 260 hours or 1040 units per year.
   b. A request to increase service hours can be made to the Department on a case-by-case basis.

8.7413 Consumer Directed Attendant Support Services (CDASS) (EBD, CMHS, CIH, BI, SLS)
~~[formerly at 8.510]~~

8.7413.01 CDASS 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 member and made available by the Department through the Financial Management Service (FMS) [contractor ~~vendor]~~ for Attendant support services available in the Consumer Directed Attendant Support Services (CDASS) delivery option.
C. ~~[Assessment means a comprehensive evaluation with the member 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 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 member or Authorized Representative through the contracted FMS [contractor ~~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 member or the member's legal guardian, if applicable, who has the judgment and ability to direct

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CDASS on a member'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 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 services delivery, evaluation of service effectiveness, and periodic reassessment of member needs.]~~

I. 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 assistance with health maintenance, personal care, and homemaker activities.

J. CDASS Support Plan Year 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 support plan year.

K. CDASS Task Worksheet means a tool used by a case manager to indicate the number of hours of assistance a member 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 [Support~~Operations~~ contractor~~vendor~~] to a member or Authorized Representative.

M. Electronic Visit Verification (EVV) means the use of technology, including mobile device technology, telephony, or Manual Visit Entry, to verify the required data elements related to the delivery of a service mandated to be provided using EVV by the "21st Century Cures Act," P.L. No. 114-255, or this rule.

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

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

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

Q. Financial Management Services (FMS) [contractor~~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.

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

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

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

U. Inappropriate Behavior means offensive behavior toward Attendants, Case Managers, the Training and [Support~~Operations~~ contractor~~vendor~~] or the FMS [contractor], and which includes documented verbal, sexual and/or physical abuse. Verbal abuse may include threats, insults or offensive language.

V. Licensed Medical Professional means the primary care provider of the member, 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.

W. ~~[Prior Authorization Request (PAR) means the Department-prescribed process used to authorize HCBS waiver services before they are provided to the member.]~~

X. 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, member account statements, Case Manager contact, or FMS [contractor~~vendor~~] contact.

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

Z. Training and [Support~~Operations~~ contractor~~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.

8.7413.02 CDASS Eligibility

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

i. Choose the CDASS delivery option.

ii. {Be enrolled in a Medicaid program approved to offer CDASS. CDASS is offered in Elderly, Blind, Disabled (EBD) Waiver; Brain Injury (BI) Waiver; Community Mental Health Supports (CMHS) Waiver; Complementary and Integrative Health (CIH) Waiver; and the Supported Living Services (SLS) waiver.}

~~iii. [Meet HCBS waiver functional and financial eligibility requirements.]~~

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

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

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

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

1. Member training obligations

a. members and ARs who have received training through the Training and [Support~~Operations~~ contractor~~vendor~~] in the past two years [~~and~~] \or\ have utilized CDASS in the previous six months may receive a modified training to [~~restart~~] \begin or resume\ CDASS \~~following an episode of closure~~. ~~The Case Manager will review the allocation and attendant management for the member's previous service utilization~~

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~~and consult with the Department to will determine whether full retraining is required, or an abbreviated training based on history of managing allocation and services is needed.\~~

b. A member 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.

8.7413.03 Consumer Directed Attendant Support Services [Inclusions ~~Covered Services]~~

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

B. Services include:

i. Homemaker

1. Refer to Homemaker task definitions

ii. Personal Care

1. Refer to Personal Care task definitions

iii. Health Maintenance Activities

1. Refer to Health Maintenance Activities task definitions ~~[Health maintenance activities include routine and repetitive health-related tasks furnished to an eligible member in the community or in the member'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:~~

~~2. Skin care, when the skin is broken, or a chronic skin condition is active and could potentially cause infection and the member 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.~~

~~3. Nail care in the presence of medical conditions that may involve peripheral circulatory problems or loss of sensation; includes soaking, filing and trimming.~~

~~4. Mouth care performed when health maintenance level skin care is required in conjunction with the task, or:~~

~~a. There is injury or disease of the face, mouth, head or neck;~~
~~b. In the presence of communicable disease;~~
~~c. When the member is unable to participate in the task;~~
~~d. Oral suctioning is required;~~
~~e. There is decreased oral sensitivity or hypersensitivity;~~
~~f. member is at risk for choking and aspiration.~~

~~5. Dressing performed when health maintenance-level skin care or transfers are required in conjunction with the dressing, or:~~

~~a. The member is unable to assist or direct care;~~
~~b. Assistance with the application of prescribed anti-embolic or pressure stockings is required;~~
~~c. Assistance with the application of prescribed orthopedic devices such as splints, braces, or artificial limbs is required.~~

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~~6. Feeding is considered a health maintenance task when the member requires health maintenance-level skin care or dressing in conjunction with the task, or:~~
   ~~a. Oral suctioning is needed on a stand-by or intermittent basis;~~
   ~~b. The member is on a prescribed modified texture diet;~~
   ~~c. The member has a physiological or neurogenic chewing or swallowing problem;~~
   ~~d. Syringe feeding or feeding using adaptive utensils is required;~~
   ~~e. Oral feeding when the member is unable to communicate verbally, non-verbally or through other means.~~

~~7. Exercise prescribed by a Licensed Medical Professional, including passive range of motion.~~

~~8. Transferring a member when they are not able to perform transfers independently due to illness, injury or disability, or:~~
   ~~a. The member lacks the strength and stability to stand, maintain balance or bear weight reliably;~~
   ~~b. The member has not been deemed independent with adaptive equipment or assistive devices by a Licensed Medical Professional;~~
   ~~c. The use of a mechanical lift is needed.~~

~~9. Bowel care performed when health maintenance-level skin care or transfers are required in conjunction with the bowel care, or:~~
   ~~a. The member is unable to assist or direct care;~~
   ~~b. Administration of a bowel program including but not limited to digital stimulation, enemas, or suppositories;~~
   ~~c. 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.~~

~~10. Bladder care performed when health maintenance-level skin care or transfers are required in conjunction with bladder care, or;~~
   ~~a. The member is unable to assist or direct care;~~
   ~~b. Care of external, indwelling and suprapubic catheters;~~
   ~~c. Changing from a leg to a bed bag and cleaning of tubing and bags as well as perineal care.~~

~~11. 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.~~

~~12. Respiratory care:~~
   ~~a. Postural drainage;~~
   ~~b. Cupping;~~
   ~~c. Adjusting oxygen flow within established parameters;~~
   ~~d. Suctioning mouth and/or nose;~~
   ~~e. Nebulizers;~~
   ~~f. Ventilator and tracheostomy care;~~
   ~~g. Assistance with set-up and use of respiratory equipment.~~

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~~13. Bathing assistance is considered a health maintenance task when the member requires health maintenance-level skin care, transfers or dressing in conjunction with bathing.~~

~~14. Medication assistance, which may include setup, handling and administering medications.~~

~~15. Accompanying includes going with the member, as necessary according to the care plan, to medical appointments, and errands such as banking and household shopping. Accompanying the member 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.~~

~~16. Mobility assistance is considered a health maintenance task when health maintenance-level transfers are required in conjunction with the mobility assistance, or:~~

~~a. The member is unable to assist or direct care;~~

~~b. When hands-on assistance is required for safe ambulation and the member is unable to maintain balance or to bear weight reliably due to illness, injury, or disability; and/or~~

~~c. The member has not been deemed independent with adaptive equipment or assistive devices ordered by a Licensed Medical Professional~~

~~17. Positioning includes moving the member from the starting position to a new position while maintaining proper body alignment, support to a member's extremities and avoiding skin breakdown. May be performed when health maintenance level skin care is required in conjunction with positioning, or;~~

~~a. The member is unable to assist or direct care, or~~

~~b. The member is unable to complete task independently~~

~~18. Services that may be directed by the member or their selected AR under the Home and Community-based Supported Living Services (HCBS-SLS) waiver are as follows:~~

~~a. Homemaker services, as defined at Section 8.500.94.~~

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

~~c. Health maintenance activities as defined at Section 8.500.94.]~~

8.7413.04 CDASS Exclusions and Limitations

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

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

ii. Following the death of the member;

iii. Tasks that are duplicative or overlapping. The Attendant cannot be reimbursed to perform tasks at the time a member 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.

8.7413.05 CDASS Attendant Support Management Plan

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A. The member/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 [Support~~Operations~~ contractor~~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 member's needs. The plan shall describe the member's:
   i. Needed Attendant support;
   ii. Plans for locating and hiring Attendants;
   iii. Plans for handling emergencies;
   iv. Assurances and plans regarding direction of CDASS Services, as described at [8.510.3] and [8.510.6], if applicable;
   v. Plans for budget management within the member's Allocation;
   vi. Designation of an AR, if applicable; and
   vii. Designation of regular and back-up employees proposed or approved for hire.

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

8.7413.06 CDASS member/AR Responsibilities

A. Member/AR shall complete the following responsibilities for CDASS management:
   i. Complete training provided by the Training and [Support~~Operations~~ contractor~~vendor~~]. members who cannot complete trainings shall designate an AR.
   ii. [~~Develop~~ Complete and submit] an ASMP at initial enrollment and at time of an **\Allocation change of 25% or more and** based on the member's needs.
   iii. 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.
   iv. Determine the required qualifications for Attendants.
   v. Recruit, hire and manage Attendants.
   vi. Complete employment reference checks on Attendants.
   vii. Train Attendants to meet the member's needs. When necessary to meet the goals of the ASMP, the member/AR shall verify that each Attendant has been or will be trained in all necessary health maintenance activities prior to performance by the Attendant.
   viii. Terminate Attendants when necessary, including when an Attendant is not meeting the member's needs.
   ix. Operate as the Attendant's legal employer of record.
   x. Complete necessary employment-related functions through the FMS [contractor~~vendor~~], including hiring and termination of Attendants and employer-related paperwork necessary to obtain an employer tax ID.
   xi. Ensure all Attendant employment documents have been completed and accepted by the FMS [contractor~~vendor~~] prior to beginning Attendant services.

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xii. Follow all relevant laws and regulations applicable to the supervision of Attendants.
xiii. Explain the role of the FMS [contractor~~vendor~~] to the Attendant.
xiv. Budget for Attendant care within the established monthly and CDASS Certification Period Allocation. Services that exceed the member's monthly CDASS Allocation by 30% or higher are not allowed and cannot be authorized by the member or AR for reimbursement through the FMS [contractor~~vendor~~].
xv. Authorize Attendant to perform services allowed through CDASS.
xvi. Ensure all Attendants required to utilize EVV are trained and complete EVV for services rendered. Timesheets shall be reviewed and reflect time worked that all required data points are captured to maintain compliance with [8.001].
xvii. Review all Attendant timesheets and statements for accuracy of time worked, completeness, and member/AR and Attendant signatures. Timesheets shall reflect actual time spent providing CDASS.
xviii. Review and submit approved Attendant timesheets to the FMS by the established timelines for Attendant reimbursement.
xix. Authorize the FMS [contractor~~vendor~~] to make any changes in the Attendant wages.
xx. Understand that misrepresentations or false statements may result in administrative penalties, criminal prosecution, and/or termination from CDASS. member/AR is responsible for assuring timesheets submitted are not altered in any way and that any misrepresentations are immediately reported to the FMS [contractor~~vendor~~].
xxi. Completing and managing all paperwork and maintaining employment records.
xxii. Select an FMS [contractor~~vendor~~] upon enrollment into CDASS.

B. Member/AR responsibilities for Verification:
i. Sign and return a responsibilities acknowledgement form for activities listed in [8.510.6] to the Case Manager.

C. Members utilizing CDASS have the following rights:
i. Right to receive training on managing CDASS.
ii. Right to receive program materials in accessible format.
iii. Right to receive advance Notification of changes to CDASS.
iv. Right to participate in Department-sponsored opportunities for input.
v. Members 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.
vi. A member/AR may request a reassessment if the member's level of service needs have changed.
vii. A member/AR may revise the ASMP at any time with case manager approval.

8.7413.07 Consumer Directed Attendant Support Services Authorized Representatives (AR)

A. A person who has been designated as an AR shall submit an AR designation affidavit attesting that he or she:
i. Is least eighteen years of age;
ii. Has known the eligible person for at least two years;
iii. Has not been convicted of any crime involving exploitation, abuse, or assault on another person; and

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

B. CDASS members who require an AR may not serve as an AR for another CDASS member.

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

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

8.7413.08 CDASS Attendants

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

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

ii. Attendants may not be reimbursed for more than 24 hours of CDASS service in one day for one or more members collectively.

iii. An AR shall not be employed as an Attendant for the same member for whom they are an AR.

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

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

vi. 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.

vii. 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.

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

ix. Attendants are not eligible for hire if their background check identifies a conviction of a crime that the Department has identified as a [high-risk~~barrier~~] crime that can create a health and safety risk to the member. A list of [high-risk~~barrier~~] crimes is available through the [Department, Training and [Support~~Operations~~ contractor~~vendor~~] and FMS [contractor~~vendors~~].

x. Attendants may not participate in training provided by the Training and [Support~~Operations~~ contractor~~vendor~~]. members 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.

8.7413.09 CDASS Financial Management Services (FMS)

A. FMS [contractor~~vendors~~] shall be responsible for the following tasks:

i. Collect and process timesheets submitted by attendants within agreed-upon timeframes as identified in FMS [contractor~~vendor~~] materials and websites.

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ii. 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.
iii. Distribute paychecks in accordance with agreements made with member/AR and timelines established by the Colorado Department of Labor and Employment.
iv. Submit authorized claims for CDASS provided to an eligible member.
v. Verify Attendants' citizenship status and maintain copies of I-9 documents.
vi. Track and report utilization of member allocations.
vii. Comply with Department regulations and the FMS [contractor~~vendor~~] contract with the Department.

B. In addition to the requirements set forth at [8.510.9.A], the FMS [contractor~~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 (2021). This statute is hereby incorporated by reference. The incorporation of these statutes excludes later amendments to, or editions of the referenced material. Pursuant to Section 24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request.

8.7413.10 CDASS Selection of FMS [Contractor~~vendors~~]

A. The member/AR shall select an FMS [contractor~~vendor~~] at the time of enrollment into CDASS from the [contractor~~vendors~~] contracted with the Department.
B. The member/AR may select a new FMS [contractor~~vendor~~] during the designated open enrollment periods. The member/AR shall remain with the selected FMS [contractor~~vendor~~] until the transition to the new FMS [contractor~~vendor~~] is completed.

8.7413.11 CDASS Start of Services

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.
B. The case manager shall approve the ASMP, establish a service period, submit a PAR and receive a PAR approval before a member is given a start date and can begin CDASS.
C. The FMS [contractor~~vendor~~] shall process the Attendant's employment packet within the Department's prescribed timeframe and ensure the member has a minimum of two approved Attendants prior to starting CDASS. The member must maintain employment relationships with two Attendants while participating in CDASS.
D. The FMS [contractor~~vendor~~] will not reimburse Attendants for services provided prior to the CDASS start date. Attendants are not approved until the FMS [contractor~~vendor~~] provides the member/AR with employee numbers and confirms Attendants' employment status.
E. If a member is transitioning from a hospital, nursing facility, or HCBS agency services, the case manager shall coordinate with the discharge coordinator to ensure that the member's discharge date and CDASS start date correspond.

8.7413.12 CDASS Service Substitution

A. Once a start date has been established for CDASS, the case manager shall establish an end date and discontinue the member from any other Medicaid-funded Attendant

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support including Long-Term Home Health, homemaker and personal care services effective as of the start date of CDASS.

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 member.

C. Members 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.

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

8.7413.13 CDASS Failure to Meet member/AR Responsibilities

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

i. Mandatory [retraining~~re-training]~~ conducted by the contracted Training and [Support~~Operations~~ contractor~~vendor]~~.

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

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

i. The member/AR does not comply with CDASS program requirements including service exclusions.

ii. The member/AR demonstrates an inability to manage Attendant support.

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

iv. The member/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.

v. The member/AR exhibits Inappropriate Behavior as defined at [8.510.1] toward Attendants, case managers, the Training and [Support~~Operations~~ contractor~~vendor]~~, or the FMS [contractor~~vendor]~~.

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

8.7413.14 CDASS Immediate Involuntary Termination

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

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

C. The member/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 member/AR to resolve the overspending have failed.

D. The member/AR exhibits Inappropriate Behavior as defined at [8.510.1] toward Attendants, case managers, the Training and [Support~~Operations~~ contractor~~vendor]~~ or the FMS [contractor~~vendor]~~, and the Department has determined that the Training and

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[Support~~Operations~~ contractor~~vendor~~] has made attempts to assist the member/AR to resolve the Inappropriate Behavior or assign a new AR, and those attempts have failed.

E. Member/AR authorized the Attendant to perform services for a person other than the member, authorized services not available in CDASS, or allowed services to be performed while the member is in a hospital, nursing facility, a long-term care facility or while incarcerated and the Department has determined the Training and [Support~~Operations~~ contractor~~vendor~~] has made adequate attempts to assist the member/AR in managing appropriate services through retraining.

F. Intentional submission of fraudulent CDASS documents or information to Case Managers, the Training and [Support~~Operations~~ contractor~~vendor~~], the Department, or the FMS [contractor~~vendor~~].

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

H. Member/AR fails to complete retraining, appoint an AR, or remediate CDASS management per [8.510.13.A.]

I. Member/AR demonstrates a consistent pattern of non-compliance with EVV requirements determined by the EVV CDASS protocol.

   i. members experiencing FMS EVV systems issues must notify the FMS [contractor~~vendor~~] and/or Department of the issue within five (5) business days. In the event of a confirmed FMS EVV system outage or failure impacting EVV submissions, the Department will not impose strikes or pursue termination, as appropriate, as outlined in the EVV Compliance protocol.

8.7413.15 Ending The CDASS Delivery Option

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

B. In the event of discontinuation of or termination from CDASS, the case manager shall:

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

   ii. 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 member. The case manager shall notify the FMS [contractor~~vendor~~] of the date on which the member is being terminated from CDASS.

C. Members 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.

D. Members 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 member or AR must have successfully completed CDASS training prior to enrollment in CDASS.

E. Members who are involuntary terminated pursuant to [8.510.14.A.3] are eligible for enrollment in CDASS with the appointment of an AR. The member must meet all CDASS

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eligibility requirements with the AR completing CDASS training prior to enrollment in CDASS.

F. Members who are involuntarily terminated pursuant to [8.510.14.A.8] are eligible for enrollment in CDASS 365 days from the date of termination. The member must meet all eligibility requirements and complete CDASS training prior to enrollment in CDASS.

8.7413.16 CDASS Case Management Functions

A. The case manager shall review and approve the ASMP completed by the member/AR. The case manager shall notify the member/AR of ASMP approval and establish a service period and Allocation.

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

C. The case manager shall calculate the Allocation for each member who chooses CDASS as follows:

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

ii. The Allocation should be determined using the Department's prescribed method at the member's initial CDASS enrollment and at reassessment. Service authorization will align with the member's need for services and adhere to all service authorization requirements and limitations established by the member's waiver program.

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

iv. **\Allocations that include Health Maintenance Activities cannot be authorized by the case manager without Department approval. The case manager will follow the Department's utilization management review process and receive authorization prior to authorizing a start date for Attendant services.**

D. Prior to training or when an Allocation changes, the case manager shall provide written Notification of the Allocation to the member and the AR, if applicable.

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

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

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

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2. The case manager shall complete a PAR revision indicating the increase in CDASS Allocation using the Department's Medicaid Management Information System and FMS [contractor~~vendor~~] system. PAR revisions shall be completed within five (5) business days of the Allocation determination.
3. The member/AR shall amend the ASMP and submit it to the case manager.

ii. The Training and [Support~~Operations~~ contractor~~vendor~~] is available to facilitate a review of services and provide mediation when there is a disagreement in the services authorized on the CDASS Task Worksheet.

iii. The case manager will notify the member of CDASS Allocation approval or disapproval by providing a long-term care notice of action form to members within ten (10) business days regarding their appeal rights in accordance with [Section 8.057, et seq].

F. In approving an increase in the member's Allocation, the case manager shall consider the following:
   i. Any deterioration in the member's functioning or change in availability of natural supports, meaning assistance provided to the member without the requirement or expectation of compensation;
   ii. The appropriateness of Attendant wages as determined by Department's established rate for equivalent services; and
   iii. The appropriate use and application of funds for CDASS services.

G. In reducing a member's Allocation, the case manager shall consider:
   i. Improvement of functional condition or changes in the available natural supports;
   ii. Inaccuracies or misrepresentation in the member's previously reported condition or need for service; and
   iii. The appropriate use and application of funds for CDASS services.

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

I. For effective coordination, monitoring and evaluation of members receiving CDASS, the case manager shall:
   i. Contact the CDASS member/AR once a month during the first three months to assess their CDASS management, their satisfaction with Attendants, and the quality of services received. case managers may refer members/ARs to the FMS [contractor~~vendor~~] for assistance with payroll and to the Training and [Support~~Operations~~ contractor~~vendor~~] for training needs, budgeting, and supports.
   ii. Contact the member/AR quarterly after the first three months to assess their implementation of Attendant services, CDASS management issues, quality of care, Allocation expenditures, and general satisfaction.
   iii. Contact the member/AR when a change in AR occurs and contact the member/AR once a month for three months after the change takes place.

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iv. Review monthly FMS [contractor~~vendor~~] reports to monitor Allocation spending patterns and service utilization to ensure appropriate budgeting and follow up with the member/AR when discrepancies occur.

v. Utilize Department overspending protocol when needed to assist CDASS member/AR.

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

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

K. Case managers shall participate in training and consulting opportunities with the Department's contracted Training and [Support~~Operations~~ contractor~~vendor~~].

8.7413.17 CDASS Attendant Reimbursement

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

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

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

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

8.7413.18 CDASS Reimbursement to Family members

A. Family members/legal guardians may be employed by the member/AR to provide CDASS, subject to the conditions below.

i. The [f]amily [member] or legal guardian shall be employed by the member/AR and be supervised by the member/AR.

ii. 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 member's household may only be paid to furnish extraordinary care as determined by the case manager. Extraordinary

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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 member and avoid institutionalization. Extraordinary care shall be documented on the service plan.

iii. A member/AR who chooses a Family member as a care provider, shall document the choice on the ASMP.

8.7414 Counseling Services (BI) ~~[formerly at 8.516.50]~~

A. Counseling services mean individualized services designed to assist members and their support systems to more effectively manage ~~[and overcome the difficulties and stresses confronted by people with brain injuries]~~ {stress related situations due to a brain injury diagnosis.]

8.7414.01 Counseling Services Inclusions

A. Counseling is available to the member's family and support network in conjunction with the ~~[Client]~~ {member} if they: a) have a significant role in supporting the ~~[Client]~~ [member] or b) live with or provide care to the ~~[Client]~~ {member}. "Family" and "support network" includes a parent, spouse, child, relative, foster family, in-laws or other person who may have significant ongoing interaction with the ~~[waiver participant]~~ {member}.

B. Services may be provided in the ~~[waiver participant's]~~ {member's} residence, in community settings, or in the provider's office.

C. Intervention may be provided in either a group or individual setting: however, charges for group and individual therapy shall reflect differences.

~~D.~~ All counseling services must be documented in the ~~[plan of care]~~ [person-centered support plan] and must be provided by individuals or agencies approved as providers of waiver services by the Department. ~~as directed by certification standards listed below.~~

E. Family training/counseling must be carried out for the direct benefit of the ~~[Client]~~ [member] of the HCBS-BI program.

F. Family training is considered an integral part of the continuity of care in transition to home and community environments. Services are directed towards instruction about treatment regimens and use of equipment specified in the ~~[plan of care]~~ [person centered support plan] and shall include updates as may be necessary to safely maintain the ~~[individual]~~ [member] at home.

G. The service is limited to thirty visits of individual, group, family, or a combination of ~~[modalities]~~ {counseling services.} ~~Re-authorization is submitted to the State Brain Injury Program [Coordinator].~~ The Department may authorize additional units based on needs identified in the support plan.

8.7414.02 Counseling Services Exclusions and Limitations

A. Family training is not available to individuals who are employed to care for the member.

8.7414.03 Counseling Services Provider Agency Requirements

A. Professionals providing counseling services must hold the appropriate license or certification for their discipline according to state law or federal regulations and represent one of the following professional categories: Licensed Clinical Social Worker, Certified Rehabilitation Counselor, Licensed Professional Counselor, or Licensed Clinical Psychologist. Master's or doctoral level counselors who meet experiential and educational requirements but lack certification or credentialing as stated above, may submit their professional qualifications via curriculum vitae or resume for consideration.

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B. All professionals applying as providers of counseling services must demonstrate or document a minimum of two years of experience in providing counseling to members with a brain injury and their families.

C. ~~[Master's or doctoral level counselors who meet experiential and educational requirements but lack certification or credentialing as stated above, may submit their professional qualifications via curriculum vitae or resume for consideration.]~~

8.7414.04 Counseling Services Reimbursement

A. Reimbursement will be on an hourly basis per type of counseling service as established by the Department. There are three separate ~~{modalities}~~ {counseling services} allowable under BI counseling services including Family Counseling, Individual Counseling, and Group Counseling.

8.7415 Day Habilitation (SLS; DD) ~~[formerly at 8.500.94.B.3; 8.500.5.B.2]~~

8.7415.01 Day Habilitation Inclusions

A. Day Habilitation shall foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. Services and supports include assistance with the acquisition, retention or improvement of self-help, socialization and adaptive skills that take place in a non-residential setting, separate from the member's private residence or other residential living arrangement.

B. Day habilitation services and supports encompass three (3) types of habilitative services; Specialized Habilitation Services, Supported Community Connections, and Prevocational Services.

i. Specialized Habilitation (SH) services are community-integrated services provided out of a non-residential setting, provided to enable the member to attain the maximum functional level or to be supported in such a manner that allows the member to gain an increased level of self-sufficiency. Specialized habilitation services:

1. Include the opportunity for members to select from Age-Appropriate Activities and Materials, as defined in Section 8.484.2.A, both within and outside of the setting;
2. Include assistance with self-feeding, toileting, self-care, sensory stimulation and integration, self-sufficiency, and maintenance skills; and
3. May reinforce skills or lessons taught in school, therapy or other settings and are coordinated with any physical, occupational or speech therapies listed in the Person-Centered Support Plan.

ii. Supported Community Connections (SCC) services are provided to support the abilities and skills necessary to enable the member to access typical activities and functions of community life, such as those chosen by the general population, including community education or training, retirement, and volunteer activities. SCC services:

1. Provide a wide variety of opportunities to facilitate and build relationships and natural supports in the community while utilizing the community as a learning environment to provide services and supports as identified in a member's Person-Centered Support Plan;
2. Are conducted in a variety of settings in which the member interacts with persons without disabilities other than those individuals who are providing services to the member. These types

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of services may include socialization, adaptive skills and personnel to accompany and support the member in community settings;

3. Provide resources necessary for participation in activities and supplies related to skill acquisition, retention or improvement and are provided by the service agency as part of the established reimbursement rate; and
4. May be provided in a group setting or on a one-to-one (1:1) basis as identified in the Person-Centered Support Plan.
5. Activities provided exclusively for recreational purposes are not a benefit and shall not be reimbursed.

iii. Prevocational services must comply with Employment regulations at Section XXX.

8.7415.02 Day Habilitation Exclusions and Limitations

A. Day Habilitation Services and Supports are to be provided outside of the person's living environment, unless otherwise indicated by the person's needs. If services cannot be provided outside of the living environment due to a person's medical or safety needs, this shall be documented.

8.7415.03 Day Habilitation Provider Agency Requirements

A. Provider agencies must maintain documentation that includes the date & start/end times of activities completed, what activities were completed, & what Person-Centered Support Plan goals of the member are being achieved through the activity/ies.
B. Integrated employment should be considered as the primary option for all persons receiving Day Habilitation Services and Supports.
C. If the provider agency provides services in the community to persons who may visit the offices of the provider agency (or another service operated facility), but the persons receive services at such location(s) for less than one hour per visit, requirements of section 8.610.A.1-4 do not apply. The service agency shall, however, ensure that the facility complies with the ADA and contains no hazards which could jeopardize the health or safety of persons visiting the site.
D. For physical facilities used as community integrated sites over which the provider agency exercises little or no control, the provider agency shall:
    i. Conduct an on-site visit to ensure that there is no recognizable safety or health hazards which could jeopardize the health or safety of individuals; and
    ii. Address any safety or health hazards which could jeopardize the health or safety of individuals with the owner/operator of the physical facility.
E. Specialized Habilitation Services Provider Setting
    i. Specialized Habilitation services must be provided out of an integrated, community-based setting, which supports participation and engagement in community life and gaining access to the greater community; members may engage in meaningful activities in integrated and community settings.
    ii. The Specialized Habilitation location shall provide a clean and sanitary environment that is physically accessible to the members, including those members with supportive devices for ambulation or who are in wheelchairs.
    iii. The Specialized Habilitation location shall provide recreational areas and age-appropriate activities appropriate to the number and needs of the members, at the times desired by the members.

8.7415.04 Day Habilitation Provider Reimbursement Requirements

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A. SLS:
   i. Day habilitation services, in combination with prevocational services and supported employment, are limited to seven thousand one hundred and twelve (7,112) units per Person-Centered Support Plan year. One (1) unit is equal to fifteen (15) minutes of service.

B. DD:
   i. Day Habilitation services, in combination with Prevocational services, are limited to four thousand eight hundred (4,800) units. When used in combination with supported employment services, the total number of units available for day habilitation services in combination with prevocational services will remain at four thousand eight hundred (4,800) units and
   ii. The cumulative total, including supported employment services, may not exceed seven thousand one hundred and twelve (7,112) units. One (1) unit is equal to fifteen (15) minutes of service.

C. DD & SLS: Day Habilitation services have 3 tiers for service provision:
   i. Tier 1 - Specialized Habilitation and Supported Community Connections services are provided virtually via telehealth. Tier 1 services should be billed at the Tier 2 rate, according to the member's Support Level.
   ii. Tier 2 - Traditional Specialized Habilitation and Supported Community Connections services provided in a group setting, apart from the member's residence, and billed for at the Tier 2 rate, according to the member's Support Level. Tier 2 Supported Community Connections services may also be provided to a single member, utilizing the community as the learning environment. Tier 2 services are delivered in-person.
   iii. Tier 3 - Supported Community Connections services are provided 1:1, to a single member, and billed for at the Tier 3 Supported Community Connections rate. Members who receive Supported Community Connections services under Tier 3 are also required to stay within the member's individual annual dollar limit for the combination of group and 1:1 Day Habilitation services. Tier 3 services must be delivered in-person.
      1. One-on-one Supported Community Connections services may be billed for at the individualized rate and when this occurs the combination of group and 1:1 Day Habilitation services are required to stay within the member's individual annual dollar limit, as well as the unit limit. Members who have an exceptional need to exceed one's individualized annual dollar limit can request additional funding through the Department's exception process.

8.7416 Day Treatment (BI) ~~[formerly at 8.515.80]~~

A. Day Treatment means intensive therapeutic services scheduled on a regular basis for two or more hours per day, one or more days per week directed at the ongoing development of community living skills. Services take place in a non-residential setting separate from the home in which the member lives.

8.7416.01 Day Treatment Inclusions

A. Day Treatment includes the following components:
   i. Social skills training, sensory motor development, reduction/elimination of maladaptive behavior and services aimed at preparing the individual for

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community reintegration (reaching concepts such as compliance, attending, task completion, problem solving, safety, money management).

ii. Professional services including occupational therapy, physical therapy, speech therapy, vocational counseling, nursing, social work, recreational therapy, case management, and neuropsychology should be directly available from the provider or available as contracted services when deemed medically necessary by the treatment plan.

B. Certified occupational therapy aides, physical therapy aides, and communication aides may be used in lieu of direct therapy with fully licensed therapists to the extent allowed in existing state statute.

C. The provider shall coordinate with other community-based resources and providers.

i. Counseling and referrals to appropriate professionals when crisis situations occur with the member and family or staff.

ii. Behavioral programming which contains specific guidelines on treatment parameters and methods.

D. Transportation between therapeutic tasks in the community shall be included in the rate for day treatment.

8.7416.02 Day Treatment Provider Agency Requirements

A. Directors of day treatment programs shall have professional licensure in a health-related program in combination with at least 2 years of experience in head trauma rehabilitation programming.

B. Providers are required to have regular contact and meetings with the members and their families to discuss support plan progress and revision.

C. Day Treatment Services Physical Setting

i. Day treatment services must be provided out of an integrated, community-based setting.

ii. The day treatment location shall provide a clean and sanitary environment that is physically accessible to the members, including those members with supportive devices for ambulation or who are in wheelchairs.

iii. The day treatment location shall provide lockers or a safe and secure place for members' personal items.

iv. Day treatment centers shall provide age-appropriate activities and provide eating and resting areas consistent with the number and needs of the members being served.

8.7416.03 Day Treatment Provider Reimbursement Requirements

A. Day treatment services will be paid on a per diem basis at a rate to be determined by the Department. In order for a provider to be paid for a day of treatment, a member must have attended and received day treatment services for a minimum of 2 hours per day.

8.7417 Dental (SLS; DD) ~~[formerly at 8.500.94.B.4]~~

A. Dental services under the Developmental Disabilities (DD) Waiver and Supported Living Services (SLS) Waivers are available to members aged twenty-one (21) and over. Dental Services and are for diagnostic and preventative care to abate tooth decay, restore dental health, are medically appropriate and include preventative, basic and major dental services.

8.7417.01 Dental Inclusions

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A. Preventative services include:
   i. Dental insurance premiums, copayments/and coinsurance;
   ii. Periodic examination and diagnosis;
   iii. Radiographs when indicated;
   iv. Non-intravenous sedation;
   v. Basic and deep cleanings;
   vi. Mouth guards;
   vii. Topical fluoride treatment; and
   viii. Retention or recovery of space between teeth when indicated

B. Basic services include:
   i. Fillings;
   ii. Root canals;
   iii. Denture realigning or repairs;
   iv. Repairs/re-cementing crowns and bridges;
   v. Non-emergency extractions including simple, surgical, full and partial;
   vi. Treatment of injuries; or
   vii. Restoration or recovery of decayed or fractured teeth.

C. Major services include:
   i. Implants when necessary to support a dental bridge for the replacement of multiple missing teeth or are necessary to increase the stability of crowns of, crowns, bridges, and dentures. The cost of implants is only reimbursable with prior approval in accordance with The Department procedures.
   ii. Crowns.
   iii. Bridges.
   iv. Dentures.

8.7417.02 Dental Exclusions and Limitations

A. Dental services are provided only when the services are not available through the Medicaid State Plan due to not meeting the need for medical necessity as defined in Health Care Policy and Financing rules at Section 8.076.1.8, or available through a third party. General limitations to dental services including frequency will follow the The Department's guidelines using industry standards and are limited to the most cost effective and efficient means to alleviate or rectify the dental issue associated with the member.

B. Implants are a benefit only when the procedure is necessary to support a dental bridge for the replacement of multiple missing teeth or is necessary to increase the stability of dentures. The cost of implants is reimbursable only with prior authorization by the Administrative Service Organization.

C. Implants shall not be a benefit for members who use tobacco daily due to the substantiated increased rate of implant failures for chronic tobacco users.

D. Subsequent implants are not a covered service when prior implants fail.

E. Full mouth implants or crowns are not covered.

F. Dental services do not include cosmetic dentistry, procedures predominated by specialized prosthodontic, maxillo-facial surgery, craniofacial surgery or orthodontia, which includes, but is not limited to:
   i. Elimination of fractures of the jaw or face,
   ii. Elimination or treatment of major handicapping malocclusion, or
   iii. Congenital disfiguring oral deformities.

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G. Cosmetic dentistry is defined as aesthetic treatment designed to improve the appearance of the teeth or smile, including teeth whitening, veneers, contouring and implants or crowns solely for the purpose of enhancing appearance.

H. Preventative and basic services are limited to two thousand ($2,000) per support plan year. Major services are limited to ten thousand ($10,000) for the five (5) year renewal period of the waiver.

8.7418 Electronic Monitoring and Supports (EBD, CHMS, CIH, BI, SLS) ~~[formerly at 8.488]~~

8.7418.01 Electronic Monitoring and Supports Definitions

A. Backup support person means the person who is responsible for responding in the event of an emergency or when a member receiving Remote Supports otherwise needs assistance or the equipment used for delivery of Remote Supports stops working for any reason. Backup support may be provided on an unpaid basis by a family member, friend, or other person selected by the member or on a paid basis by an agency provider.

B. Electronic monitoring services means electronic equipment, [~~or~~] adaptations, or [~~other~~] remote supports that are related to an eligible person's disability and/or that enable the member to remain at home, and includes the installation, purchase, or rental of electronic monitoring devices which:

i. Enable the member to secure help in the event of an emergency;
ii. May be used to provide reminders to the member of medical appointments, treatments, or medication schedules;
iii. Are required because of the member's illness, impairment or disability {as identified and documented in the person centered support plan}. [~~as documented in the department prescribed LOC Screen, the Assessment, and Service Plan~~];
iv. Are essential to prevent institutionalization of the member; and,
v. May allow an off-site direct service provider to monitor and respond to a member's health, safety, and other needs using live communication.

C. Electronic monitoring provider means a provider agency as defined at Section 8.487 and Section 25.5-6-303. C.R.S., that has met [~~all~~] the [~~certification~~] {provider agency requirements} [~~standards~~] for electronic monitoring services specified in Section [8.488.40.]

D. {Medication Reminders are devices, controls, or appliances that remind or signal the participant to take actions related to medications including items necessary for the proper functioning of devices, controls, or appliances.}

E. Monitoring base means the off-site location from which the Remote Supports Provider monitors the member.

F. {Personal Emergency Response System (PERS) provides ongoing remote monitoring through a device designed to signal trained alarm monitoring personnel in an emergency situation.}

~~G.~~ Remote Supports mean the provision of support by staff at {a HIPPA compliant} Monitoring Base who [~~are~~] engage with a member [~~to~~] {through live two-way communication to} provide prompts and respond to the member's health, safety, and other needs {identified through a person-centered support plan to increase their independence in their home and community when not engaged other HCBS services}. [~~through technology/devices with the capability of live two-way communication.~~]

H. Remote supports provider means the provider agency selected by the member to provide Remote Supports.

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I. Sensor means equipment used to notify the Remote Supports Provider of a situation that requires attention or activity which may indicate deviations from routine activity and/or future needs. Examples include, but are not limited to, seizure mats, door sensors, floor sensors, motion detectors, heat detectors, and smoke detectors.

8.7418.02 Electronic Monitoring {and Supports} Inclusions

A. Electronic monitoring {and supports} services shall include personal emergency response systems, medication reminder systems, Remote Supports or other devices which comply with the definition above and are not included in the non-benefit items below at 10 CCR 2505-10 section 8.488.30.

i. Remote Supports services shall include but are not limited to the following technology options:

1. Motion sensing system;
2. Radio frequency identification;
3. Live audio feed;
4. Web-based monitoring system; or,
5. Another device that facilitates two-way communication.

ii. Remote Supports includes the following general provisions:

1. Remote Supports shall only be approved when it is the member's preference and will reduce the need for in-person care.
2. \Remote Supports may only be approved for personal care or homemaker tasks that the member can perform through coaching, prompts, supervision and consultations.\
3. The member, their case manager, and the selected Remote Supports provider shall determine whether Remote Supports is sufficient to ensure the member's health and welfare.
4. Remote Supports shall be provided in real time[~~, not via a recording,~~] by awake staff at a Monitoring Base using the appropriate technology. While Remote Support is being provided, the Remote Supports staff shall not have duties other than the provision of Remote Supports.

8.7418.03 Electronic Monitoring and Supports Exclusions and Limitations

A. Electronic Monitoring {and Supports} [~~Services~~] shall be authorized only for members who live alone, or who are alone for significant parts of the day, or whose only companion for significant parts of the day is too impaired to assist in an emergency, and who would otherwise require extensive supervision.

i. Remote Supports shall not be utilized for members who reside in any congregate or HCBS provider owned setting.

B. Electronic Monitoring {and Supports} [~~Services~~] shall be authorized only for members who have the physical and mental capacity to utilize the particular system requested for that member.

C. Electronic Monitoring {and Supports} [~~Services~~] shall not be authorized under HCBS if the service or device is available as a state plan Medicaid benefit.

D. \Electronic Monitor and Remote Supports shall not allow:

i. Video cameras in bathrooms.
ii. Security or alarm systems solely intended to protect the home or property.
iii. Visual or audio recording.

E. Should immobile devices be used for two-way communication, the device must be located in a common area; otherwise, members will have the ability to move two-way communication devices freely throughout their residence.\

F. The following are not benefits of electronic monitoring {and supports} [~~Services~~]:

i. Augmentative communication devices and communication boards;
ii. Hearing aids and accessories;
iii. Phonic ears;

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iv. Environmental control units, unless required for the medical safety of a member living alone unattended; or as part of Remote Supports;
v. Computers and computer software unrelated to the provision of Remote Supports;
vi. Wheelchair lifts for automobiles or vans
vii. Exercise equipment, such as exercise cycles; or
viii. Hot tubs, Jacuzzis, or similar items.

8.7418.04 Electronic Monitoring {and Supports} Provider Agency Requirements

A. ~~[Electronic monitoring providers shall conform to all general certification standards and procedures at Section 8.487, EBD WAIVER PROVIDER AGENCIES.]~~
B. Electronic monitoring {and supports} providers shall conform to the following standards for electronic monitoring services:
i. All equipment, materials or appliances used as part of the electronic monitoring service shall carry a UL (Underwriter's Laboratory) number or an equivalent standard. All telecommunications equipment shall be FCC registered.
ii. All equipment, materials or appliances shall be installed by properly trained individuals, and the installer and/or provider of electronic monitoring shall train the member in the use of the device.
iii. All equipment, materials or appliances shall be tested for proper functioning at the time of installation, and at periodic intervals thereafter, and be maintained based on the manufacturer's recommendations. Any malfunction shall be promptly repaired, and equipment shall be replaced when necessary, including buttons and batteries.
iv. All telephone calls generated by ~~[electronic]~~ monitoring equipment shall be toll-free, and all members shall be allowed to run unrestricted tests on their equipment.
v. Electronic monitoring {and supports} providers shall send written information to each member's case manager about the system, how it works, and how it will be maintained.

8.7418.05 {Remote Supports} Provider Requirements

A. ~~[Remote Supports Providers shall conform to the following additional standards for provision of Remote Supports services:~~
i. ~~When Remote Supports includes the use of live audio and/or video equipment that permits a Remote Supports Provider to view activities and/or listen to conversations in the residence, the member who receives the service and each person who lives with the member shall consent in writing after being fully informed of what Remote Support entails including, but not limited to:~~
1. ~~The Remote Supports Provider will observe their activities and/or listen to their conversations in the residence;~~
2. ~~The location in the residence where the Remote Supports service will take place; and,~~
3. ~~Whether or not the Remote Supports provider will record audio and/or video.~~
4. ~~If the member or a person who lives with the member has a guardian, the guardian shall consent in writing. The member's Case Manager and Remote Supports Provider shall keep a copy of each signed consent form.]~~
ii. The Remote Support Provider shall provide a member who receives Remote Supports with initial and ongoing training on how to use the Remote Supports system(s)
iii. The Remote Supports Provider shall provide initial and ongoing training to its staff to ensure they know how to use the Monitoring Base System.

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iv. The Remote Supports provider shall have a backup power system (such as battery power and/or generator) in place at the Monitoring Base in the event of electrical outages. The Remote Supports Provider shall have additional backup systems and additional safeguards in place which shall include, but are not limited to, contacting the Backup Support Person in the event the Monitoring Base System stops working for any reason.

v. The Remote Support Provider shall have an effective system for notifying emergency personnel in the event of an emergency.

vi. If a known or reported emergency involving a member arises, the Remote Supports Provider shall immediately assess the situation and call emergency personnel first, if that is deemed necessary, and then contact the Backup Support Person. The Remote Supports Provider shall maintain contact with the member during an emergency until emergency personnel or the Backup Support Person arrives.

vii. The Backup Support Person shall verbally acknowledge receipt of a request for assistance from the Remote Supports Provider. Text messages, email, or voicemail messages will not be accepted as verbal acknowledgment.

viii. When a member requests in-person assistance, the Backup Support Person shall arrive at the member's location within a reasonable amount of time (to be specified in documentation maintained by the Remote Support Provider.

ix. When a member needs assistance, but the situation is not an emergency, the Remote Supports provider shall:
    1. Address the situation from the Monitoring Base, or,
    2. Contact the member's Backup Support Person if necessary.

x. The Remote Support Provider shall maintain detailed and current written protocols for responding to a member's needs, including contact information for the Backup Support Person to provide assistance.

xi. The Remote Support Provider shall maintain documentation of the protocol to be followed should the member request that the equipment used for delivery of Remote Supports be turned off.

xii. The Remote Supports Provider shall maintain daily service provision documentation\, including electronic verification of visits requirements related to personal care and homemaker tasks,\ that shall include the following:
    1. Type of Service;
    2. Date of Service;
    3. Place of Service;
    4. Name of member receiving service;
    5. Medicaid identification number of member receiving service;
    6. Name of Remote Supports Provider;
    7. Identify the Backup Support Person and their contact information, if/when utilized;
    8. Begin and end time of the Remote Supports service;
    9. Begin and end time of the Remote Supports service when a Backup Support Person is needed on site;
    10. Begin and end time of the Backup Support Person when on site, whether paid or unpaid;

xiii. Number of units of Remote Supports service delivered per calendar day; and

xiv. Description and details of the outcome of providing Remote Supports, and any new or identified needs that are outside of the individual's current Service Plan, which shall be communicated to the individual's case manager.

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8.7418.06 Electronic Monitoring and {Supports} Reimbursement

A. Payment for Electronic Monitoring Services shall be the lower of the billed charges or the prior authorized amount.

B. For Electronic Monitoring, excluding Remote Supports, the unit of reimbursement shall be one unit per service for non-recurring services, or one unit per month for services recurring monthly.

C. For Remote Supports, the unit of reimbursement shall include one unit per installation/equipment purchase and/or the units as designated on the Department's fee schedule and/or billing manuals for ongoing Remote Supports service.

~~D.~~ There shall be no reimbursement under this section for Electronic Monitoring {and Supports} Services provided {in provider owned settings}. [~~in uncertified congregate facilities.~~]

8.7419 Expressive Therapy-Art, Music, Play Therapy (CLII) ~~[formerly at 8.504.05.6.E]~~

~~A.~~ Expressive Therapy means creative art, music or play therapy which provides ~~[children]~~ [members] the ability to express their medical situation creatively and kinesthetically for the purpose of allowing the member to express feelings of isolation, to improve communication skills, to decrease emotional suffering due to health status, and to develop coping skills.

8.7419.01 Expressive Therapy Inclusions

A. Expressive Therapy may be provided in an individual or group setting.

8.7419.02 Expressive Therapy Exclusions and Limitations

A. Expressive Therapy is limited to the member's assessed need up to a maximum of 39 hours per annual ~~[certification period~~] [person centered service plan year].

8.7419.03 Expressive Therapy Provider Agency Requirements

A. Individuals providing Expressive Therapy shall enroll with the fiscal agent or be employed by a qualified Medicaid home health or hospice agency.

i. Individuals providing Expressive Therapy delivering art or play therapy services shall meet the requirements for individuals providing Therapeutic Life Limiting Illness Support services and shall have at least one year of experience in the provision of art or play therapy to pediatric/adolescent members.

ii. Individuals providing Expressive Therapy delivering music therapy services shall hold a Bachelor's, Master's or Doctorate in Music Therapy, maintain certification from the Certification Board for Music Therapists, and have at least one year of experience in the provision of music therapy to pediatric/adolescent members.

8.7420 Habilitation (CHRP) ~~[formerly at 8.508.100.A-F]~~

8.7420.01 CHRP Habilitation Inclusions

A. CHRP Habilitation is a twenty-four (24) hour service {that includes those that assist a member in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. Service components include the following: }

i. Independent living training, which may include personal care, household services, infant and childcare when the ~~[Client]~~ [member] has a child, and communication skills.

ii. Self-advocacy training and support which may include assistance and teaching of appropriate and effective ways to make individual choices, accessing needed services, asking for help, recognizing Abuse, Neglect, Mistreatment, and/or Exploitation of self, responsibility for one's own actions, and participation in meetings.

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B. Cognitive services which include ~~[s]~~ assistance with additional concepts and materials to enhance communication. {Cognitive Services are intended to help the member better understand cause and effect and the connection between behaviors and consequences. Services may also include training in repetitive directions, staying on task, levels of receptive language capabilities, and retention of information.}

C. Emergency assistance which includes safety planning, fire and disaster drills, and crisis intervention.

D. Community access supports which includes assistance developing the abilities and skills necessary to enable the [member] to access typical activities and functions of community life such as education, training, and volunteer activities. Community access supports includes providing a wide variety of opportunities to develop socially appropriate behaviors, facilitate and build relationships and natural supports in the community while utilizing the community as a learning environment to provide services and supports as identified in the ~~[Client's Service Plan]~~ [member's person centered support plan]. These activities are conducted in a variety of settings in which the member interacts with non-disabled individuals (other than those individuals who are providing services to the [member]). These services may include socialization, adaptive skills, and personnel to accompany and support the [member] in community settings, resources necessary for participation in activities and supplies related to skill acquisition, retention, or improvement and are based on the interest of the [member].

E. Transportation services are encompassed within Habilitation and are not duplicative of the non-emergent medical transportation that is authorized in the Medicaid State Plan. Transportation services facilitate member access to activities and functions of community life.

F. Follow-up counseling, behavioral, or other therapeutic interventions, and physical, occupational or speech therapies delivered under the direction of a licensed or certified professional in that discipline.

G. Medical and health care services that are integral to meeting the daily needs of the member and include such tasks as routine administration of medications or providing support when the member is ill.

8.7420.02 CHRP Habilitation Service Requirements

A. Services may be provided to members who require additional care for the member to remain safely in home and community-based settings. The member must demonstrate the need for such services above and beyond those of a typical child of the same age.

B. Habilitation services under the CHRP waiver differ in scope, nature, supervision, and/or provider type (including provider training requirements and qualifications) from any other services in the Medicaid State Plan.

C. Habilitation may be provided in a Foster Care Home or Kinship Foster Care Home certified by a licensed Child Placement Agency or County Department of Human Services, Specialized Group Facility licensed by the Colorado Department of Human Services, or Residential Child Care Facility licensed by the Colorado Department of Human Services.

D. Habilitation may be provided for members aged eighteen (18) to twenty (20) in a Host Home. The Host Home must meet all requirements as defined in Section 8.600.

E. Service Providers and child placement agencies must comply with the habilitation capacity limits must not exceed limits at 12 CCR 2505-8 7.701.2, 7.702.1.A.2, 7.710.41.C (2022), which are hereby incorporated by reference. Pursuant to Section 24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular

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business hours at 1570 Grant Street, Denver, CO, 80203. Copies of incorporated materials are provided at cost upon request.

8.7420.03 CHRP Habilitation Provider Agency Requirements

A. The Service Provider or child placement agency shall ensure choice is provided to all ~~[Clients]~~ [members] in their living arrangement.

B. The Foster Care Home or Kinship Foster Care Home provider must ensure a safe environment and safely meet the needs of all ~~[Clients]~~ [members] living in the home.

C. The Service Provider shall provide the [Case Management Agency] (CMA) a copy of the Foster Care Home or Kinship Foster Care Home certification before any child or youth can be placed in that home. If emergency placement is needed outside of business hours, the provider agency or child placement agency shall provide the CMA a copy of the Foster Care Home or Kinship Foster Care Home certification the next business day.

D. Provider agencies for habilitation services and services provided outside the family home shall meet all of the certification, licensing, waiver, and quality assurance regulations related to their provider type.

8.7420.04 CHRP Habilitation Reimbursement

A. A Support Need Level Assessment must be completed upon determination of eligibility. The Support Need Level Assessment is used to determine the level of reimbursement for Habilitation ~~[and per diem Respite~~] services.

B. Reimbursement for Habilitation service does not include the cost of normal facility maintenance, upkeep, and improvement. This exclusion does not include costs for modifications or adaptations required to assure the health and safety of ~~[Client]~~ [member] or to meet the requirements of the applicable life safety code.

C. Room and board shall not be a benefit of habilitation services. Members shall be responsible for room and board, per XXX.

8.7421 {Self-Directed} Health Maintenance [Activities ~~(SLS; CHCBS, (CFC))] [formerly at 8.500.94.B.5, CDASS, IHSS]~~

A. Health maintenance activities means routine and repetitive health related tasks furnished to an eligible member in the community or in the member's home, which are necessary for health and normal bodily functioning that a person with a disability is unable to physically carry out.

8.7422.01 Health Maintenance [Activities] Inclusions

A. {As part of Consumer Directed Attendant Support Services within the HCBS-BI, HCBS-CIH, HCBS-CMHS, HCBS-EBD, and HCBS-SLS waivers.}

B. {As part of In-Home Support Services within the HCBS-CHCBS, HCBS-CIH, and HCBS-EBD waivers.}

i. ~~[Health maintenance activities are available only as a participant directed supported living service in accordance with Section 8.500.94.C.]~~

ii. {Services may include:

1. Skin care, when the skin is broken, or a chronic skin condition is active and could potentially cause infection and the member 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.}

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

a. The member is unable to complete task independently;

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   b. **Application of a prescribed shampoo/conditioner which has been dispensed by a pharmacy; or**
   c. **The member has open wound(s) or neck stoma(s).**
3. {Nail care in the presence of medical conditions that may involve peripheral circulatory problems or loss of sensation; includes soaking, filing, and trimming.
4. Mouth care performed when health maintenance level skin care is required in conjunction with the task, or:
   a. There is injury or disease of the face, mouth, head, or neck;
   b. In the presence of communicable disease;
   c. When the member is unable to participate in the task;
   d. Oral suctioning is required;
   e. There is decreased oral sensitivity or hypersensitivity;
   f. member is at risk for choking and aspiration.}
5. **\Shaving performed when health maintenance level skin care is required in conjunction with the shaving, or:**
   a. **The member has a medical condition involving peripheral circulatory problems;**
   b. **The member has a medical condition involving loss of sensation;**
   c. **The member has an illness or takes medications that are associated with a high risk for bleeding;**
   d. **The member has broken skin at/near shaving site or a chronic active skin condition.**
6. {Dressing performed when health maintenance-level skin care or transfers are required in conjunction with the dressing, or:}
   ~~a. \The member is unable to assist or direct care;\~~
   b. {Assistance with the application of prescribed anti-embolic or pressure stockings is required;
   c. Assistance with the application of prescribed orthopedic devices such as splints, braces, or artificial limbs is required.
7. Feeding is considered a health maintenance task when the member requires health maintenance-level skin care or dressing in conjunction with the task, or:
   a. Oral suctioning is needed on a stand-by or intermittent basis;
   b. The member is on a prescribed modified texture diet;
   c. The member has a physiological or neurogenic chewing or swallowing problem;
   d. Syringe feeding or feeding using adaptive utensils is required;
   e. Oral feeding when the member is unable to communicate verbally, non-verbally or through other means.
8. Exercise including passive range of motion. Exercises must be specific to the member's documented medical condition and require hands on assistance to complete.
   a. For CDASS, [home] exercise [plan] must be prescribed by a Licensed Medical Professional, **\Occupational Therapist, or Physical Therapist\.**

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9. Transferring a member when they are not able to perform transfers independently due to illness, injury, or disability, or:
    a. The member lacks the strength and stability to stand, maintain balance or bear weight reliably;
    b. The member has not been deemed independent with adaptive equipment or assistive devices by a Licensed Medical Professional;
    c. The use of a mechanical lift is needed.
10. Bowel care performed when health maintenance-level skin care or transfers are required in conjunction with the bowel care, or:}
    ~~a. \The member is unable to assist or direct care;\~~
    b. {Administration of a bowel program including but not limited to digital stimulation, enemas, or suppositories;
    c. 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.
11. Bladder care performed when health maintenance-level skin care or transfers are required in conjunction with bladder care, or;}
    ~~a. \The member is unable to assist or direct care;~~
    b. {Care of external, indwelling, and suprapubic catheters;
    c. Changing from a leg to a bed bag and cleaning of tubing and bags as well as perineal care.
    d. 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.
    e. 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.
12. Bathing assistance is considered a health maintenance task when the member requires health maintenance-level skin care, transfers or dressing in conjunction with bathing.
13. Medication assistance, which may include setup, handling and administering medications.
    a. For IHSS only, The IHSS Agency's Licensed Health Care Professional must validate Attendant skills for medication administration and ensure that the completion of task does not require clinical judgment or assessment skills.
14. Accompanying includes going with the member, as necessary according to the care plan, to medical appointments, and errands such as banking

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

15. Mobility assistance is considered a health maintenance task when health maintenance-level transfers are required in conjunction with the mobility assistance, or:}
    - ~~a. \The member is unable to assist or direct care;\~~
    - b. {When hands-on assistance is required for safe ambulation and the member is unable to maintain balance or to bear weight reliably due to illness, injury, or disability; and/or
    - c. The member has not been deemed independent with adaptive equipment or assistive devices ordered by a Licensed Medical Professional
    - d. Positioning includes moving the member from the starting position to a new position while maintaining proper body alignment, support to a member's extremities and avoiding skin breakdown. May be performed when health maintenance level skin care is required in conjunction with positioning, or;}
        - ~~i. \The member is unable to assist or direct care, or\~~
        - ii. {The member is unable to complete task independently}
    - **e. \Health Maintenance Activity tasks can be approved at the discretion of the Department if not all rule criteria are met but the member still presents a need for skilled care for the specific task\.**

~~i. [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,~~

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

~~iii. Mouth care performed when:~~

~~a. there is injury or disease of the face, mouth, head or neck,~~

~~b. in the presence of communicable disease,~~

~~c. the member is unconscious, or~~

~~d. oral suctioning is required,~~

~~iv. 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,~~

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~~v. Feeding~~

~~a. When suctioning is needed on a stand-by or other basis,~~

~~b. 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,~~

~~c. Syringe feeding, OR~~

~~d. Feeding using an apparatus,~~

~~vi. Exercise prescribed by a licensed medical professional including passive range of motion,~~

~~vii. Transferring a member when he/she is unable to assist or the use of a lift such as a Hoyer is needed,~~

~~viii. Bowel care provided to a member including digital stimulation, enemas, care of ostomies, and insertion of a suppository if the member is unable to assist,~~

~~iv. 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,~~

~~v. Medical management required by a medical professional to monitor blood pressures, pulses, respiratory assessment, blood sugars, oxygen saturations, pain management, intravenous, or intramuscular injections,~~

~~vi. Respiratory care, including:~~

~~a. Postural drainage,~~

~~b. Cupping,~~

~~c. Adjusting oxygen flow within established parameters,~~

~~d. Suctioning of mouth and nose,~~

~~e. Nebulizers,~~

~~f. Ventilator and tracheostomy care,~~

~~g. Prescribed respiratory equipment.~~

~~B. HCBS CHILD HOME AND COMMUNITY BASED SERVICES (CHCBS) WAIVER:~~

~~1. IHSS for CHCBS members shall be limited to tasks defined as Health Maintenance Activities as set forth in Section 8.552.~~

~~2. Family members of a member can only be reimbursed for extraordinary care.]~~

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8.7422 Hippotherapy (CES; SLS; CHRP) ~~[formerly at 8.503.40.A.4; 8.508.100.G]~~

A. Hippotherapy [means] [is a] therapeutic treatment strategy that uses the movement of a horse to assist in the development [/] [or] enhancement of skills including gross motor, sensory integration, attention, cognitive, social, behavioral, and communication [skills].

8.7422.01 Hippotherapy Inclusions

A. Hippotherapy is included when it meets an identified need in the ~~[Service Plan]~~ [Person Centered Support Plan].

8.7422.02 Hippotherapy Exclusions and Limitations

A. HCBS Children's Extensive Services (CES) Waiver; HCBS Supportive Living Services (SLS); HCBS Children's Habilitation Residential Program (CHRP) Waiver:

i. The following items are excluded under the HCBS waivers and are not eligible for reimbursement:

~~1. [Acupuncture,~~
~~2. Chiropractic care,~~
~~3. Fitness trainer,]~~
4. Equine therapy,
~~5. [Art therapy,~~
~~6. Warm water therapy,]~~
7. Experimental treatments or therapies, and

ii. Hippotherapy is not available if it is available under the Medicaid State Plan, {Early and Periodic Screening, Diagnostic and Treatment (EPSDT)}, or from a Third-Party Resource.

8.7422.03 Hippotherapy Service Provider Agency Requirements

A. {Hippotherapy must be recommended or prescribed by a licensed physician or therapist who is enrolled as a Medicaid provider.

B. The recommendation must clearly identify the need for hippotherapy, recommended treatment, and expected outcome.}

8.7423 Home Delivered Meals EBD, CHMS, CIH, BI, SLS, DD, (CFC) 8.553.4

8.7423.01 Home Delivered Meals Definitions

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

8.7423.02 Home Delivered Meals Inclusions

A. To obtain approval for Home Delivered Meals, the member must demonstrate a need for the service, as follows:

1. The member demonstrates a need for nutritional counseling, meal planning, and preparation;
2. The member shows documented dietary restrictions or specific nutritional needs;
3. The member lacks or has limited access to outside assistance, services, or resources through which they can access meals with the type of nutrition vital to meeting their dietary restrictions or special nutritional needs;
4. The member is unable to prepare meals with the type of nutrition vital to meeting their dietary restrictions or special nutritional needs;
5. The member's inability to access and prepare nutritious meals demonstrates a need-related risk to health, safety, or institutionalization

B. To establish eligibility for Home Delivered Meals, for members transitioning into the community, the member must satisfy general criteria for accessing service:

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1. The member is transitioning from an institutional setting to a home and community-based setting, or is experiencing a qualifying change in life circumstance that affects a member's stability and endangers their ability to remain in the community;
2. The member demonstrates a need to develop or sustain independence to live or remain in the community upon their transitioning; and
3. The member demonstrates that they need the service to establish community supports or resources where they may not otherwise exist.
4. Members accessing Home Delivered Meals post-hospital discharge must have been discharged from the hospital following a 24-hour admission.

8.7423.03 Home Delivered Service Requirements:

A. The member's Person-Centered Support Plan must specifically identify:
   1. The member's need for individualized nutritional counseling and development of a Nutritional Meal Plan, which describes the member's nutritional needs and selected meal types, and provides instructions for meal preparation and delivery; and
   2. The member's specifications for preparation and delivery of meals, and any other detail necessary to effectively implement the individualized meal plan.

A. The service must be provided in the home or community and in accordance with the member's Person-Centered Support Plan. All Home Delivered Meal services shall be documented in the Person-Centered Support Plan.
B. For members transitioning into the community, the assessed need is documented in the member's Person-Centered as part of their skills acquisition process of gradually becoming capable of preparing their own meals or establishing the resources to obtain their needed meals.
C. Members transitioning into the community may be approved for Home Delivered Meals for no more than 365 days. The Department, in its sole discretion, may grant an exception based on extraordinary circumstances.
D. Members accessing meals post-hospital discharge may be approved for Home Delivered Meals for no more than 30 days post qualifying hospital discharge. Benefit may be accessed for no more than two 30-day periods during a member's certification period.
E. Meals are to be delivered up to two meals per day, with a maximum of 14 meals delivered per week.
F. Meals may include liquid, mechanical soft, or other medically necessary types.
G. Meals may be ethnically or culturally-tailored.
H. Meals may be delivered hot, cold, frozen, or shelf-stable, depending on the member's or caregiver's ability to complete the preparation of, and properly store the meal.
I. The provider shall confirm meal delivery to ensure the member receives the meal in a timely fashion, and to determine whether the member is satisfied with the quality of the meal.
J. For members transitioning into the community, the providing agency's certified RD or RDN will check in with the member no less frequently than every 90 days to ensure the meals are satisfactory, that they promote the member's health, and that the service is meeting the member's needs.
K. For members transitioning into the community, the RD or RDN will review a member's progress toward the nutritional goal(s) outlined in the member's Person-Centered

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Support Plan no less frequently than once per calendar quarter, and more frequently, as needed.

L. For members transitioning into the community, the RD or RDN shall make changes to the Nutritional Meal Plan if the quarterly assessment results show changes are necessary or appropriate.

i. For members transitioning into the community, the RD or RDN will send the Nutritional Meal Plan to the Case Management Agency no less frequently than once per quarter to allow the Case Management Agency to verify the plan with the member during the quarterly check-in, and to make corresponding updates to the Person-Centered Support Plan, as needed.

8.7423.04 Home Delivered Meals Exclusions and Limitations

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

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

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

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

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

8.7423.05 Home Delivered Provider Agency Requirements

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

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

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

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

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

1. Documentation pertaining to the provider agency, including employee files, claim submission documents, program and financial records, insurance policies, and licenses, including a Retail Food License and Food Handling License for Staff, or, if otherwise applicable, documentation of compliance and good

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standing with the City and County municipality in which this service is provided; and

2. Documentation pertaining to services, including:
   i. A signed authorization from appropriate licensed professional for dietary restrictions or specific nutritional needs;
   ii. Member demographic information;
   iii. A Meal Delivery Schedule;
   iv. Documentation of special diet requirements;
   v. A determination of the type of meal to be provided (e.g. hot, cold, frozen, shelf stable);
   vi. A record of the date(s) and place(s) of service delivery;
   vii. Monitoring and follow-up (contacting the member after meal deliver to ensure the member is satisfied with the meal); and
   viii. Provision of nutrition counseling or documentation of member declination.

8.7423.06 Home Delivered Meals Provider Agency Reimbursement:

A. Home Delivered Meals services are reimbursed based on the number of units of service provided, with one unit equal to one meal.
B. Payment for Home Delivered Meals shall be the lower of the billed charges or the maximum rate of reimbursement.
C. Reimbursement is limited to services described in the Person-Centered Support Plan.

8.7424 Home Accessibility {Modifications and Adaptations} [~~and Modifications~~] (EBD, CMHS, CIH, BI, SLS, CES) ~~[formerly at 8.493;]~~

8.7424.01 Home Accessibility and Modifications Definitions

A. ~~[Case Management Agency (CMA) means an agency within a designated service area where an applicant or client can obtain Case Management services. CMAs include Single Entry Points (SEP), Community Centered Boards (CCB), and private case management agencies.~~
B. ~~Case Manager means an individual employed by a CMA who is qualified to perform the following case management activities: determination of an individual client's functional eligibility for the Home and Community Based Services (HCBS) waivers, development and implementation of an individualized and person-centered care plan for the member, coordination and monitoring of HCBS waiver services delivery, evaluation of service effectiveness, and the periodic reassessment of such client's needs.~~
C. ~~Department means the Department of Health Care Policy and Financing.]~~
D. The Division of Housing (DOH) is a State entity within the Department of Local Affairs that is responsible for approving Home Modification PARs, oversight on the quality of Home Modification projects, and inspecting Home Modification projects, as described in
E. Eligible member means a member who is enrolled in the following Home and Community-Based Services waivers: Brain Injury, Complementary and Integrative Health, Community Mental Health Supports, or Elderly, Blind and Disabled, {Supported Living Services (SLS) and Children's Extensive Supports (CES)}
F. Home Modification means specific modifications, adaptations or improvements in an eligible member's existing home setting which, based on the member's medical condition:
   i. Are necessary to ensure the health, welfare and safety of the member and

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ii. Enable the member to function with greater independence in the home, and
iii. Are required because of the member's illness, impairment or disability, as documented on the Assessment and support plan; and
iv. Prevents institutionalization or supports the deinstitutionalization of the member.

G. Home Modification Provider means a provider agency that has met all the standards for Home Modification and is an enrolled Medicaid provider.

H. ~~[Person-Centered Planning as applies to Home Modifications means that Home Modifications shall be agreed upon through a process that is driven by the individual member and can include people chosen by the client, as well as the appropriate health care professionals, providers, and appropriate state and local officials or organizations. The home modification process provides necessary information, support, and choice to the member to ensure that the member directs the process to the maximum extent possible. member choice shall be documented throughout according to Department prescribed processes and procedures.]~~

8.7424.02 Home Modification Inclusions

A. Home Modifications, adaptations, or improvements may include but are not limited to the following:
i. Installing or building ramps.
ii. Installing grab-bars and installing other Durable Medical Equipment (DME) items if such installation cannot be performed by a DME supplier.
iii. Widening doorways.
iv. Modifying [~~bathrooms.~~] {a bathroom facility for the purposes of accessibility, health and safety, and independence in Activities of Daily Living}
v. Modifying kitchen facilities.
vi. Installing specialized electric and plumbing systems that are necessary to accommodate medically necessary equipment and supplies.
vii. Installing stair lifts or vertical platform lifts.
viii. Modifying an existing second exit or egress window for emergency purposes.
1. The modification of a second exit or egress window must be approved by the Department or its agent as recommended by an occupational or physical therapist (OT/PT) for the health, safety, and welfare of the member.

B. Previously completed home modifications, regardless of original funding source, shall be eligible for maintenance or repair within the member's remaining [~~lifetime cap~~]{money} while remaining subject to [8.493.3(to be updated, Exclusions and Limitations.]

C. {HCBS EBD,CMHS,CIH,BI Waivers}
i. There shall be a lifetime cap of $14,000 per member. The Department may authorize funds in excess of the member's lifetime cap if there is:
1. An immediate risk of the member being institutionalized; or
2. A significant change in the member's needs since a previous home modification.

D. \HCBS SLS and CES Waivers
i. The combined cost of Home Accessibility Adaptations, Vehicle Modifications, and Assistive Technology shall not exceed $10,000 per member Participant.
ii. Costs that exceed this cap may be approved by the Department or DOH to ensure the health, and safety of the member Participant, or enable the member to function with greater independence in the home, if:
1. The adaptation decreases the need for paid assistance in another waiver service on a long-term basis, and
2. Either:
a. There is an immediate risk to the member's health or safety, or

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b. There has been a significant change in the member's needs since a previous Home Accessibility Adaptation.\

8.7424.03 Home Modification Exclusions and Limitations

A. Home Modifications must be a direct benefit to the member as defined in [10 CCR 2505-10 Section 8.493.1(needs to be updated)] and not for the benefit or convenience of caregivers~~, [family members,]~~ or other residents of the home.

B. Duplicate adaptations, improvements, or modifications are not a benefit. This includes, but is not limited to, multiple bathrooms within the same home.

C. Adaptations, improvements, or modifications as a part of new construction costs are not a benefit.

i. \Finishing unfinished areas in a home to add to or complete habitable square footage is prohibited.

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

1. improve entrance or egress to a residence; or,
2. configure a bathroom to accommodate a wheelchair.

iii. Any request to add square footage to the home must be approved by the Department or DOH and shall be prior authorized in accordance with Department procedures.\

D. The purchase of {items available through the Durable Medical Equipment (DME) is not a benefit.} ~~[Durable Medical Equipment (DME) is not a benefit.]~~

E. \Adaptations or improvements to the home that are considered to be on-going homeowner maintenance and are not related to the member's ability and needs are prohibited.

F. Upgrades beyond what is the most cost-effective means of meeting the member's identified need, including, but not limited to, items or finishes required by a Homeowner Association's (HOA), items for caregiver convenience, or any items and finishes beyond the basic required to meet the need, are prohibited.

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

i. Roof repair,
ii. Central air conditioning,
iii. Air duct cleaning,
iv. Whole house humidifiers,
v. Whole house air purifiers,
vi. Installation and repair of driveways and sidewalks, unless the most cost-effective means of meeting the identified need,
vii. Monthly or ongoing home security monitoring fees,
viii. Home furnishings of any type,
ix. HOA fees.\

H. The Department may deny requests for Home Modification projects that exceed usual and customary charges or do not meet local building requirements, the LTSS Home Modification Benefit Construction Specifications developed by the Division of Housing (DOH), or industry standards. The LTSS Home Modification Benefit Construction Specifications (2016) are hereby incorporated by reference. The incorporation of these guidelines excludes later amendments to, or editions of, the referenced material. The 2016 LTSS Home Modification Benefit Construction Specifications can be found on the Department website. Pursuant to §24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver Colorado 80203. Certified copies of incorporated materials are provided at cost upon request.

I. Home Modification ~~[projects are not a benefit in any type of certified or non-certified congregate facility, as defined in 10 CCR 2505-10 Section 8.485.50.F and G.]~~ {projects

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are prohibited in any type of certified or non-certified congregate facility, including, but not limited to, Assisted Living Residences, Nursing Facilities, Group Homes, Host Homes, and any settings where accessibility or safety modifications to the location are included in the provider reimbursement.}

J. Volunteer work on a Home Modification project approved by the Department shall be completed under the supervision of the Home Modification Provider as stated on the bid.
   i. Volunteer work performed by Department-approved organizations must be described according to Department prescribed processes and procedures. A list of these organizations can be found on the Department website.
   ii. Work performed by an unaffiliated party, such as, but not limited to, volunteer work performed by a friend or family member, or work performed by a private contractor hired by the member or family, must be described and agreed upon, in writing, by the provider responsible for completing the home modification, according to Department prescribed processes and procedures.

K. If a member lives in a property where adaptations, improvements, or modifications as a reasonable accommodation through federally funded assisted housing are required by the Fair Housing Act, the member's Home Modification funds may not be used unless reasonable accommodations have been denied. The Fair Housing Act (42 U.S.C. § 3601, et seq.)(1995) is hereby incorporated by reference. The incorporation of this Act excludes later amendments to, or editions of, the referenced material. Pursuant to §24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver Colorado 80203. Certified copies of incorporated materials are provided at cost upon request.

8.7424.04 Home Modification Case Management Agency Responsibilities

A. The Case Manager shall consider alternative funding sources to complete the Home Modification~~[, including, but not restricted to those sources identified and recommended by the Department and DOH on the Department website.]~~ These alternatives and the reason they are not available shall be documented in the case record.
   i. The Case Manager must confirm that the member is unable to receive the proposed adaptations, improvements, or modifications as a reasonable accommodation through federally funded assisted housing as required by the Fair Housing Act.

B. The Case Manager may approve Home Modification projects estimated at less than $2,500 without ~~[prior authorization]~~{Department approval}, contingent on member authorization and confirmation of Home Modification fund availability.

C. The Case Manager shall obtain prior approval by submitting a Prior ~~[Authorization]~~ request ~~[form (PAR)]~~ to the Department for Home Modification projects estimated at between $2,500 and $14,000.
   i. The Case Manager must submit the ~~[required PAR]~~ {request} and all supporting documentation according to Department prescribed processes and procedures. Home Modification requests submitted with improper documentation cannot be authorized.
   ii. The Case Manager and CMA are responsible for retaining and tracking all documentation related to a ~~[client's]~~{members previous} home modification {benefit} ~~[lifetime cap]~~ use and communicating that information to the ~~[client]~~ {member} and providers. The Case Manager may request confirmation of a ~~[client's]~~{members} home modification ~~[lifetime cap]~~ use from the Department, its fiscal agent, or DOH.

D. Home Modifications estimated to cost $2,500 or more shall be evaluated according to the following procedures:

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i. An occupational or physical therapist (OT/PT) shall assess the ~~[client's]~~ {members} needs and the therapeutic value of the requested Home Modification. When an OT/PT with experience in Home Modification is not available, a Department-approved qualified individual may be substituted. An evaluation specifying how the Home Modification would contribute to a ~~[client's]~~{members} ability to remain in or return to ~~[his/her]~~ {their} home, and how the Home Modification would increase the individual's independence and decrease the need for other services, shall be completed before bids are solicited. This evaluation shall be submitted with the PAR.

ii. The evaluation services may be provided by a home health agency or other qualified and approved OT/PT through Medicaid Home Health consistent with Home Health rules set forth in Section 8.520, including physician orders and plans of care.

1. A Case Manager may initiate the OT/PT evaluation process before the ~~[client]~~ {member} has been approved for waiver services, as long as the ~~[client]~~ {member} is Medicaid eligible.
2. A Case Manager may initiate the OT/PT evaluation process before the ~~[client]~~ {member} physically resides in the home to be modified, as long as the current property owner agrees to the evaluation.

iii. The Case Manager and the OT/PT shall consider less expensive alternative methods of addressing the ~~[client's]~~ {members} needs. ~~[The Case Manager shall document these alternatives in the client's case file.]~~

E. The Case Manager shall solicit bids according to the following procedures:

i. The Case Manager shall solicit bids from at least two Home Modification Providers.

1. The Case Manager must verify that the provider is an enrolled Home Modification Provider.
2. The bids must be submitted according to Department prescribed processes and procedures ~~[as found on the Department website.]~~

ii. The bids shall include a breakdown of the costs of the project including:

1. Description of the work to be completed.
2. Description and estimate of the materials and labor needed to complete the project. Material costs should include price per square foot for materials purchased by the square foot. Labor costs should include price per hour.
3. Estimate for building permits, if needed.
4. Estimated timeline for completing the project.
5. Name, address and telephone number of the Home Modification Provider.
6. Signature, including option for digital signature, of the Home Modification Provider.
7. Signature, including option for digital signature, of the ~~[client]~~ {member or guardian} or other indication of approval.
8. Signature, including option for digital signature, of the homeowner or property manager if applicable.

iii. Home Modification Providers have a maximum of thirty (30) days to submit a bid for the Home Modification project after the Case Manager has solicited the bid.

1. If the Case Manager has made three attempts to obtain a written bid from a Home Modification Provider and the Home Modification Provider has not responded within thirty (30) calendar days, the Case Manager may request approval of one bid. Documentation of the attempts shall be attached to the PAR.

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iv. The Case Manager shall submit copies of the bid(s) and the OT/PT evaluation with the PAR to the Department {or its agent}. The Department {or its agent} shall authorize the lowest bid that complies with the requirements of [Section 8.493 (to be updated)] and the recommendations of the OT/PT evaluation.
    1. If a [~~client~~]{member} or homeowner requests a bid that is not the lowest of the submitted bids, the Case Manager shall request approval by submitting a written explanation with the PAR.

v. A revised [~~PAR~~] {bid} and Change Order request shall be submitted according to the procedures outlined in this section for any changes from the original approved PAR according to Department prescribed processes and procedures.

F. If a property to be modified is not owned by the [~~client~~] {member}, the Case Manager shall obtain signatures from the homeowner or property manager on the submitted bids authorizing the specific modifications described therein. Signatures may be completed using a digital signature based on preference of the individual signing the form.
    i. Written consent of the homeowner or property manager, as evidenced by the above-mentioned signatures, is required for all projects that involve permanent installation within the [~~client's~~] {members} residence or installation or modification of any equipment in a common or exterior area.
    ii. If the [~~client~~]{member} vacates the property, these signatures {can be used as} evidence that the homeowner or property manager agrees to allow the [~~client~~] {member} to leave the modification in place or remove the modification as the [~~client~~] {member} chooses. If the [~~client~~] {member} chooses to remove the modification, the property must be left equivalent or better to its pre-modified condition. The homeowner or property manager may not hold any party responsible for removing all or part of a home modification project.

G. If the CMA does not comply with the process described above resulting in increased cost for a home modification, the Department may hold the CMA financially liable for the increased cost.

H. The Department or its agent may conduct on-site visits, or any other investigations deemed necessary prior to approving or denying the Home Modification request.

I. V. Home Modification Provider Agency Requirements

J. Home Modification Providers shall conform to all general certification standards and procedures set forth in [10 CCR 2505-10 section 8.487.11(needs to change)].

K. Home Modification Providers shall be licensed in the city or county in which they propose to provide Home Modification services to perform the work proposed, if required by that city or county.

L. Home Modification Providers shall begin work within sixty (60) days of signed approval from the Department. Extensions of time may be granted by DOH or the Department for circumstances outside of the provider's control upon request by the provider. Requests must be received within the original deadline period and be supported by documentation, including [~~client~~]{member} notification. Reimbursement may be reduced for delays in accordance with [Section 8.493.6.F(needs to change)].
    i. If any changes to the approved scope of work are made without Department authorization, the cost of those changes will not be reimbursed.
    ii. Projects shall be completed within thirty (30) days of beginning work. Extensions of time may be granted by DOH or the Department for circumstances outside of the provider's control upon request by the provider. Requests must be received within the original deadline period and be supported by documentation, including [~~client~~] {member} notification. Reimbursement may be reduced for delays in accordance with [Section 8.493.6.F(needs to change)].

M. The Home Modification Provider shall provide a one-year written warranty on materials and labor from{the} date of final inspection on all completed work and perform work covered under that warranty at their expense.

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N. The Home Modification Provider shall comply with the LTSS Home Modification Benefit Construction Specifications developed by the DOH, which can be found on the Department website, and with local, and state building codes.

O. All Home Modification projects within a Department-established sampling threshold shall be inspected upon completion by DOH, a state, local or county building inspector or a licensed engineer, architect, contractor or any other person as designated by the Department. Home Modification projects may be inspected by DOH upon request by the [~~client~~]{member} at any time determined to be reasonable by DOH or the Department. [~~Clients~~]{members} must provide access for inspections.

i. DOH shall perform an inspection within fourteen (14) days of receipt of notification of project completion or receipt of a [~~client's~~] {members}reasonable request.

ii. DOH shall produce a written inspection report within three (3) days of performing an inspection that notes the [~~client's~~]{members} specific complaints. The inspection report shall be sent to the [~~client~~] {member}, Case Manager, and provider.

iii. Home Modification providers must repair or correct any noted deficiencies within twenty (20) days, or the time required by the inspection, whichever is shorter. Extensions of time may be granted by DOH or the Department for circumstances outside of the provider's control upon request by the provider. Requests must be received within the original deadline period and be supported by documentation, including [~~client~~]{member} notification. Reimbursement may be reduced for delays in accordance with [Section 8.493.6.D(needs to change)].

P. Copies of building permits and inspection reports shall be submitted to DOH. In the event that a permit is not required, the Home Modification Provider shall formally attest in their initial bid that a permit is not required. Incorrectly attesting that a permit is not required shall be justification for recovery of payment by the Department.

8.7424.05 Home Modification Reimbursement

A. Payment for Home Modification services shall be the prior authorized amount, or the amount billed, whichever is lower. Reimbursement shall be made in two payments per Home Modification.

B. The Home Modification Provider may submit a claim for an initial payment of no more than fifty percent of the project cost for materials, permits, and initial labor costs.

C. The Home Modification Provider may submit a claim for final payment when the Home Modification project has been completed satisfactorily as shown by the submission of the documentation below to DOH:

i. Signed lien waivers for all labor and materials, including lien waivers from subcontractors;

ii. Required permits;

iii. {Photographs taken before and after the Home Modification has been completed;}

iv. One-year written warranty on materials and labor; and

v. Documentation in the [~~client's~~]{members} file that the Home Modification has been completed satisfactorily through:

1. Receipt of inspection report approving work from the building inspector or other inspector as referenced at [10 C.C.R. 2505-10, Section 8.493.5.F(needs to be updated)]
2. Approval by the [~~client~~] {member, guardian,} representative, or other designee;
3. Approval by the homeowner or property manager;
4. By conducting an on-site inspection; or

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5. ~~[DOH acceptance of photographs taken both before and after the Home Modification.]~~

D. If DOH notifies a Home Modification Provider that an additional inspection is required, the Home Modification Provider may not submit a claim for final payment until DOH has received documentation of a satisfactory inspection report for that additional inspection.

E. The Home Modification Provider shall only be reimbursed for materials and labor for work that has been completed satisfactorily and as described on the approved Home Modification Provider Bid form or Home Modification Provider Change Order form.

i. All recommended repairs noted on inspections shall be completed before the Home Modification Provider submits a final claim for reimbursement.

ii. If a Home Modification Provider has not completed work satisfactorily, DOH shall determine the value of the work completed satisfactorily by the Provider during an inspection. The Provider shall only be reimbursed for the value of the work completed satisfactorily.

1. A Home Modification Provider may request DOH perform one (1) redetermination of the value of the work completed satisfactorily. This request may be supported by an independent appraisal of the work, performed at the Provider's expense.

F. Reimbursement may be reduced at a rate of 1% (one percent) of the total project amount every seven (7) calendar days beyond the deadlines required for project completion, including correction of all noted deficiencies and inspection deficiencies.

i. Extensions of time may be granted by DOH or the Department for circumstances outside of the provider's control upon request by the provider. Requests must be received within the original deadline period and be supported by documentation, including [~~client~~]{member} notification.

ii. The home modification reimbursement reduced pursuant to this subsection shall be incorporated into the computation of the [~~client's~~] {members}remaining [~~lifetime cap~~]{money}.

G. The Home Modification Provider shall not be reimbursed for the purchase of DME available as a Medicaid state plan benefit to the [~~client~~]{member}. The Home Modification Provider may be reimbursed for the installation of DME if such installation is outside of the scope of the [~~client's~~]{members} DME benefit.

H. {Work that was previously completed prior Department approval is not eligible for reimbursement}

8.7425 Homemaker Services (EBD, CMHS, CIH, BI; SLS; CES; (CFC)) ~~[formerly at 8.490; 8.500.94.B.8; 8.503.40.A.6]~~

8.7425.01 {Homemaker Services Definitions

A. Homemaker Provider Agency means a provider agency that is certified by the state fiscal agent to provide Homemaker Services.

B. Homemaker means services provided to an eligible member that include general household activities to maintain a healthy and safe home environment for a member.

8.7425.02 Homemaker Inclusions

A. HCBS Elderly, Blind, Disabled (EBD) Waiver; Brain Injury (BI) Waiver when the member is receiving Personal Care Service; Complementary and Integrative Health (CIH) Waiver; Community Mental Health Supports (CMHS) Waiver:

i. Service shall be for the benefit of the member and not for the benefit of other persons living in the home. Services shall be applied only to the permanent living space of the member.

ii. Homemaker tasks may include:

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1. Routine light housecleaning, such as dusting, vacuuming, mopping, and cleaning bathroom and kitchen areas.
2. Meal preparation.
3. Dishwashing.
4. Bedmaking.
5. Laundry.
6. Shopping.
7. Teaching the skills listed above to members who are capable of learning to do such tasks for themselves. Teaching shall result in a decrease of weekly units required within ninety days. If such a savings in service units is not realized, teaching shall be deleted from the care plan.

B. Children's Extensive Support (CES) Waiver; Supported Living Services (SLS) Waiver:
   i. Homemaker services are provided in the member's home and are allowed when the member's disability creates a higher volume of household tasks or requires that household tasks are performed with greater frequency.
   ii. There are two types of homemaker services Basic and Enhanced
      1. Basic homemaker services include cleaning, completing laundry, completing basic household care or maintenance within the member's primary residence only in the areas where the member frequents.
         a. Assistance may take the form of hands-on assistance including actually performing a task for the member or cueing to prompt the member to perform a task.
      2. Enhanced homemaker services include basic homemaker services with the addition of either procedures for habilitation or procedures to perform extraordinary cleaning
         a. Habilitation services shall include direct training and instruction to the member 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 member or enhanced prompting and cueing.
         b. The provider shall be physically present to provide step-by-step verbal or physical instructions throughout the entire task:
            i. When such support is incidental to the habilitative services being provided, and
            ii. To increase the independence of the member,
         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 member.
         d. Extraordinary cleaning are those tasks that are beyond routine sweeping, mopping, laundry or cleaning and require additional cleaning or sanitizing due to the member's disability.

8.7425.03 Homemaker Exclusions and Limitations

A. Elderly, Blind, Disabled (EBD) Waiver; Brain Injury (BI) Waiver when the member is receiving Personal Care Service; Complementary and Integrative Health (CIH) Waiver; Community Mental Health Supports (CMHS) Waiver; Children's Extensive Support (CES) Waiver; Supported Living Services (SLS) Waiver Homemaker service may NOT include, but is not limited to the following:
   i. Personal care services.
   ii. Services the person can perform independently.
   iii. Homemaker services provided by family members per [10 CCR 2505-10 SECTION 8.485.200.]

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1. CDASS only: a family member or member of the member's household may only be paid to furnish extraordinary care as defined in [CDASS Definition Reg #].

iv. Homemaker services provided in uncertified congregate facilities are not a benefit.}

v. \Lawn care, snow removal, routine air duct cleaning, and animal care are specifically excluded and shall not be reimbursed.

vi. Billing for travel time is prohibited

vii. Services that do not meet the task definition for Homemaker may not be approved\

8.7425.04 {**Homemaker Provider Agency Requirements**

A. Elderly, Blind, Disabled (EBD) Waiver; Complementary and Integrative Health (CIH) Waiver; Brain Injury (BI) Waiver when the member is receiving Personal Care Service; Community Mental Health Supports (CMHS) Waiver:

i. All providers shall be certified by the Department as a Homemaker Provider Agency.

ii. The Homemaker Provider Agency shall assure and document that all staff receive at least eight hours of training or have passed a skills validation test prior to providing unsupervised homemaker services. Training or skills validation shall include:

1. Tasks included in the [] Homemaker Inclusions.
2. Proper food handling and storage techniques.
3. Basic infection control techniques including universal precautions.
4. Informing staff of policies concerning emergency procedures.

iii. All Homemaker Provider Agency staff shall be supervised by a person who, at a minimum, has received training or passed the skills validation test required of homemakers, as specified above. Supervision shall include, but not be limited to, the following activities:

1. Train staff on agency policies and procedures.
2. Arrange and document training.
3. Oversee scheduling and notify members of schedule changes.
4. Conduct supervisory visits to member's homes at least every three months or more often as necessary for problem resolution, staff skills validation, observation of the home's condition and assessment of member's satisfaction with services.

iv. Investigate complaints and critical incidents

B. Supported Living Services (SLS) Waiver:

i. SLS providers must comply with requirements found at [8.500.98]

8.7425.05 Homemaker Provider Reimbursement Requirements:

A. Elderly, Blind, Disabled (EBD) Waiver; Brain Injury (BI) Waiver when the member is receiving Personal Care Service; Complementary and Integrative Health (CIH) Waiver; Community Mental Health Supports (CMHS) Waiver:

i. Payment for Homemaker Services shall be the lower of the billed charges or the maximum rate of reimbursement set by the Department. Reimbursement shall be per unit of 15 minutes.

ii. Payment does not include travel time to or from the member's residence.

iii. If a visit by a home health aide from a home health agency includes Homemaker Services, only the home health aide visit shall be billed.

iv. If a visit by a personal care provider from a personal care provider agency includes Homemaker Services, the Homemaker Services shall be billed separately from the personal care services.

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v. Each visit shall be billed to the Medicaid fiscal agent with the following documentation to be retained at the provider agency
   1. The nature and extent of services.
   2. The provider's signature.

8.7425.06 Supported Living Services (SLS) Waiver:

A. SLS providers must comply with requirements found at} {8.5}00.104 PROVIDER REIMBURSEMENT}