

## DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Community First Choice Section 8.7000.

Rule Number: MSB 24-11-07-A

Division / Contact / Phone: [Office of Community Living](#) / Eileen Saunders / 303-866-2354

## SECRETARY OF STATE

### RULES ACTION SUMMARY AND FILING INSTRUCTIONS

#### SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 24-07-11-A, Revision to the Medical Assistance Act Rule concerning Community First Choice Section 8.7000.
3. This action is an adoption of: new rules and amendments to existing rules.
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):  
Sections(s) 8.7000.A, 8.7001, 8.7200, 8.7400, 8.7500, and 8.7600, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No                      No  
If yes, state effective date:  
Is rule to be made permanent? (If yes, please attach notice of hearing).              Yes

#### PUBLICATION INSTRUCTIONS\*

Replace the current text at 8.7000 with the proposed text beginning at 8.7001 through the end of 8.7608.3. This rule is effective June 30, 2025.

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### STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

Community First Choice (CFC), also known as 1915(k), is an optional Medicaid program that allows states to offer select home and community-based services and supports to eligible members on the State Plan, expanding these long-term care services to more Health First Colorado (Colorado's Medicaid Program) members. Not only does CFC expand select 1915(c) waiver services to all members eligible for CFC, but it gives members the ability to self-direct their care to the extent of their choosing. CFC gives members access to service delivery models that allow them to control their own budget, select and dismiss their attendants, and provide training for the people who provide their care. By expanding these options, members will experience greater choice and control over how they receive services. Furthermore, the CFC option provides a 6-percentage point increase in Federal matching payments to states for CFC service expenditures.

This rule expands and streamlines existing legal authority, member rights, case management agency responsibilities, and provider agency requirements that exist within other Long-Term Services and Supports programs (LTSS), such as HCBS waivers, to include CFC. This rule amends existing HCBS services, changing eligibility from HCBS waivers to CFC, and makes necessary changes to services and provider requirements due to CFC. Finally, this rule creates a new section that outlines general provisions and eligibility for the CFC program.

2. An emergency rule-making is imperatively necessary

- ☐ to comply with state or federal law or federal regulation and/or  
☐ for the preservation of public health, safety and welfare.

Explain: N/A

3. Federal authority for the Rule, if any:

Initial Review

**[date]**

Final Adoption

**[date]**

Proposed Effective Date

**[date]**

Emergency Adoption

**[date]**

**DOCUMENT #**

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1915 (k), State Plan Amendment (CO-24-0035) approved in December 2024 with an effective date of July 1, 2025. Proposed rule anticipated to be effective 7/1/2025.

4. State Authority for the Rule:

Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2024);  
Sections 25.5-6-1901 through 25.5-6-1905, C.R.S. (2024);

Initial Review  
Proposed Effective Date

**[date]**  
**[date]**

Final Adoption  
Emergency Adoption

**[date]**  
**[date]**  
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### REGULATORY ANALYSIS

5. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

The Department anticipates that the proposed rule will have a positive impact on Health First Colorado members who access Long-Term Services and Supports (LTSS), such as HCBS Waivers, and all Medicaid-eligible individuals who meet an institutional level of care. This rule allows the Department to implement CFC. The implementation of CFC will expand existing waiver services, such as personal care, to populations not currently covered by the HCBS waivers but still need this vital care. CFC will also make select HCBS services, such as In-Home Support Services (IHSS), available to all existing waiver members, regardless of diagnosis or disability. Through CFC, all eligible members will have the option to self-direct their care to the extent of their choosing. Through the implementation of CFC, more Coloradans will have access to a wider array of services and delivery options to meet their long-term care needs.

The Department anticipates that Case Management Agencies and HCBS Service providers will see an increased workload due to an increase in member enrollment from the State Plan.

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

Health First Colorado members who access LTSS will experience an increase in choice and independence with the passage of this rule. Stakeholders have advocated for the implementation of the CFC program since it became a federally available option through the Affordable Care Act. By implementing CFC through this proposed rule, the Department will streamline existing HCBS waiver services by eliminating differences within these services depending on a member's age, diagnosis, or disability. This rule is most impactful to children. This rule will ensure that children have greater access to services that support them with activities of daily living (ADL) and instrumental activities of daily living (IADL) and will allow for more flexibility when accessing these services by expanding caregiver options to allow for families to provide more care.

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The Department anticipates that Case Management Agencies may see an increased workload due to members who have historically been ineligible for LTSS now being eligible for services under CFC.

The Department has worked internally and externally to mitigate any negative impacts on Case Managers and providers. Additionally, the Department has delayed the implementation of other interconnected projects to mitigate burden to the current Case Management and Long Term Services and Supports systems. The Department has conducted extensive stakeholder engagement on these issues and has pivoted to amend policies where possible.

Finally, there will likely be both positive and negative impacts to existing provider agencies. There are historical inequities between provider rates for providers who are providing the same service depending on the waiver the member is on. With the implementation of CFC, these differences can no longer exist. Thus, some providers will experience an increase in rates while others will experience a decrease.

7. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

The Department anticipates a cost savings with the implementation of this rule. Under CFC, certain services that assist with ADLs and IADLs will be moving from the 1915(c) waivers and under the 1915(k) CFC. The federal government provides a 50/50 match on funding for HCBS waiver services. The state is able to claim a 6-percentage point increase in Federal matching payments for service expenditures under CFC. Given this enhanced match, the Department anticipates over \$40 million in savings. All costs and potential savings associated with this rule have been approved by the Joint Budget Committee.

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

Inaction on this rule would cause a delay in implementation of CFC. A delay to CFC implementation would mean the state does not have a set of rules and regulations to accompany the effective State Plan Amendment with CMS, risk noncompliance with state statute, jeopardize the state and Department budget, and cause a negative effect on stakeholders. Senate Bill 23-289 mandates that the Department seek federal approval through a State Plan Amendment from the CMS by July 1, 2025. The State Plan Amendment was approved in December 2024 with an effective date of July 1, 2025. CMS expects that any approved federal program is live at the time of the effective date.

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Part of the budgetary approval for CFC included the creation of a cash fund to move the General Fund savings that accrue from the enhanced federal match from the first twelve months of implementation to maintain state expenditures. The Department would then move the revenue that has accumulated in the cash fund back to the General Fund after the 12-month maintenance of state expenditure period has concluded. Thus, a delay in implementation would mean that the state would not see those savings in the fiscal year the savings were accounted for. This would require a rebalancing of the Department's budget and require the Department to account for the \$40 million from other programs.

Finally, the Department has maintained significant stakeholder support for the implementation of this program. A delay in implementation would mean that members cannot access critical services and service delivery models they need and have been anticipating in 2025/2026.

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

This proposed rule is the most cost effective and least intrusive method to ensure more members can access these critical services and service delivery models.

10. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

Per CRS 25.5-6-1901-1903, the Department sought federal approval for the CFC program through a State Plan Amendment. The State Plan Amendment will be effective on July 1, 2025. Thus, the Department must put forth regulations for the program to ensure compliance with our State Plan.

There are few alternative options as impactful as CFC to provide expanded access to home and community-based services while receiving a higher federal match. The Department has analyzed the implications and costs associated with implementing CFC for almost 15 years. The analyses for this program have included two contracted studies, internal analysis, and stakeholder review. The Department has concluded that CFC is the best path forward to provide the services and supports needed for Coloradoans while saving the state money.

## **8.7000 Home and Community-Based Services**

### **8.7000.A Legal Authority**

1. Authority
  - a. These rules are promulgated under the authorities established in Section 25.5-10, C.R.S.
  - b. These rules and the program guidelines, standards and policies of the Colorado Department of Health Care Policy and Financing, shall apply to all Case Management Agencies, Community Centered Boards, Provider Agencies and regional centers receiving funds administered by the Colorado Department of Health Care Policy and Financing.
2. Scope and Purpose
  - a. These rules govern services and supports for individuals with disabilities authorized and funded in whole or in part through the Colorado Department of Health Care Policy and Financing. These services and supports include the following, as provided by the Colorado Revised Statutes and through annual appropriation authorizations by the Colorado General Assembly:
    - i. Services and supports provided to residents of a State operated facility or program or purchased by the Department.
    - ii. The purchase of services and supports through Community Centered Boards, Case Management Agencies, and Provider Agencies.
    - iii. Other services and supports specifically authorized by the Colorado General Assembly.
    - iv. Services and supports funded through ~~the~~ Home and Community-Based Services ~~waivers~~ under Sections 1915(c), 1915(k), 1902(a)(10), and 1902(a)(1) of the Social Security Act and under Section 25.5- 4-401, et seq., C.R.S.\_
3. Consequences for Non-Compliance
  - a. Pursuant to Title 25.5, Article 10, C.R.S., upon a determination by the Executive Director or designee that services and supports have not been provided in accordance with the program or financial administration standards contained in these rules, the Executive Director or designee may reduce, suspend, or withhold payment to a Case Management Agency, or Provider Agency from which the Department purchases services or supports directly.
  - b. Prior to initiating action to reduce, suspend, or withhold payment to a Case Management Agency, for failure to comply with rules and regulations of the Department, the Executive Director or designee shall specify the reasons therefore in writing and shall specify the actions necessary to achieve compliance.
4. The Department retains the authority to enter emergency orders, when necessary, to preserve the health, safety or welfare of the public or of persons receiving services, including, but not limited to, situations that:

- a. Are ongoing or likely to recur if not promptly corrected or otherwise resolved and, likely to result in serious harm to the individual or others; or,
  - b. Arise out of a Provider Agency discontinuance of operation generally, or discontinuance of services to a particular individual because the Provider Agency is unable to ensure that person's safety or the safety of others.
- 5. The party requesting the Department to enter an emergency order shall submit all relevant documentation to the Department to which the opposing party shall have the opportunity to respond. The Department may request additional information as needed and shall determine the timeframes for the submission of documentation and responses. In addition to ruling on the request for emergency order, the Department may review the substantive issues involved in the dispute and determine the required course of action.

## **8.7001 Home and Community-Based Services Member Rights and Responsibilities**

### **8.7001.A Definitions: Unless otherwise specified, the following definitions apply throughout Sections 8.7000-8.76500.**

- 1. Age-Appropriate Activities and Materials means activities and materials that foster social, intellectual, communicative, and emotional development and that challenge the individual to use their skills in these areas while considering their chronological age, developmental level, and physical skills.
- 1-A. Community First Choice (CFC) means services and supports authorized by a 1915(k) granted pursuant to the Social Security Act and provided in home or community settings to a Member who requires a level of institutional care that would otherwise be provided in a hospital, nursing facility, inpatient psychiatric institution for individuals under 21 years of age, or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID).
- 1-B. Contractor means an individual who performs work on behalf of a Provider Agency but is not an employee of the Agency.
- 2. Covered HCBS means any Home and Community-Based Service(s) provided under the Colorado State Medicaid Plan, a Colorado Medicaid waiver program, Community First Choice, or a State-funded program administered by the Department. This category excludes Respite Services and Palliative/Supportive Care services provided outside the child's home as a benefit of the Children with Life-Limiting Illness Waiver.
- 3. Discrimination means the unfair or prejudicial treatment of people and groups based on characteristics such as race, color, ethnic or national origin, ancestry, age, sex, gender, sexual orientation, gender identity and expression, religion, creed, political beliefs, or disability.
- 3-B. Guardian means an individual at least 21 years of age, resident, or non-resident, who has qualified as a Guardian of a minor or incapacitated person pursuant to appointment by a Parent or by the court. The term includes a limited, emergency, and temporary substitute Guardian as set forth in Section 15-14-102 (4), C.R.S, but not a Guardian Ad Litem.
- 4. Home and Community-Based Services (HCBS) Setting means any physical location where Covered HCBS are provided.
  - a. HCBS Settings include, but are not limited to, Provider-Owned or -Controlled Non-Residential Settings, Other Non-Residential Settings, Provider-Owned or -Controlled Residential Settings, and Other Residential Settings.



- b. If Covered HCBS are provided at a physical location to one or more individuals, the setting is considered an HCBS Setting, regardless of whether some individuals at the setting do not receive Covered HCBS. The requirements of Section 8.7001.B apply to the setting as a whole and protect the rights of all individuals receiving services at the setting regardless of payer source.
- 5. Informed Consent means the informed, freely given, written agreement of the individual (or, if authorized, their Guardian or other Legally Authorized Representative) to a Rights Modification. The Case Manager ensures that the agreement is informed, freely given, and in writing by confirming that the individual (or, if authorized, their Guardian or other Legally Authorized Representative) understands all of the information required to be documented in Section 8.7001.B.4 and has signed the Department-prescribed form to that effect.
- 6. Intensive Supervision means one-on-one (1:1), line-of-sight, or 24-hour supervision. Intensive Supervision is a Rights Modification if the individual verbally or non-verbally expresses that they do not want the supervision or if the supervision limits an individual's privacy, autonomy, access to the community, or other rights protected in Section 8.7001.B, because of the individual's challenging behavior(s).
- 7. Legally Authorized Representative means a person with legal authority to represent an individual in a particular matter. Such a person may be:
  - a. the Parent of a minor;
  - b. the court-appointed Guardian of an individual, only with respect to matters within the scope of, and in the manner authorized by, the guardianship order; or
  - c. anyone granted authority pursuant to any other type of court order or voluntary appointment or designation (e.g., conservator, agent under power of attorney, member of a supportive community in connection with a supported decision-making agreement, Long-Term Services and Supports Representative under Section 8.7001.A.8, or Authorized Representative under Sections 8.7515 or 8.7528), only with respect to matters within the scope of, and in the manner authorized by, the court order or voluntary appointment or designation.

In situations arising under subsections b and c, the applicable court order or voluntary appointment or designation must be consulted to determine whether it is still in effect, and to ensure the appointed or designated person exercises only those powers it specifically grants.

- 8. Long-Term Services and Supports Representative means a person designated by the individual receiving services, by the Parent of a minor, or by the Guardian of the Member receiving services, if appropriate, to assist the individual in acquiring or utilizing part or all of their Long-Term Services and Supports. This term encompasses any authorized representative as defined by Sections 25.5-6-1702 and 25.5-10-202, C.R.S.
  - a. A Long-Term Services and Supports Representative shall have the judgment and ability to assist the individual in acquiring and utilizing the services covered by the designation.
  - b. The appointment of a Long-Term Services and Supports Representative shall be in writing and shall be subject to the standards set forth in Section 8.7001.C.5.
- 8-B. Member means a person enrolled in the state medical assistance program, the children's basic health plan, HCBS waiver program, [Community First Choice](#), or State General Fund program.

9. Other Non-Residential Setting means a physical location that is non-residential and that is not owned, leased, operated, or managed by an HCBS Provider Agency or by an independent Contractor providing nonresidential services.
- a. Other Non-Residential Settings include, but are not limited to, locations in the community where Covered HCBS are provided.
10. Other Residential Setting means a physical location that is residential and that is not owned, leased, operated, or managed by an HCBS Provider Agency or by an independent Contractor providing residential services.
- a. Other Residential Settings include, but are not limited to, Residential Settings owned or leased by individuals receiving HCBS or their families (personal homes) and those owned or leased by relatives paid to provide HCBS unless such relatives are independent Contractors of HCBS Provider Agencies.
11. Person-Centered Support Plan means a service and support plan that is directed by the individual whenever possible, with the individual's representative acting in a participatory role as needed, is prepared by the Case Manager, identifies the supports needed for the individual to achieve personally identified goals, and is based on respecting and valuing individual preferences, strengths, and contributions.
12. Plain Language means language that is understandable to the individual and in their native language, and it may include pictorial methods, if warranted.
- 12-B. Provider Agency means an Agency certified by the Department and which has a contract with the Department to provide one or more of the services listed at Section 8.7500.
13. Provider-Owned or -Controlled Non-Residential Setting means a physical location that is non-residential and that is owned, leased, operated, or managed by an HCBS Provider Agency or by an independent Contractor providing non-residential services.
- a. Provider-Owned or -Controlled Non-Residential Settings include, but are not limited to, provider-owned facilities where Adult Day, Day Treatment, Specialized Habilitation, Supported Community Connections, Prevocational Services, Supported Employment Services, and Youth Day Services (including Youth Day Services at homes owned, leased, or operated by Provider Agencies/independent Contractors) are provided.
14. Provider-Owned or -Controlled Residential Setting means a physical location that is residential and that is owned, leased, operated, or managed by an HCBS Provider Agency or by an independent Contractor providing residential services.
- a. Provider-Owned or -Controlled Residential Settings include, but are not limited to, Alternative Care Facilities (ACFs); Supported Living Program (SLP) and Transitional Living Program (TLP) facilities; group homes for adults with Intellectual or Developmental Disabilities (IDD) (Group Residential Services and Supports (GRSS)); Host Homes for adults with IDD; any Individual Residential Services and Supports (IRSS) setting that is owned or leased by a service Provider Agency or independent Contractor of a Provider Agency; foster care homes, Host Homes, group homes, residential child care facilities, and Qualified Residential Treatment Programs (QRTPs) in which Children's Habilitation Residential Program (CHRP) services are provided; and Mental Health Transitional Living Homes.

- 14-B. Provider Participation Agreement means the contract between the Department and the Provider Agency that describes the terms and conditions governing participation in the programs administered by the Department.
15. Restraint means any manual method or direct bodily contact or force, physical or mechanical device, material, or equipment that restricts normal functioning or movement of all or any portion of a person's body, or any drug, medication, or other chemical that restricts a person's behavior or restricts normal functioning or movement of all or any portion of their body. Physical or hand-over-hand assistance is a Restraint if the individual verbally or non-verbally expresses that they do not want the assistance or if the assistance limits an individual's autonomy or other rights protected in Section 8.7001.B.
16. Restrictive or Controlled Egress Measures means devices, technologies, or approaches that have the effect of restricting or controlling egress or monitoring the coming and going of individuals. The following measures are deemed to have such an effect and are Restrictive or Controlled Egress Measures: locks preventing egress; audio monitors, chimes, motion-activated bells, silent or auditory alarms, and alerts on entrances/exits at residential settings; and wearable devices that indicate to anyone other than the wearer their location or their presence/absence within a building. Other measures that have the effect of restricting or controlling egress or monitoring the coming and going of individuals are also Restrictive or Controlled Egress Measures.
17. Rights Modification means any situation in which an individual is limited in the full exercise of their rights.
- a. Rights Modifications include, but are not limited to:
- i. the use of Intensive Supervision if deemed a Rights Modification under the definition in Section 8.7001.A.6 above;
  - ii. the use of Restraints;
  - iii. the use of Restrictive or Controlled Egress Measures;
  - iv. modifications to the other rights in Section 8.7001.B.2 (basic criteria applicable to all HCBS Settings) and Section 8.7001.B.3 (additional criteria for HCBS Settings);
  - v. any provider actions to implement a court order limiting any of the foregoing individual rights; and
  - vi. rights suspension/modifications under Section 25.5-10-218(3), C.R.S.
  - vi. ~~all situations formerly covered by the Department's processes for rights suspensions or restrictive procedures pursuant to the version of Sections 8.600.4, 8.604.3, and 8.608.1-2 in effect on December 30, 2021.~~
- b. Modifications to the rights to dignity and respect, the rights in Sections 8.7001.B.2.a.vi-vii covering such matters as Person-Centeredness, civil rights, and freedom from abuse, and the right to physical accessibility are not permitted.
- c. For children under age 18, a limitation or restriction to any of the rights in Sections 8.7001.B.2 and 8.7001.B.3 that is typical for children of that age, including children not receiving HCBS, is not a Rights Modification. Consider age-appropriate behavior when assessing what is typical for children of that age. If the child is not able to fully exercise the right because of their age, then there is no need to pursue the Rights Modification

process under Section 8.7001.B.4. However, if the proposed limitation or restriction is above and beyond what a typically developing peer would require, then it must be handled as a Rights Modification under Section 8.7001.B.4.

## **8.7001.B Individual Rights under the Home and Community-Based Services (HCBS) Settings Final Rule**

### **1. Statement of Purpose, Scope, and Enforcement**

- a. The purpose of this Section 8.7001.B is to implement the requirements of the federal Home and Community-Based Services (HCBS) Settings Final Rule, 79 Fed. Reg. 2947 (2014), codified at 42 C.F.R. § 441.301(c)(4). These rules identify individual rights that are protected at settings where people live or receive HCBS. They also set out a process for modifying these rights as warranted in individual cases. These rules apply to all HCBS under all authorities, except where otherwise noted.
- b. This Section 8.7001.B is enforced pursuant to existing procedures.

### **2. Basic Criteria Applicable to All HCBS Settings**

- a. All HCBS Settings must have all of the following qualities and protect all of the following individual rights, based on the needs of the individual as indicated in their Person-Centered Support Plan, subject to the Rights Modification process in Section 8.7001.B.4:
  - i. The setting is integrated in and supports full access of individuals to the greater community, including opportunities to seek employment and work in competitive integrated settings, control personal resources, receive services in the community, and engage in community life, including with individuals who are not paid staff/Contractors and do not have disabilities, to the same degree of access as individuals not receiving HCBS.
    - 1) Individuals are not required to leave the setting or engage in community activities. Individuals must be offered and have the opportunity to select from Age-Appropriate Activities and Materials both within and outside of the setting.
    - 2) Integration and engagement in community life includes supporting individuals in accessing public transportation and other available transportation resources.
    - 3) Individuals receiving HCBS are not singled out from other community members through requirements of individual identifiers, signage, or other means.
    - 4) Individuals may communicate privately with anyone of their choosing.
    - 5) Methods of communication are not limited by the provider.
      - a) The setting must always provide access to shared telephones if it is a Provider-Owned or -Controlled Residential Setting and during business hours if it is a Provider-Owned or -Controlled Non-Residential Setting.

- b) Individuals are allowed to maintain and use their own cell phones, tablets, computers, and other personal communications devices, at their own expense.
    - c) Individuals are allowed to access telephone, cable, and Ethernet jacks, as well as wireless networks, in their rooms/units, at their own expense.
  - 6) Individuals have control over their personal resources, including money and personal property. If an individual is not able to control their resources, an Assessment of their skills must be completed and documented in their Person-Centered Support Plan. The Assessment and Person-Centered Support Plan must identify what individualized assistance the provider or other person will provide and any training for the individual to become more independent, based on the outcome of the Assessment.
    - a) Provider Agencies may not insist on controlling an individual's funds as a condition of providing services and may not require individuals to sign over their Social Security checks or paychecks.
    - b) A Provider Agency may control an individual's funds if the individual so desires, or if it has been designated as their representative payee under the Social Security Administration's (SSA's) policies. If a Provider Agency holds or manages an individual's funds, their signed Person-Centered Support Plan must:
      - i) Document the request or representative payee designation;
      - ii) Document the reasons for the request or designation; and
      - iii) Include the parties' agreement on the scope of managing the funds, how the Provider Agency should handle the funds, and what they define as "reasonable amounts" under Section 25.5-10-227, C.R.S.
    - c) The Provider Agency must ensure that the individual can access and spend money at any time, including on weekends, holidays, and evenings, including with assistance or supervision if necessary.
- ii. The setting is selected by the individual from among setting options, including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the Person-Centered Support Plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.
- iii. The setting ensures an individual's rights of privacy, dignity, and respect, and freedom from coercion and Restraint.

- 1) The right of privacy includes the right to be free of cameras, audio monitors, and devices that chime or otherwise alert others, including silently, when a person stands up or passes through a doorway.
    - a) The use of cameras, audio monitors, chimes, and alerts in (a) interior areas of residential settings, including common areas as well as bathrooms and bedrooms, and in (b) typically private areas of non-residential settings, including bathrooms and changing rooms, is acceptable only under the standards for modifying rights on an individualized basis pursuant to Section 8.7001.B.4.
    - b) If an individualized Assessment indicates that the use of a camera, audio monitor, chime, or alert in the areas identified in the preceding paragraph is necessary for an individual, this modification must be reflected in their Person-Centered Support Plan. The Person-Centered Support Plans of other individuals at that setting must reflect that they have been informed in Plain Language of the camera(s)/monitor(s)/chime(s)/alert(s) and any methods in place to mitigate the impact on their privacy. The provider must ensure that only appropriate staff/Contractors have access to the camera(s)/monitor(s)/chime(s)/alert(s) and any recordings and files they generate, and it must have a method for secure disposal or destruction of any recordings and files after a reasonable period.
    - c) Cameras, audio monitors, chimes, and alerts on staff-only desks and exterior areas, cameras on the exterior sides of entrances/exits, and cameras typically found in integrated employment settings, generally do not raise privacy concerns, so long as their use is similar to that practiced at non-HCBS Settings. In Provider-Owned or -Controlled Settings, notice must be provided to all individuals that they may be on camera and specify where the cameras are located. If such devices have the effect of restricting or controlling egress or monitoring the coming and going of individuals, they are subject to the Rights Modification requirements of Section 8.7001.B.4.
    - d) Audio monitors, chimes, motion-activated bells, silent or auditory alarms, and alerts on entrances/exits at residential settings have the effect of restricting or controlling egress and are subject to the Rights Modification requirements of Section 8.7001.B.4. If such devices on entrances/exits at non-residential settings have the effect of restricting or controlling egress or monitoring the coming and going of individuals, they are subject to the Rights Modification requirements of Section 8.7001.B.4.
  - 2) The right of privacy includes the right not to have one's name or other confidential items of information posted in common areas of the setting.
- iv. The setting fosters individual initiative and autonomy, and the individual is afforded the opportunity to make independent life choices. This includes, but is not limited to, daily activities, physical environment, and with whom to interact.

- v. The setting facilitates individual choice regarding services and supports, and who provides them.
- vi. The Person-Centered Support Plan drives the services afforded to the individual, and the setting staff/Contractors are trained on this concept and person-centered practices, as well as the concept of dignity of risk.
- vii. Each individual is afforded the opportunity to:
  - 1) Lead the development of, and grant informed consent to, any provider-specific treatment, care, supports, or service plan;
  - 2) Have freedom of religion and the ability to participate in religious or spiritual activities, ceremonies, and communities;
  - 3) Live and receive services in a clean, safe environment;
  - 4) Be free to express their opinions and have those included when any decisions are being made affecting their life;
  - 5) Be free from physical abuse and inhumane treatment;
  - 6) Be protected from all forms of sexual exploitation;
  - 7) Access necessary medical care which is adequate and appropriate to their condition;
  - 8) Exercise personal choice in areas including personal style; and
  - 9) Accept or decline services and supports of their own free will and on the basis of informed choice.
- viii. Nothing in this rule shall be construed to prohibit necessary assistance as appropriate to those individuals who may require such assistance to exercise their rights.
- ix. Nothing in this rule shall be construed to interfere with the ability of a Guardian or other Legally Authorized Representative to make decisions within the scope of their guardianship order or other authorizing document.

### 3. Additional Criteria for HCBS Settings

- a. Provider-Owned or -Controlled Residential Settings must have all of the following qualities and protect all of the following individual rights, based on the needs of the individual as indicated in their Person-Centered Support Plan, subject to the Rights Modification process in Section 8.7001.B.4:
  - i. The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord/tenant laws do not apply, a lease, residency agreement, or other form of written agreement must be in place for each individual, and the document must provide protections that

address eviction processes and appeals comparable to those provided under the jurisdiction's landlord/tenant law.

- 1) The lease, residency agreement, or other written agreement must:
  - a) Provide substantially the same terms for all individuals;
  - b) Be in Plain Language, or if the Provider Agency/its independent Contractor cannot adjust the language, at least be explained to the individual in Plain Language;
  - c) Provide the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of their State, county, city, or other designated entity, or comparable responsibilities and protections, as the case may be, and indicate the authorities that govern these responsibilities, protections, and related disputes;
  - d) Specify that the individual will occupy a particular room or unit;
  - e) Explain the conditions under which people may be asked to move or leave;
  - f) Provide a process for individuals to dispute/appeal and seek review by a neutral decisionmaker of any notice that they must move or leave, or tell individuals where they can easily find an explanation of such a process, and state this information in any notice to move or leave;
  - g) Specify the duration of the agreement;
  - h) Specify rent or room-and-board charges;
  - i) Specify expectations for maintenance;
  - j) Specify that staff/Contractors will not enter a unit without providing advance notice and agreeing upon a time with the individual(s) in the unit;
  - k) Specify refund policies in the event of a resident's absence, hospitalization, voluntary or involuntary move to another setting, or death; and
  - l) Be signed by all parties, including the individual or, if within the scope of their authority, their Guardian or other Legally Authorized Representative.
- 2) The lease, residency agreement, or other written agreement may:
  - a) Include generally applicable limits on furnishing/decorating of the kind that typical landlords might impose; and
  - b) Provide for a security deposit or other provisions outlining how property damage will be addressed.



- 3) The lease, residency agreement, or other written agreement may not modify the individual rights protected under Sections 8.7001.B.2 and 8.7001.B.3, such as (a) by imposing individualized terms that modify these conditions or (b) by requiring individuals to comply with house rules or resident handbooks that modify everyone's rights.
  - 4) Provider Agencies and their independent Contractors must engage in documented efforts to resolve problems and meet residents' care needs before seeking to move individuals or asking them to leave. Provider Agencies and their independent Contractors must have a substantial reason for seeking any move/eviction (e.g., protection of someone's health/safety), and minor personal conflicts do not meet this threshold.
  - 5) A violation of a lease or residency agreement, a change in the resident's medical condition, or any other development that leads to a notice to leave must include at least 30 calendar days' notice to the individual (or, if authorized, their Guardian or other Legally Authorized Representative).
  - 6) If an individual has not moved out after the end of a 30-day (or longer) notice period, the Provider Agency/its independent Contractor may not act on its own to evict the individual until the individual has had the opportunity to pursue and complete any applicable Grievance, Complaint, dispute resolution, and/or court processes, including obtaining a final decision on any appeal, request for reconsideration, or further review that may be available.
  - 7) A Provider Agency/its independent Contractor may not require an individual who has nowhere else to live to leave the setting.
  - 8) This Subsection 8.7001.B.3.a.i. does not apply to children under age 18.
- ii. Individuals have the right to dignity and privacy, including in their living/sleeping units. This right to privacy includes the following criteria:
- 1) Individuals must have a key or key code to their home, a bedroom door with a lock and key, lockable bathroom doors, privacy in changing areas, and a lockable place for belongings, with only appropriate staff/Contractors having keys to such doors and locks. Staff/Contractors must knock and obtain permission before entering individual units, bedrooms, bathrooms, and changing areas. Staff/Contractors may use keys to enter these areas and to open private storage spaces only under limited circumstances agreed upon with the individual. If an individual's lockable place for their belongings is a locker, the Provider Agency must supply a padlock and key/combination.
  - 2) Individuals shall have choice in a roommate/housemate. Provider Agencies must have a process in place to document expectations and outline the process to accommodate choice.
  - 3) Individuals have the right to furnish and decorate their sleeping and/or living units in the way that suits them, while maintaining a safe and sanitary environment and, for individuals age 18 and older, complying with the applicable lease, residency agreement, or other written agreement.

- iii. The Residential Setting does not have institutional features not found in a typical home, such as staff uniforms; entryways containing staff postings or messages; or labels on drawers, cupboards, or bedrooms for staff convenience.
  - iv. Individuals have the freedom and support to determine their own schedules and activities, including methods of accessing the greater community;
  - v. Individuals have access to food at all times, choose when and what to eat, have input in menu planning (if the setting provides food), have access to food preparation and storage areas, can store and eat food in their room/unit, and have access to a dining area for meals/snacks with comfortable seating where they can choose their own seat, choose their company (or lack thereof), and choose to converse (or not);
  - vi. Individuals are able to have visitors of their choosing at any time and are able to socialize with whomever they choose (including romantic relationships);
  - vii. The setting is physically accessible to the individual, and the individual has unrestricted access to all common areas, including areas such as the bathroom, kitchen, dining area, and comfortable seating in shared areas. If the individual wishes to do laundry and their home has laundry machines, the individual has physical access to those machines; and
  - viii. Individuals are able to smoke and vape nicotine products in a safe, designated outdoor area, unless prohibited by the restrictions on smoking near entryways set forth in the Colorado Clean Indoor Air Act, Section 25-14-204(1)(ff), C.R.S., or any law of the county, city, or other local government entity.
- b. Other Residential Settings in which one or more individuals receiving 24-hour residential services and supports reside must have all of the qualities of and protect all of the same individual rights as Provider-Owned or -Controlled Residential Settings, as listed above, other than Subsection 8.7001.B.3.a.i relating to a lease or other written agreement providing protections against eviction, subject to the Rights Modification process in Section 8.7001.B.4.
- c. Other Residential Settings in which no individuals receiving 24-hour residential services and supports reside are excluded from this Section 8.7001.B.3.
  - i. This group of settings includes, but is not limited to, homes in which no individual receives Individual Residential Service and Supports (IRSS) and one or more individuals receive Consumer-Directed Attendant Support Services (CDASS), Health Maintenance Services, Homemaker Services, In-Home Support Services (IHSS), and/or Personal Care Services.
- d. Provider-Owned or -Controlled Non-Residential Settings must have all of the qualities of and protect all of the same individual rights as Provider-Owned or -Controlled Residential Settings, as listed above, other than Subsection 8.7001.B.3.a.i relating to a lease or other written agreement providing protections against eviction and Subsection 8.7001.B.3.a.ii relating to privacy in one's living/sleeping unit, subject to the Rights Modification process in Section 8.7001.B.4.
  - i. Provider-Owned or -Controlled Non-Residential Settings must afford individuals privacy in bathrooms and changing areas and a lockable place for belongings, with only the individuals and appropriate staff/Contractors having keys to such

doors and locks. In addition to supplying a locker, the Provider Agency must supply a padlock and key/combination.

- ii. This Section 8.7001.B.3 does not require Non-Residential Settings to provide food if they are not already required to do so under other authorities. This Section 8.7001.B.3 requires Non-Residential Settings to ensure that individuals have access to their own food at any time.
- e. Other Non-Residential Settings must have all of the qualities of and protect the same individual rights as Provider-Owned or -Controlled Non-Residential Settings, as stated immediately above, to the same extent for HCBS participants as they do for other individuals, subject to the Rights Modification process in Section 8.7001.B.4.

#### 4. Rights Modifications

- a. Any modification of an individual's rights must be supported by a specific assessed need and justified in the Person-Centered Support Plan, pursuant to the process set out in Sections 8.7001.B.4.c and 8.7001.B.4.d below. Rights Modifications may not be imposed across-the-board and may not be based on the convenience of the Provider Agency/its independent Contractor. The Provider Agency/its independent Contractor must ensure that a Rights Modification does not infringe on the rights of individuals not subject to the modification. Wherever possible, Rights Modifications should be avoided or minimized, consistent with the concept of dignity of risk.
- b. The process set out in Sections 8.7001.B.4.c-d below applies to all Rights Modifications.
- c. For a Rights Modification to be implemented, the following information must be documented in the individual's Person-Centered Support Plan, and any Provider Agency/its independent Contractor implementing the Rights Modification must maintain a copy of the documentation:
  - i. The right to be modified.
  - ii. The specific and individualized assessed need for the Rights Modification.
  - iii. The positive interventions and supports used prior to any Rights Modification, as well as the plan going forward for the Provider Agency/its independent Contractor to support the individual in learning skills so that the modification becomes unnecessary.
  - iv. The less intrusive methods of meeting the need that were tried but did not work.
  - v. A clear description of the Rights Modification that is directly proportionate to the specific assessed need. Rights of an individual receiving services may be modified only in a manner that will promote the least restriction on the individual's rights and in accordance with rules herein.
  - vi. A plan for regular collection of data to measure the ongoing effectiveness of and need for the Rights Modification, including specification of the positive behaviors and objective results that the individual can achieve to demonstrate that the Rights Modification is no longer needed.
  - vii. An established timeline for periodic reviews of the data collected under the preceding paragraph. The Rights Modification must be reviewed and updated as necessary upon reassessment of functional need at least every 12 months, and

sooner if the individual's circumstances or needs change significantly, the individual requests a review/revision, or another authority requires a review/revision.

- viii. The Informed Consent of the individual (or, if authorized, their Guardian or other Legally Authorized Representative) agreeing to the Rights Modification, as documented on a completed and signed Department-prescribed form. To be completed, the form must be filled out using Plain Language, addressed directly to the individual, and it must address only one Rights Modification. Informed Consent may not be requested or granted for a Rights Modification extending beyond the 12-month or shorter period as set out in Section 8.7001.B.4.c.vii.
  - ix. An assurance that interventions and supports will cause no harm to the individual, including documentation of the implications of the modification for the individual's everyday life and the ways the modification is paired with additional supports or other approaches to prevent harm or discomfort and to mitigate any effects of the modification.
  - x. Alternatives to consenting to the Rights Modification, along with their most significant likely consequences.
  - xi. An assurance that the individual will not be subject to retaliation or prejudice in their receipt of appropriate services and supports for declining to consent or withdrawing their consent to the Rights Modification.
- d. Additional Rights Modification process requirements:
- i. Prior to obtaining Informed Consent, the Case Manager must offer the individual the opportunity to have an advocate, who is identified and selected by the individual, present at the time that Informed Consent is obtained. The Case Manager must offer to assist the individual, if desired, in identifying an independent advocate who is not involved with providing services or supports to the individual. These offers and the individual's response must be documented by the Case Manager.
  - ii. Any Provider Agencies that desire or expect to be involved in implementing a Rights Modification may supply to the Case Manager information required to be documented under this Section 8.7001.B.4, except for documentation of Informed Consent and the offers and response relating to an advocate, which may be obtained and documented only by the Case Manager. The individual determines whether any information supplied by the Provider Agency is satisfactory before the Case Manager enters it into their Person-Centered Support Plan.
  - iii. When a Rights Modification is proposed, it is reviewed by the individual, their Guardian or other Legally Authorized Representative, and the rest of the individual's Member Identified Team and, if consented to, it is documented in the Person-Centered Support Plan.
  - iv. When a right has been modified, the continuing need for such modification shall be reviewed by the individual's Member Identified Team, as led by the individual or their Guardian or other Legally Authorized Representative, at a frequency decided by the team, but at least every six months.

- 1) Such review shall include the original reason for modification, current circumstances, success or failure of programmatic intervention, and the need for continued modification.
  - 2) Restoration of affected rights shall occur as soon as circumstances justify.
  - 3) If the review indicates that changes are needed to the Rights Modification, the Case Manager shall obtain a new signature on an updated Department-prescribed Informed Consent form. If the review indicates that no changes are needed, then the original signature is still valid for the remaining period (up to six months).
- v. At the time a right is modified, such action if subject to Human Rights Committee review shall be referred to the Human Rights Committee for review and recommendation. Such review shall include an opportunity for the individual or Member who is affected, Parent of a minor, Guardian or other Legally Authorized Representative, after being given reasonable notice of the meeting, to present relevant information to the Human Rights Committee.
- e. Use of Restraints
- i. If Restraints are used with an individual at an HCBS Setting, their use must:
    - 1) Be based on an assessed need after all less restrictive interventions have been exhausted;
    - 2) Be documented in the individual's Person-Centered Support Plan as a modification of the generally applicable rights protected under Section 8.7001.B.2, consistent with the Rights Modification process in this Section 8.7001.B.4; and
    - 3) Be compliant with any applicable waiver [or CFC program](#).
  - ii. Prone Restraints are prohibited in all circumstances. Nothing in this Subsection 8.7001.B.4.e permits the use of any Restraint that is precluded by other authorities.
- f. If Restrictive or Controlled Egress Measures are used at an HCBS Setting, they must:
- i. Be implemented on an individualized (not setting-wide) basis;
  - ii. Make accommodations for individuals in the same setting who are not at risk of unsafe wandering or exit-seeking behaviors;
  - iii. Be documented in the individual's Person-Centered Support Plan as a modification of the generally applicable rights protected under Section 8.7001.B.2, consistent with the Rights Modification process in this Section 8.7001.B.4, with the documentation including:
    - 1) An Assessment of the individual's unsafe wandering or exit-seeking behaviors (and the underlying conditions, diseases, or disorders relating to such behaviors) and the need for safety measures;

- 2) Options that were explored before any modifications occurred to the Person-Centered Support Plan;
  - 3) The individual's understanding of the setting's safety features, including any Restrictive or Controlled Egress Measures;
  - 4) The individual's choices regarding measures to prevent unsafe wandering or exit-seeking;
  - 5) The individual's (or, if authorized, their Guardian's or other Legally Authorized Representative's) consent to restrictive- or controlled-egress goals for care;
  - 6) The individual's preferences for engagement within the setting's community and within the broader community; and
  - 7) The opportunities, services, supports, and environmental design that will enable the individual to participate in desired activities and support their mobility; and
- iv. Not be developed or used for non-person-centered purposes, such as punishment or staff/Contractor convenience.
- g. If there is a serious risk to anyone's health or safety, a Rights Modification may be implemented or continued for a short time without meeting all the requirements of this Section 8.7001.B.4, so long as the Provider Agency/its independent Contractor immediately (a) implements staffing and other measures to deescalate the situation and (b) reaches out to the Case Manager to set up a meeting as soon as possible, and in no event past the end of the third business day following the date on which the risk arises. At the meeting, the individual can grant or deny their Informed Consent to the Rights Modification. The Rights Modification may not be continued past the conclusion of this meeting or the end of the third business day, whichever comes first, unless all the requirements of this Section 8.7001.B.4 have been met.
- h. When a Provider Agency proposes a Rights Modification and supplies to the Case Manager the unsigned Informed Consent form with all of the information required to be documented under this Section 8.7001.B.4, except for documentation that may be obtained only by the Case Manager, the Case Manager shall arrange for a meeting with the individual to discuss the proposal and facilitate the individual's decision regarding whether to grant or deny their Informed Consent. Except when the timeline in Section 8.7001.B.4.g applies, the Case Manager shall arrange for this meeting to occur by the end of the tenth business day following the date on which they received from the Provider Agency all of the required information. The individual may elect to make a final decision during or after this meeting. If the individual does not inform their Case Manager of their decision by the end of the fifth business day following the date of the meeting, they are deemed not to have consented.

#### **8.7001.C Additional Provisions Regarding Rights and Responsibilities of Members and Other Individuals**

1. Member and Other Individual Rights
  - a. An individual receiving services has the same legal rights and responsibilities guaranteed to all other individuals under the federal and state constitutions and federal and state

laws including, but not limited to, those contained in Sections 25.5-10-201 through 24-40, C.R.S., unless such rights are modified pursuant to state or federal law. Many rights of Members and other individuals and a process for modifying those rights in individual cases are set forth in Section 8.7001.B. Members and other individuals have additional rights as set forth below and elsewhere in these rules. These additional rights apply not just at HCBS Settings, but also in the context of Case Management, and unless otherwise specified, they are not subject to modification.

- b. Every person has the right to receive the same consideration and treatment as anyone else regardless of race, color, ethnic or national origin, ancestry, age, sex, gender, sexual orientation, gender identity and expression, religion, creed, political beliefs, or disability.
- c. No individual, their Family Members, Guardians, or other Legally Authorized Representatives may be retaliated against in their receipt of Case Management services or supports or direct services and supports as a result of attempts to advocate on their own behalf.
- d. Each individual receiving services has the right to read or have explained in their and their family's native language any policies and/or procedures adopted by their provider(s) and their Case Management Agency.
- e. The individual and the individual's Legally Authorized Representative as necessary is fully informed of the individual's rights and responsibilities.
- f. The individual and/or the individual's Legally Authorized Representative participates in the development and approval of, and is provided a copy of, the individual's Person-Centered Support Plan.
- g. The individual and/or the individual's Legally Authorized Representative selects service providers from among available qualified and willing providers.
- h. The individual and/or the individual's Legally Authorized Representative has access to a uniform Complaint system provided for all individuals served by the Case Management Agency.
- i. The individual who applies for or receives publicly funded benefits and/or the individual's Legally Authorized Representative has access to a uniform appeal process, which meets the requirements of Section 8.057 when benefits or services are denied or reduced, and the issue is appealable.
- j. Members shall have the right to read or have explained any rules or regulations adopted by the Department and policies and procedures of the Case Management Agency pertaining to such people's activities and services and supports, and to obtain copies of Sections 25.5-10-201 through 24-40, C.R.S., rules, policies or procedures at no cost or at a reasonable cost in accordance with Section 24-72-205, C.R.S.
- k. Members and other individuals have the right to request that an Assessment be completed even if the intake Case Management Agency staff determines otherwise. If an Assessment is requested, the Case Management Agency must complete it.
- l. Members and other individuals have the right to include anyone they would like in the service and Person-Centered Support Planning process.

- m. Members and other individuals have the right to be provided with support to help them direct the planning process to the maximum extent possible and to help them make informed choices and decisions.
- n. Members and other individuals have the right to schedule the planning process at a time and place convenient to them.
- o. Members and other individuals have the right to choose any Long-Term Services and Supports programs and services that they are eligible for. Members may only enroll in one waiver at a time.
- p. Members and other individuals have the right to know in advance if services are going to be stopped.
- q. Members and other individuals have the right to be provided with services and supports that do not have any potential conflict of interest with their Case Management or the development of their Person-Centered Support Plan.

## 2. Case Management Requirement for Preservation of Member Rights

- a. Members have the right to receive Case Management services in accordance with Section 8.7201.J in the preservation of their rights.
- b. If rights are not preserved by Case Management Agencies to the degree necessary, Members may engage in the Complaint process with the Agency or escalate their Complaints to the Department of Health Care Policy & Financing (HCPF) via the escalation process on the Department of Health Care Policy & Financing website and/or explained to them by their Case Manager.

## 3. Member and Other Individual Rights to Access the Case Management Agency

- a. Members and other individuals have the right to access the Case Management Agency without physical or programmatic barriers, in compliance with the Americans with Disabilities Act, 42 U.S.C. § 12101, et seq.
- b. Members and other individuals have a right to request meetings outside of the Case Management Agency office.
- c. Members and other individuals have the right to be free from Discrimination and to file a Complaint with a Case Management Agency about their services without fear of retaliation. This includes if or when an advocate files a Complaint on behalf of a Member or individual.
- d. Members and other individuals have the right to Person-Centered Case Management delivery. Case Management Agency functions shall be based on a person-centered model of Case Management service delivery.

## 4. Member Responsibilities

- a. To the degree possible, each Member or Guardian is responsible to:
  - i. Provide accurate information regarding the individual's ability to complete Activities of Daily Living,
  - ii. Assist in promoting the individual's independence,



- iii. Cooperate in the determination of Financial Eligibility for Medicaid,
- iv. Participate in all waiver program [and CFC program](#) required activities, including but not limited to:
  - 1) Level of Care Screen;
  - 2) Needs Assessment;
  - 3) Person-Centered Support Planning;
  - 4) Monitoring, including in the Member's home; and
  - 5) All required in-person activities except in cases of natural disaster, pandemic or other emergency
- v. Notify the Case Manager within thirty (30) calendar days or as soon as possible when:
  - 1) There are changes in the individual's support system, medical, physical or psychological condition or living situation including any hospitalizations, emergency room admissions, or placement in a nursing home or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID),
  - 2) The individual has not received an HCBS waiver service during one (1) month,
  - 3) There are changes in the individual's care needs,
  - 4) There are problems with receiving HCBS Waiver Services,
  - 5) There are changes that may affect Medicaid Financial Eligibility, including changes in income or assets,
  - 6) There are changes in legal status, such as guardianship or Legally Authorized Representative.

5. Use of a Long-Term Services and Supports Representative

- a. People who are eligible for services and supports and their Legally Authorized Representative(s) shall have the opportunity at the time of enrollment and at each annual review of the Person-Centered Support Plan to designate a Long-Term Services and Supports Representative to be included in their Member Identified Team. The designation of a Long-Term Services and Supports Representative must occur with informed consent of the person receiving services or, if applicable, their Legally Authorized Representative.
- b. Such designation shall be in writing and shall specify the duration of the Long-Term Services and Supports Representative's involvement and specific authority in assisting the Member in acquiring or utilizing Long-Term Services and Supports and in protecting their rights.
- c. The written designation of a Long-Term Services and Supports Representative shall be maintained in the record of the person receiving services.

- d. The person receiving services or, if applicable, their Legally Authorized Representative may withdraw their designation of a Long-Term Services and Supports Representative at any time.

## **8.7200 Case Management Agency Requirements**

### **8.7200.B. Definitions**

Unless otherwise specified, the following definitions apply throughout Sections 8.7000-7500.

- 1-A. Business Day means any day in which the state is open and conducting business, but shall not include Saturday, Sunday, or any day in which the state observes one of the holidays listed in Section 24-11-101(1), C.R.S.
- 9. Conflict Free Case Management means Members enrolled in any Long-Term Services and Supports and/or Community First Choice (CFC) programs and/or Home and Community-Based Services waivers and/or Community First Choice (CFC) must receive direct Home and Community-Based Services and Case Management from separate entities.
- 19. Long-Term Services and Supports (LTSS) means the services and supports used by individuals of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities. Long term Services and Supports includes but is not limited to long term care such as nursing facility care as part of the standard Medicaid benefit package, Community First Choice (CFC) services, and Home and Community-Based Services provided under waivers granted by the Federal government.
- 21. Long Term Services and Supports (LTSS) Program means any of the following: publicly funded programs, Medicaid Nursing Facility Care, Program for All-Inclusive Care for the Elderly (PACE) (where applicable), Hospital Back-up (HBU), and Adult Long-Term Home Health (LTHH), and Community First Choice (CFC).
- 22. Member means as defined in 8.7001.A.8-B.
- 24-A. Performance and Quality Review means a review conducted by the Department or its contractor at any time but no less than the frequency as specified in the approved waiver application. The review shall include a review of required case management services performed by the agency to ensure quality and compliance with all requirements.
- 26-A. Prior Authorization Requests (PAR) means approval for an item or service that is obtained in advance either from the Department, a state fiscal agent or the Case Management Agency. 26-B. Post Eligibility Treatment of Income (PETI) means the calculation used to determine the Member's obligation (payment) for the payment of residential services.
- 27-A. Regional Center means as defined at § 24-10.5-102, C.R.S. 27-B. Service Plan Authorization Limit (SPAL) means an annual upper payment limit of total funds available to purchase services to meet the Member's ongoing needs. Purchase of services not subject to the SPAL are set forth at Section 8.500.102.B. A specific limit is assigned to each of the six support levels in the HCBS-SLS waiver. The SPAL is determined by the Department based on the annual appropriation for the HCBS-SLS waiver, the number of Members in each level, and projected utilization.
- 28-A. Supports Intensity Scale (SIS) means as defined at 8.7100.A.62.
- 28-B. Support Level means as defined at 8.7100.A.63.

29. Target Group Criteria means as defined at 8.7100.A.63-A.
- 29-A. Targeted Case Management (TCM) means case management services provided to Members enrolled in the HCBS waivers [or CFC](#) in accordance with Section 8.760 et seq.<sup>17</sup>

## **8.7201 Case Management Agency Overall Requirements**

### **8.7201.F Staffing Patterns**

3. Case Management Agencies shall maintain staffing patterns in accordance with Department prescribed best practices for Long-Term Services and Supports Case Manager-level caseloads for all Targeted Case Management Activities and shall comply with all contractual requirements.
  - a. Case Management Agency shall not exceed the best practice standards for HCBS waiver [or CFC](#) caseload sizes without written approval from the Department.

## **8.7202 Functions of A Case Management Agency**

### **8.7202.C Nursing Facility Admission and Discharge**

4. A Case Manager may determine that an individual is eligible to receive Waiver [or CFC](#) Services while the individual resides in a nursing facility when the individual meets the eligibility criteria as established at Section 8.7100 and the individual requests to transition out of the nursing facility.
5. A Case Manager may determine that an individual is eligible to receive Waiver [or CFC](#) Services while the individual resides in a nursing facility when the individual meets the eligibility criteria as established at Sections 8.400, and 8.7100 and the individual requests to transition out of the nursing facility.

### **8.7202.E Level of Care Determination**

1. The Level of Care Screen shall be used to establish a Member's Level of Care.
2. At the time of completing the Level of Care Screen, unless the individual opposes community living, the Case Manager shall provide options counseling on community-based services to the individual to determine if they desire to live in the community with additional support.
3. The Case Management Agency shall complete the Level of Care Screen within the following time frames:
  - a. For an individual who is not being discharged from a hospital or a nursing facility, the individual Assessment shall be completed and documented in the Department prescribed technology system within 10 working days after receiving confirmation that the Medicaid application has been received by the county department of social services, unless a different time frame specified below applies.
  - b. The Case Management Agency shall complete and document the Assessment within five (5) working days after notification by the nursing facility for a resident who is changing pay source (Medicare/private pay to Medicaid) in the nursing facility, the Case Management Agency shall complete and document the Assessment within five (5) working days after notification by the nursing facility.

- c. For a resident who is being admitted to the nursing facility from the hospital, the Case Management Agency shall complete and document the Assessment, including a Pre-Admission Screening and Resident Review (PASRR) Level 1 Screen within two (2) working days after notification.
    - i. For Pre-Admission Screening and Resident Review (PASRR) Level 1 Screen regulations, Section 8.401.18
  - d. For an individual who is being transferred from a nursing facility to ~~an~~ CFC or an HCBS program or between nursing facilities, the Case Management Agency shall complete and document the Assessment within five (5) working days after notification by the nursing facility.
  - e. For an individual who is being transferred from a hospital to CFC or an HCBS program the Case Management Agency shall complete and document the Assessment within two (2) working days after notification from the hospital.
- 4. Under no circumstances shall the start date for Functional Eligibility based on the Level of Care Screen be backdated by the Case Manager.
  - 5. The Case Management Agency shall complete and document the Level of Care Screen for Long-Term Services and Supports Programs, in accordance with Section 8.401.1. Under no circumstances shall late PAR revisions be approved by the State or its agent.
  - 6. The Case Management Agency shall assess the individual's functional status face-to-face in the location where the person currently resides. Upon Department approval, Assessment may be completed by the Case Manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the Case Manager or individual (e.g. natural disaster, pandemic, etc.).
  - 7. The Case Management Agency shall conduct the following activities when completing a Level of Care Screen of an individual seeking services:
    - a. Obtain diagnostic information in the manner prescribed by the Department from the individual's medical provider for individuals in nursing facilities, ICF-IID, CFC, or HCBS waivers.
    - b. Determine the individual's functional capacity during an assessment, with observation of the individual and family, if appropriate, in his or her residential setting and determine the functional capacity score in each of the areas identified in Section 8.401.1.
    - c. Determine the length of stay for individuals seeking/receiving nursing facility care using the Nursing Facility Length of Stay Assignment Form in accordance with Section 8.402.15.
    - d. Determine the need for Long-Term Services and Supports on the Level of Care Screen during the assessment.
    - e. For CFC and HCBS Programs and admissions to nursing facilities from the community, the original Level of Care Screen and Person-Centered Support Plan copy shall be sent to entities or persons of the Member's choosing. If changes to the individual's condition occur which significantly change the payment or services amount, a copy of the Person-Centered Support Plan must be sent to the Provider Agency, and a copy is to be maintained in the Member's record.

- f. When the Case Management Agency assesses the individual's functional capacity on the Level of Care Screen, it is not an Adverse Action that is directly appealable. The individual's right to appeal arises only when an individual is denied enrollment into a Long-Term Services and Supports Program by the Case Management Agency based on the Level of Care Screen for Functional Eligibility. The appeal process is governed by the provisions of Section 8.057.

#### **8.7202.J Person-Centered Support Coordination**

- 1. Service and support coordination shall be the responsibility of the Case Management Agencies. Service and support coordination shall be provided in partnership with the Member receiving services, the Parents of a minor, and legal Guardians.
  - a. The Member shall designate a Member Identified Team which may include but not be limited to: a LTSS Representative, family members, or individuals from public and private agencies to the extent such partnership is requested by the Member.
- 9. Individuals and/or their Guardians and other Legally Authorized Representatives, as appropriate, who enroll in HCBS Waiver Services [or CFC Services](#) shall have the freedom to choose from qualified Provider Agencies in accordance with Section 8.7400, as applicable.
- 12. Case Managers shall follow all documented policy and operational guidance from the Department for Case Management services including but not limited to:
  - a. Home modification
  - b. Vehicle modification
  - c. Organized Health Care Delivery System
  - d. Consumer-Directed Attendant Supports Services
  - e. In-Home Support Services
  - f. Nursing Facilities
  - g. Transition Services
  - h. Long Term Home Health
  - i. Private Duty Nursing

#### **8.7202.R Denials/Discontinuations/Adverse Actions**

- 1. Individuals seeking or receiving services shall be denied or discontinued from services provided pursuant to publicly funded programs for which the Case Management Agency provides case management services if they are determined ineligible for any of the reasons below. Individuals shall be notified of any of the adverse actions and appeal rights as follows:
  - a. Financial Eligibility
    - i. The eligibility enrollment specialist from the county department of social services shall issue to the Member a Long Term Care Waiver Program Notice of Action (LTC-803) regarding denial or discontinuation of services for reasons of Financial

Eligibility which shall inform the individual of appeal rights in accordance with Section 8.057.

- ii. If the individual or Member is found to be financially ineligible for HCBS or Long-Term Services and Supports benefits, the Case Management Agency shall issue to the Member a Long Term Care Waiver Program Notice of Action (LTC-803) that informs the individual of their appeal rights in accordance with Section 8.057. The Case Manager shall not attend the appeal hearing for a denial or discontinuation based on Financial Eligibility, unless subpoenaed, or unless requested by the Department.

b. Functional Eligibility and Target Group

- i. The Case Management Agency shall notify the individual of the denial or discontinuation and appeal rights by sending the Long-Term Care Waiver Program Notice of Action and shall attend the appeal hearing to defend the denial or discontinuation, when:
  - 1) The individual does not meet the Functional Eligibility requirement for HCBS waiver and Long-Term Services and Supports Programs or nursing facility admissions or CFC Level of Care requirements outlined in Section 8.7604; or
  - 2) The individual does not meet the Target Group Criteria as specified by the HCBS waivers; or
  - 3) The individual failed to submit the required paperwork, documents or any other part of the eligibility criteria and/or application within 90 days from Level of Care Screen.

c. Receipt of Services

- i. The Case Management Agency shall notify the individual of the denial or discontinuation and appeal rights by sending the Long-Term Care Waiver Program Notice of Action and shall attend the appeal hearing to defend the denial or discontinuation, when:
  - 1) The individual has not received ~~long-term services or supports~~ an HCBS Waiver service for one calendar month ~~, unless those services or supports are provided through CFC;~~
  - 2) The individual does not keep or schedule an appointment for Assessment or monitoring two (2) times in a one month consecutive period as required by these regulations.

- 4. The Case Management Agency shall provide the Long-Term Care Waiver Program Notice of Action form to Applicants and individuals within 11 business days regarding their appeal rights in accordance with Section 8.057 et seq. when

- a. The individual or Applicant is determined to not have a Developmental Disability,

- b. The individual or Applicant is found ineligible for Long-Term Services and Supports-.
  - c. The individual or Applicant is determined eligible or ineligible for placement on a waiting list for Long-Term Services and Supports,
  - d. An adverse action occurs that affects the individual's or Applicant's waiver enrollment status,
  - e. The individual or Applicant voluntarily withdraws.
8. The Case Manager shall follow procedures to close the individual's case in the Information Management System within one (1) business day of discontinuation for all [CFC or](#) HCBS Programs

#### **8.7202.Z Targeted Case Management Activity Billing and Payment Liability**

1. Billing:
- a. Claims are reimbursable only when supported by the following documentation:
    - i. The name of the individual;
    - ii. The date of the activity;
    - iii. The nature of the activity including whether it is direct or indirect contact with the individual;
    - iv. The content of the activity including the relevant observations, Assessments, findings;
    - v. Outcomes achieved, and as appropriate, follow up action;
    - vi. For HCBS waiver [or CFC](#) programs, documentation required pursuant to Sections 8.519 and 8.760.
  - b. Claims are subject to a post-payment review by the Department. If the Department identifies an overpayment or a claim reimbursement not in compliance with requirements, the amount reimbursed shall be subject to reversal of claims, recovery of the amount reimbursed, or the Case Management Agency may be subject to suspension of payments.
  - c. Targeted Case Management services consist of facilitating enrollment; locating, coordinating, and monitoring Long-Term Services and Supports services; and coordinating with other non waiver [or non-CFC](#) funded services, such as medical, social, educational, and other services to ensure non-duplication of services and monitor the effective and efficient provision of services across multiple funding sources. The individual does not need to be physically present for this service to be performed if it is done on the individual's/Member's behalf.
  - d. TCM services provided to Members enrolled in HCBS waiver programs [or CFC](#) are to be reimbursed based on the Department's TCM Fee Schedule.
  - e. TCM providers shall record what documentation exists in the log notes and enter necessary documentation into the Department prescribed system as required by the Department.

- i. Case Management Agencies shall document all targeted Case Management services and meet the following criteria:
    - 1) All targeted Case Management services must be documented in the Department's system within 10 business days of the activity and prior to submitting a claim for reimbursement.
    - 2) Documentation must be specific to the Member and clearly and concisely detail the activity completed.
    - 3) Documentation must specify the Member's preference for in-person or virtual for monitoring contacts in adherence with Department direction and requirements.
    - 4) The use of mass email communication, robotic and/or automatic voice messages cannot be used to replace the Case Management Agencies required Case Management services or any billable targeted Case Management service.
  - e. Reimbursement rates shall be published prior to their effective date in accordance with Federal requirements at 42 C.F.R. § 447.205(d) and shall be based upon a market-based research and standards.
  - f. TCM services may not be claimed prior to the first day of enrollment into an eligible program nor prior to the actual date of eligibility for Medicaid benefits.
- 2. Exclusions
  - a. Case Management services provided to any individuals enrolled in the following programs are not billable as Targeted Case Management services as specified in Section 8.7202.Z:
    - i. Persons enrolled in a Home and Community-Based Services waiver [or CFC](#) not included as an eligible HCBS service as described in Sections 8.7000-8.7100 and 8.7500.
    - ii. Persons residing in a Class I nursing facility.
    - iii. Persons residing in an Intermediate Care Facility for the Intellectually Disabled (ICF-ID).
- 3. Payment Liability
  - a. Failure to prepare the service plan and prior authorization or failure to submit the service plan forms in accordance with Department policies and procedures shall result in the reversal and recovery of reimbursement for services authorized retroactive to the first date of service. The Case Management Agency and/or providers may not seek reimbursement for these services from the Member.
  - b. If the Case Management Agency causes an individual enrolled in HCBS Waiver Services to have a break in payment authorization, the Case Management Agency shall ensure that all services continue and shall be solely financially responsible for any losses incurred by Provider Agencies until payment authorization is reinstated.



## 8.7202.CC PRIOR AUTHORIZATION REQUESTS (PAR)

1. All Home and Community-based Services must be prior authorized by the Department or its agent.
  - a. The Case Manager shall complete and submit the Department's approved PAR form within one calendar month of determination of eligibility for a waiver [or CFC](#).
2. All units of service requested shall be listed on the Person-Centered Support Plan.
3. The first date for which services may be authorized is the latest date of the following:
  - a. The financial eligibility start date, as determined by the financial eligibility site.
  - b. The assigned start date on the certification page of the Department approved assessment tool.
  - c. The date, on which the Member's parent(s) and/or legal guardian signs the Person-Centered Support Plan or Intake form, as prescribed by the Department, agreeing to receive services.
4. The PAR shall not cover a period of time longer than the certification period assigned on the certification page of the Department approved assessment tool.
5. The Case Manager shall submit a revised PAR if a change in the Person Centered Support Plan results in a change in services.
6. The revised Person Centered Support Plan shall list the service being changed and state the reason for the change. The services being revised, as indicated in the revised Person Centered Support Plan, plus all services not revised, as shown on the Plan prior to revision, shall be entered on the revised PAR.
7. Revisions to the Person Centered Support Plan requested by providers after the end date on a PAR shall be disapproved.
8. If the revisions to the Person Centered Support Plan result in a decrease in services without the Member's parent's(s) and/or legal guardian's agreement, the Case Manager shall notify the Member's parent(s) and/or legal guardian of the adverse action and appeal rights using the appropriate forms, timelines and process as described in 8.7202.R.
9. REIMBURSEMENT
  - a. Providers shall be reimbursed at the lower of:
    - i. Submitted charges; or
    - ii. The fee schedule amount as determined by the Department.
  - b. Claims for services are not reimbursable if:
    - i. Services are not consistent with the Member's documented medical condition and functional capacity;
    - ii. Services are not medically necessary or are not reasonable in amount, scope, frequency, and duration;

- iii. Services are duplicative of other services included in the Member's Support Plan;
  - iv. The Member is receiving non-Medicaid funds to purchase services; or
  - v. Services total more than 24 hours per day of care.
10. Revisions to the PAR that are requested six months or more after the end date shall be disapproved.
11. Payment for HCBS waiver [and/or CFC](#) services is also conditional upon:
- a. The Member's eligibility for HCBS waiver [and/or CFC](#) services;
  - b. The provider's certification status, if appropriate; and
  - c. The submission of claims in accordance with proper billing procedures.
12. Prior authorization of services is not a guarantee of payment. All services must be provided in accordance with regulations and medically necessary.
13. Services requested on the PAR shall be supported by information on the Person Centered Support Plan and written documentation of the Member's current monthly income from the income maintenance technician.
14. The PAR start date shall not precede the start date of HCBS waiver [or CFC](#) eligibility.
15. The PAR end date shall not exceed the end date of the HCBS [waiver or CFC](#) eligibility certification period.

#### **8.7400 Home and Community-Based Services Provider Agency Requirements**

##### **8.7401 Statement of Purpose and Scope**

- A. The purpose of this Section 8.7400 is to outline requirements for Home and Community-Based Services (HCBS) Provider Agencies. These rules apply to all HCBS waivers [and Community First Choice](#).

#### **8.7500 HCBS Benefits and Services Requirements**

##### **8.7501 Statement of Purpose and Scope**

- A. The purpose of this Section 8.7500, et seq. is to outline the Waiver Benefit and Service [and CFC Benefit](#) requirements under the Home and Community-Based Services (HCBS) Waivers [and Community First Choice \(CFC\)](#).

##### **8.7502 Definitions: Unless otherwise specified, the following definitions apply throughout Sections 8.7000-8.7500.**

- A. [Acquisition, Maintenance, and Enhancement of Skills \(AME\)](#) means functional skills training necessary for the individual to accomplish ADLs ~~and, IADLs, and health-related tasks~~. AME is a task available through Personal Care and Homemaker.

- AB.** Activities of Daily Living (ADLs) is as defined at Section 8.7100.A.1.
- BC.** Adaptive Equipment means one or more devices used to assist with completing Activities of Daily Living.
- CD.** Case Management Agency is as defined ~~as~~ at Section 8.7100.A.8.
- DE.** Case Manager is as defined at Section 8.7200.B.5.
- F.** Community First Choice (CFC) is as defined at Section 8.7001.A.1-A.
- G.** CFC Benefit means services defined in the current federally approved CFC State Plan Amendment and does not include other Medicaid State Plan benefits or Waiver Benefits.
- EH.** Congregate Facility is as defined at Section 8.7100.A.12.
- FI.** Department is as defined in Section 8.7200.B.14.
- GJ.** Developmental Disability is as defined at Section 8.7100.A.23.
- K.** Direct Care Services Calculator means a tool used by a Case Manager or vendor to indicate the number of hours of Attendant services a Member needs for each covered personal care services, homemaker services, and health maintenance activities. For children, Case Managers must utilize the Age-Appropriate Guidelines provided by the Department.
- HL.** Direct Care Worker is as defined at Section 8.7402.F.
- IM.** Durable Medical Equipment is as defined at Section 8.580.
- JN.** Early And Periodic Screening, Diagnosis and Treatment (EPSDT) is as defined at Section 8.280.1.
- KO.** Family Member means any person or relative related to the Member by blood, marriage, or adoption, or by common law as determined by a court of law.
- LP.** Financial Eligibility is as defined at Section 8.7100.A.28.
- MQ.** Functional Eligibility is as defined at Section 8.7100.A.29.
- NR.** Home and Community-Based Services (HCBS) waiver is as defined at 8.7100.A.35
- OS.** Intellectual and Developmental Disability is defined at § 25.5-6-403(3.3)(a), C.R.S. and 8.7100.A.40.
- PT.** Instrumental Activities of Daily Living (IADLs) means activities related to independent living, including preparing meals, managing money, shopping for groceries or personal items, performing light or heavy housework and communication.
- QU.** Licensed Medical Professional (LMP) 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). License Medical Professional practices shall adhere to the Colorado Medical Practice Act or the Colorado Nurse Practice Act, as applicable to the professional licensure category.
- RV.** Legally Authorized Representative is as defined at 8.7001.A.7.

W. Legally Responsible Person means any person who has legal responsibility to care for another person such as the parent or guardian of a minor child or the member's spouse.

SX. Long Term Services and Supports Representative is as defined at Section 8.7001.A.8.

TY. Member is as defined at 8.7001.A.8-B.

UZ. Person-Centered Support Plan is as defined at 8.7001.A.11.

V-AA. Prior Authorization Request (PAR) is as defined at 8.7202.B.

WBB. Provider Agency is as defined at 8.7001.A.12-B.

XCC. Provider Care Plan is as defined at 8.7402.T.

YDD. Restraint is as defined at Section 8.7001.A.15.

ZEE. Universal Precautions means a system of infection control that prevents the transmission of communicable diseases. Precautions include, but are not limited to, disinfecting of instruments, isolation and disinfection of the environment, use of personal protective equipment, hand washing, and proper disposal of contaminated waste.

AAFF. Waiver Benefit is as defined at section 8.7200.B.31

BBGG. Waiver Service is as defined at 8.7100.A.68.

## **8.7515 Consumer Directed Attendant Support Services (CDASS)**

### **8.7515A CDASS Eligibility**

1. CDASS is a covered benefit available to Members enrolled in CFC ~~one of the following Home and Community Based Services (HCBS) waivers:~~

a. ~~Brain Injury Waiver~~

b. ~~Community Mental Health Supports Waiver~~

c. ~~Complementary and Integrative Health Waiver~~

d. ~~Elderly, Blind, and Disabled Waiver~~

e. ~~Supported Living Services Waiver~~

### **8.7515.B CDASS Definitions**

1. Adaptive Equipment is as defined at 8.7502.B

2. 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 for Attendant support services available in the Consumer Directed Attendant Support Services (CDASS) delivery option.

3. Attendant means the individual who meets qualifications in 8.7515.I who provides CDASS as described in Section 8.7515.D and is hired by the Member or Authorized Representative through the FMS Contractor.
4. Attendant Support Management Plan (ASMP) means the documented plan described in Section 8.7515.F, detailing management of Attendant support needs through CDASS.
5. Authorized Representative (AR) means an individual designated by the Member or the Member's legal Guardian, if applicable, who has the judgment and ability to direct CDASS on a Member's behalf and meets the qualifications contained in Sections 8.7515.G and 8.7515.H.
6. 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-CFC](#) Benefit. CDASS benefits may include assistance with health maintenance, personal care, and homemaker activities.
7. CDASS Person-Centered Support Plan Year Allocation means the funds determined by the Case Manager to be required to cover the cost of Attendant services, made available by the Department for the period the Member is approved to receive CDASS within the annual support plan year.
- ~~8. CDASS Task Worksheet means a tool used by a Case Manager to indicate the number of hours of Attendant services a Member needs for each covered CDASS personal care services, homemaker services, and health maintenance activities.~~
- ~~9. CDASS Training means the required CDASS training and comprehensive assessment provided by the Training and Support Contractor to a Member or Authorized Representative.~~
- ~~8. CDASS Coaching means technical support provided to Members/Authorized Representatives by the Training and Support Contractor for skills related to allocation and budget management, planning and organizing attendant services, managing employer of record responsibilities, communication skills, assessing resources, care quality, and working with the Financial Management Services vendor. The Department may mandate CDASS coaching as outlined in section 8.7514.N.2.~~
- ~~9. CDASS Orientation means the required orientation for CDASS members and Authorized Representatives that includes, but is not limited to: an overview of the program, member/and or authorized rights and responsibilities, planning and organizing attendant services, managing personnel issues, communication skills, recognizing and recruiting quality attendant support, managing health, allocation budgeting, accessing resources, safety, and prevention strategies, managing emergencies, and working with the Financial Management Services vendor.~~
- ~~10. CDASS Training is voluntary and supplemental to CDASS Orientation and CDASS Coaching. Including additional support surrounding the topics covered in Orientation and Coaching, CDASS Training topics may include, but are not limited to, Electronic Visit Verification compliance, employer of record requirements, and self-advocacy techniques for additional self-directed services needs.}~~
- ~~11. 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 Section 8.001.~~
124. 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.

- 132. Family Member means any person related to the Member by blood, marriage, adoption, or common law as determined by a court of law.
- 143. Financial Eligibility means the Health First Colorado Financial Eligibility criteria based on Member income and resources.
- 154. Financial Management Services (FMS) Contractor 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.
- 165. 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.
- 176. Inappropriate Behavior means offensive behavior toward Attendants, Case Managers, the Training and Support Contractor or the FMS Contractor, and which includes documented verbal, sexual and/or physical abuse. Verbal abuse may include threats, insults or offensive language.
- 187. Notification means a communication from the Department or its designee concerning information about CDASS. Notification methods include but are not limited to announcements via the Department's CDASS website, Member account statements, Case Manager contact, or FMS Contractor contact.
- 198. Stable Health means a medically predictable progression or variation of disability or illness.
- 2049. Training and Support Contractor means the organization contracted by the Department to provide [orientation, coaching](#), training, and customer service for self-directed service delivery options to Members, Authorized Representatives, and Case Managers.

#### **8.7515.C CDASS Member Eligibility**

- 1. To be eligible for the CDASS delivery option, the Member shall meet the following eligibility criteria:
  - a. Choose the CDASS delivery option.
  - b. Be enrolled in [CFC-a-Medicaid-program-approved-to-offer-CDASS](#).
  - c. Demonstrate a current need for covered Attendant support services.
  - ~~d. Document a pattern of Stable Health indicating appropriateness for community-based services and a predictable pattern of CDASS Attendant support.~~
  - de. Provide a statement, at ~~an interval determined by the Department~~ [enrollment and following any change in condition](#), 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 the ability of a required AR to direct the care on the Member's behalf.

ef. Members under the age of 18 are not required to provide a statement from their primary care physician as outlined in 8.7515.C.1.d and are required to have an AR.

f. Complete all aspects of the Attendant Support Management Plan (ASMP) and training orientation and demonstrate the ability to direct care or have care directed by an Authorized Representative (AR).

i. Member training-orientation obligations

- 1) Members and ARs who have received training-completed orientation through the Training and Support Contractor in the past two years or utilized CDASS in the previous six months may receive a modified training-orientation to begin or resume CDASS. A Member who was terminated from CDASS due to a Medicaid Financial Eligibility denial that has been resolved may resume CDASS without attending training orientation if they received CDASS in the previous six months.

#### **8.7515.D CDASS Inclusions and Covered Services**

1. Covered services shall be for the benefit of the Member only and not for the benefit of other persons.
2. Services include:
  - a. Homemaker services as described at Section 8.7527.
  - b. Personal Care services as described at Section 8.7538.
  - c. Health Maintenance Activities services as described at Section 8.7523.

#### **8.7515.E CDASS Exclusions and Limitations**

1. CDASS Attendants shall not perform services and shall not receive reimbursement for services performed:
  - a. While Member is admitted to a nursing facility, hospital, a long-term care facility or is incarcerated;
  - b. Following the death of the Member;
2. The Attendant shall not be reimbursed to perform tasks at the same time a Member is concurrently receiving a waiver service or CFC service in which a provider is required to perform the same task during the provision of a billed service. The Attendant shall not 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 waiver service being rendered.
3. Companionship is not a covered CDASS service.
4. Billing for travel time is prohibited. Accompaniment of a Member by a Direct Care Worker in the community is reimbursable. Employers must follow all Department of Labor and Employment guidelines on time worked.

#### **8.7515.F CDASS Attendant Support Management Plan**

1. The Member/Authorized Representative (AR) shall develop a written Attendant Support Management Plan (ASMP) after completion of [training-orientation](#) but prior to the start date of services, which shall be reviewed by the Training and Support Contractor and approved by the Case Manager. CDASS shall not begin until the Case Manager approves the plan and provides a start date to the Financial Management Services (FMS) Contractor. The Attendant Support Management Plan shall be completed following initial [training-orientation](#) and [retraining mandatory coaching](#) and shall be modified when there is a change in the Member's needs. The plan shall describe the Member's:
  - a. Attendant support needs;
  - b. Plans for locating and hiring Attendants;
  - c. Plans for handling emergencies;
  - d. Assurances and plans regarding direction of CDASS Services, as described at Sections 8.7515.G; 8.7523.C; 8.7528.C; and 8.7538.C as applicable;
  - e. Plans for budget management within the Member's Allocation;
  - f. Designation of an AR, if applicable; and
  - g. Designation of regular and back-up employees proposed or approved for hire.
2. If the ASMP is disapproved by the Case Manager, the Member or AR has the right to Case Management Agency review of the disapproval. The Member or AR shall submit a written request to the Case Management Agency 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.

#### **8.7515.G CDASS Member/AR Responsibilities**

1. Member/AR shall complete the following responsibilities for CDASS management:
  - a. Complete [training-orientation](#) provided by the Training and Support Contractor. Members who cannot complete [training-orientation](#) shall designate an AR.
  - b. Complete and submit an ASMP at initial enrollment when a Member's Allocation changes by 25% or more and whenever required based on the Member's needs.
  - c. Determine wages for each Attendant not to exceed the rate established by the Department.
  - d. Determine the required qualifications for Attendants.
  - e. Recruit, hire and manage Attendants.
  - f. Complete employment reference checks on Attendants.
  - g. 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 before the Attendant provides direct care to the Member.



- h. Terminate Attendants when necessary, including when an Attendant is not meeting the Member's needs.
  - i. Operates as the Attendant's legal employer of record.
  - j. Complete necessary employment-related functions through the Financial Management Services (FMS) Contractor, including hiring and termination of Attendants and employer-related paperwork necessary to obtain an employer tax ID.
  - k. Ensure all Attendant employment documents have been completed and accepted by the FMS Contractor prior to beginning Attendant services.
  - l. Follow all relevant laws and regulations applicable to the supervision of Attendants.
  - m. Explain the role of the FMS Contractor to the Attendant.
  - n. 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 unless prior approval is obtained from the Department or its designee.
  - o. Authorize Attendant to perform services allowed through CDASS.
  - p. Ensure all Attendants required to utilize Electronic Visit Verification (EVV) are trained and complete EVV for services rendered. Timesheets shall reflect time worked and capture all required data points to maintain compliance with Section 8.001, et seq.
  - q. 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.
  - r. Review and submit approved Attendant timesheets to the FMS by the established timelines for submission of timesheets for Attendant reimbursement.
  - s. Authorize the FMS Contractor to make any changes in the Attendant wages.
  - t. 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.
  - u. Complete and manage all paperwork and maintain employment records.
  - v. Select an FMS Contractor upon enrollment into CDASS.
2. Member/AR responsibilities for Verification:
- a. Sign and return a responsibilities acknowledgement form for activities listed in Section 8.7515.G to the Case Manager.
3. Members utilizing CDASS have the following rights:
- a. To receive training on managing CDASS.

- b. To receive program materials in accessible format.
- c. To receive advance Notification of changes to CDASS.
- d. To participate in Department-sponsored opportunities for input.
- e. To transition to alternative service delivery options at any time. The Case Manager shall coordinate the transition and Referral process.
- f. To request a Reassessment if the Member's level of service needs have changed.
- g. To revise the ASMP at any time with Case Manager approval.

#### **8.7515.H CDASS Authorized Representatives (AR)**

1. A person who has been designated as an AR shall submit an AR designation affidavit attesting that he or she:
  - a. Is at least eighteen years of age;
  - b. Has known the eligible person for at least two years;
  - c. Has not been convicted of any crime involving exploitation, abuse, or assault on another person; and
  - d. Does not have a mental, emotional, or physical condition that could result in harm to the Member.
2. CDASS Members who require an AR may not serve as an AR for another CDASS Member.
3. An AR shall not receive reimbursement for CDASS AR services and shall not be reimbursed as an Attendant for the Member they represent.
4. An AR must comply with all requirements contained in Section 8.7515.G.
5. An AR who has failed to meet the responsibilities of an AR as outlined in 8.7514.N for a member will be removed as the AR and cannot become or continue to be an AR for another member.

#### **8.7515.I CDASS Attendants**

1. Attendants shall be at least 16 years of age and demonstrate competency in caring for the Member to the satisfaction of the Member/Authorized Representative (AR).
  - a. Minor attendants ages 16 to 17 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).
  - b. Attendants may not be reimbursed for more than 24 hours of CDASS service in one day for one or more Members collectively. Attendants may not be reimbursed for more than sixteen (16) hours of care per day for one or more members collectively.
  - c. An AR shall not be employed as an Attendant for the same Member for whom they are an AR.

- d. Attendants must be able to perform the tasks on the Attendant Support Management Plan (ASMP) they are being reimbursed for and the Member must have adequate Attendants to assure compliance with all tasks on the ASMP.
- e. Attendant timesheets submitted for approval must be accurate and reflect time worked.
- f. Attendants shall not misrepresent themselves to the public as a licensed nurse, a certified nurse's aide, a licensed practical or professional nurse, a registered nurse or a registered professional nurse.
- g. Attendants shall not have had their license as a nurse or certification as a nurse aide suspended or revoked or their application for such license or certification denied.
- h. 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 Financial Management Services (FMS) Contractor shall make all payments from the Member's Allocation under the direction of the Member/AR within the limits established by the Department.
- i. 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 crime that can create a health and safety risk to the Member. A list of high-risk crimes is available through the Department, Training and Support Contractor and FMS Contractor.
- j. Attendants may not participate in [Member orientation or coaching](#) provided by the Training and Support Contractor. Members may request to have their Attendant, or a person of their choice, present to assist them during the [training session](#) based on their personal assistance needs. Attendants may not be present during the budgeting portion of the [training orientation or coaching](#).

#### **8.7515.J CDASS Financial Management Services (FMS)**

1. FMS Contractor shall be responsible for the following tasks:
  - a. Collect and process timesheets submitted by attendants within agreed-upon timeframes as identified in FMS Contractor materials and websites.
  - b. 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.
  - c. Distribute paychecks in accordance with agreements made with Member/Authorized Representative (AR) and timelines established by the Colorado Department of Labor and Employment.
  - d. Submit authorized claims for CDASS provided to an eligible Member.
  - e. Verify Attendants' citizenship status and maintain copies of I-9 documents.
  - f. Track and report utilization of Member Allocations.
  - g. Comply with Department regulations and the FMS Contractor contract with the Department.

h. Maintain compliance with Electronic Visit Verification (EVV) requirements as defined under Section 8.001 et seq. and 8.7514 et seq., including the provision of an EVV system for Members and their attendants to collect and maintain data that verifies when CDASS services have occurred.

2. In addition to the requirements set forth at Section 8.7515.J.1, the FMS Contractor operating under the Fiscal/Employer Agent (F/EA) model shall be responsible for obtaining designation as a Fiscal/Employer Agent in accordance with Section 3504 of the Internal Revenue Code, 26 U.S.C § 2504 (2024<sup>43</sup>).

~~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 303 E 17th Ave, Denver, CO 802031570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request.~~

#### **8.7515.K CDASS Selection of Financial Management Services (FMS) Contractor**

1. The Member/Authorized Representative (AR) shall select an FMS ~~Contractor~~ from the ~~Contractor list of FMS~~ contracted with the Department at the time of enrollment.
2. The Member/AR may select a new FMS ~~Contractor~~ during the designated open enrollment periods. The Member/AR shall remain with the ~~ir~~ selected FMS ~~Contractor~~ until the transition to the new FMS Contractor is completed.

#### **8.7515.L CDASS Start of Services**

1. The CDASS start date shall not occur until all of the requirements contained in Sections 8.7515.C, 8.7515.F, 8.7515.G, 8.7515.H have been met.
2. The Case Manager shall approve the Attendant Support Management Plan (ASMP), establish a service period, submit a Prior Authorization Request (PAR) and receive a Prior Authorization Request (PAR) approval before a Member is given a start date and may begin CDASS.
3. The FMS Contractor 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.
4. The FMS Contractor will not reimburse Attendants for services provided prior to the CDASS start date. Attendants are not approved until the FMS Contractor provides the Member/Authorized Representative (AR) with employee numbers and confirms Attendants' employment status.
5. 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.

#### **8.7515.M CDASS Service Substitution**

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

2. Case Managers shall not authorize Prior Authorization Requests (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.
3. Members may receive up to 60 days of Medicaid Acute Home Health services directly following acute episodes as defined by 8.520.4.C.1.c. Members are permitted to utilize Long Term Home Health and Private Duty Nursing in conjunction with CDASS so long as the services are not utilized concurrently and are not duplicative of the services received through CDASS. provided through Long Term Home Health are not duplicative of the services received through CDASS. CDASS service plans shall be modified to ensure no duplication of services.
4. Members may receive Hospice services in conjunction with CDASS services. CDASS service plans shall be reviewed and may be modified to ensure no duplication of services.

#### **8.7515.N CDASS Failure to Meet Member/Authorized Representative (AR) Responsibilities**

1. 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:
  - a. Mandatory retraining-coaching conducted by the contracted Training and Support Contractor.
  - b. Required designation of an AR if one is not in place, or mandatory re-designation of an AR if one has already been assigned.
2. Actions requiring retrainingmandatory coaching, or appointment or change of an AR include any of the following:
  - a. The Member/AR does not comply with CDASS program requirements including service exclusions.
  - b. The Member/AR demonstrates an inability to manage Attendant support.
  - c. 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.
  - d. 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.
  - e. The Member/AR exhibits Inappropriate Behavior as defined at Section 8.7515.B toward Attendants, Case Managers, the Training and Support Contractor, or the Financial Management Services (FMS) Contractor.
  - f. 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.

#### **8.7515.O CDASS Immediate Involuntary Termination**

1. Members may be involuntarily terminated immediately from CDASS for the following reasons:
  - a. A Member no longer meets program criteria due to deterioration in physical or cognitive health AND the Member refuses to designate an Authorized Representative (AR) to direct services.

- b. 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.
- c. The Member/AR exhibits Inappropriate Behavior as defined at Section 8.7515.B toward Attendants, Case Managers, the Training and Support Contractor or the Financial Management Services (FMS) Contractor, and the Department has determined that the Training and Support Contractor has made attempts to assist the Member/AR to resolve the Inappropriate Behavior or assign a new AR, and those attempts have failed.
- d. 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 Contractor has made adequate attempts to assist the Member/AR in managing appropriate services through [retrainingmandatory coaching](#).
- e. Intentional submission of fraudulent CDASS documents or information to Case Managers, the Training and Support Contractor, the Department, or the FMS Contractor.
- f. Instances of proven fraud, abuse, and/or theft in connection with the Colorado Medical Assistance program.
- g. Member/AR fails to complete [retrainingmandatory coaching](#), appoint an AR, or remediate CDASS management per Section 8.7515.N.1.
- h. Member/AR demonstrates a consistent pattern of non-compliance with Electronic Visit Verification (EVV) requirements determined by the EVV CDASS protocol.
- i. Members experiencing FMS EVV systems issues must notify the FMS Contractor 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.

#### **8.7515.P Ending ~~t~~The CDASS Delivery Option**

- 1. 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.
- 2. In the event of discontinuation of or termination from CDASS, the Case Manager shall:
  - a. Complete the Long Term Care Notice of Action (LTC-803) and provide the Member or Authorized Representative (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.
  - b. 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 of the date on which the Member is being terminated from CDASS.

3. Members who are involuntarily terminated pursuant to Sections 8.7515.O.1.b, 8.7515.O.1.d, 8.7515.O.1.e, 8.7515.O.1.f, and 8.7515.O.1.g may not be re-enrolled in CDASS as a service delivery option.
4. Members who are involuntary terminated pursuant to Section 8.7515.O.1.a are eligible for enrollment in CDASS with the appointment of an AR or eligibility documentation as defined at 8.7515.C.1.e. The Member or AR must have successfully completed CDASS [training-orientation](#) prior to enrollment in CDASS.
5. Members who are involuntary terminated pursuant to 8.7515.O.1.c are eligible for enrollment in CDASS with the appointment of an AR. The Member must meet all CDASS eligibility requirements with the AR completing CDASS [training-orientation](#) prior to enrollment in CDASS.
6. Members who are involuntarily terminated pursuant to 8.7515.O.1.h are eligible for enrollment in CDASS 365 days from the date of termination. The Member must meet all eligibility requirements and complete CDASS [training-orientation](#) prior to enrollment in CDASS.

#### **8.7515.Q CDASS Case Management Functions**

1. The Case Manager shall review and approve the Attendant Support Management Plan (ASMP) completed by the Member/Authorized Representative (AR). The Case Manager shall notify the Member/AR of ASMP approval and establish a service period and Allocation.
2. 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.
3. The Case Manager shall calculate the Allocation for each Member who chooses CDASS as follows:
  - a. 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.
  - b. 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.
  - c. The Case Manager shall follow the Department's ~~assessment~~[utilization management review](#) process and receive prior authorization before authorizing a [CDASS](#) start date for Attendant services for Person-Centered Support Plan that;
    - i. Contain Health Maintenance Activities; or
    - ii. ~~Service Accommodation requests~~[Exceed the cost of care received in an institutional setting.](#)
4. Prior to [training-orientation](#) or when an Allocation changes, the Case Manager shall provide written Notification of the Allocation to the Member and the AR, if applicable.

5. 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 [Direct Care Services Calculator CDASS Task Worksheet](#) and [CDASS](#) Allocation for services. Review should be completed within five (5) business days.
  - a. If the review indicates that a change in Attendant support is justified, the following actions will be taken:
    - i. 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.
    - ii. The Case Manager shall complete a Prior Authorization Request (PAR) revision indicating the increase in CDASS Allocation using the Department's Medicaid Management Information System and FMS Contractor system. Prior Authorization Request (PAR) revisions shall be completed within five (5) business days of the Allocation determination.
    - iii. The Member/AR shall amend the ASMP and submit it to the Case Manager.
  - b. The Training and Support Contractor is available to facilitate a review of services and provide mediation when there is a disagreement in the services authorized on the [Direct Care Services Calculator CDASS Task Worksheet](#).
  - c. 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.
6. In approving an increase in the Member's Allocation, the Case Manager shall consider the following:
  - a. 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;
  - b. The appropriateness of Attendant wages as determined by Department's established rate for equivalent services; and
  - c. The appropriate use and application of funds for CDASS services.
7. In reducing a Member's Allocation, the Case Manager shall consider:
  - a. Improvement of functional condition or changes in the available natural supports;
  - b. Inaccuracies or misrepresentation in the Member's previously reported condition or need for service; and
  - c. The appropriate use and application of funds for CDASS services.
8. Case Managers shall cease payments for all existing Medicaid-funded personal care, homemaker, [and/or](#) 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.



9. For effective coordination, monitoring and evaluation of Members receiving CDASS, the Case Manager shall:
  - a. 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 for assistance with payroll and to the Training and Support Contractor for training needs, budgeting, and support.
  - b. 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.
  - c. 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.
  - d. Review monthly FMS Contractor reports to monitor Allocation spending patterns and service utilization to ensure appropriate budgeting and follow up with the Member/AR when discrepancies occur.
  - e. Utilize Department overspending protocol when needed to assist CDASS Member/AR.
  - f. Follow protocols established by the Department for Case Management Activities.
10. Reassessment: The Case Manager will follow in-person and phone contact requirements based on the Member's waiver program [or CFC requirements](#). 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.
11. Case Managers shall participate in training and consulting opportunities with the Department's contracted Training and Support Contractor.

#### **8.7515.R CDASS Attendant Reimbursement**

1. Attendants shall receive an hourly wage not to exceed the rate established by the Department and negotiated between the Attendant and the Member/Authorized Representative (AR) hiring the Attendant. 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 local, state, and federal requirements for the location where the service is provided. The Financial Management Services (FMS) Contractor 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 Attendant Support Management Plan (ASMP).
2. 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 unless prior approval is obtained from the Department or its designee.
3. Once the Member's yearly Allocation is used, further payment will not be made by the FMS Contractor, 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.
- ~~4. Allocations that exceed the cost of providing services in a facility cannot be authorized by the Case Manager without Department approval.~~

## **8.7515.S CDASS Reimbursement to Family Members**

1. Family Members/legal Guardians may be employed by the Member/Authorized Representative (AR) to provide CDASS, subject to the conditions below.
  - a. The Family Member or legal Guardian shall be employed by the Member/AR and be supervised by the Member/AR.
  - b. 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:
    - i. ~~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.~~
    - ii. 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 that the Family Member has a higher level of skill.
    - iii. A Member of the Member's household may only be paid to furnish extraordinary care as determined by the Case Manager. Extraordinary care is determined by assessing whether the care to be provided exceeds the range of care that a Family Member would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age, and which is necessary to assure the health and welfare of the Member and/or avoid institutionalization. Extraordinary care shall be documented on the service plan.
  - c. Legally Responsible Persons shall not be reimbursed for more than 520 hours of homemaker services annually.
  - d. ~~A Member/AR who chooses a Family Member as a care provider, shall document the choice on the Attendant Support Management Plan (ASMP).~~

## **8.7520 Electronic Monitoring**

### **8.7520.A Electronic Monitoring Eligibility**

1. Electronic Monitoring is a covered benefit available to Members enrolled in CFC ~~one of the following HCBS waivers:~~
  - a. ~~Brain Injury Waiver~~
  - b. ~~Community Mental Health Supports Waiver~~
  - c. ~~Complementary and Integrative Health Waiver~~
  - d. ~~Elderly, Blind, and Disabled Waiver~~
  - e. ~~Supported Living Services Waiver~~

### **8.7520.B Electronic Monitoring Definitions**

1. Electronic Monitoring services means electronic equipment, or adaptations, 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:
  - a. Enable the Member to secure help in the event of an emergency;
  - b. May be used to provide reminders to the Member of medical appointments, treatments, or medication schedules;
  - c. Are required because of the Member's illness, impairment or disability as identified and documented in the Person-Centered Support Plan or service plan; and
  - d. Are essential to prevent institutionalization of the Member.
2. Electronic Monitoring Provider means a Provider Agency as defined in Section 8.7400 and Section 25.5-6-303. C.R.S., that has met the Provider Agency requirements for electronic monitoring services specified in Section 8.7520.E.
3. Medication Reminders means devices, controls, or appliances that remind or signal the participant to take actions related to medications
4. Personal Emergency Response System (PERS) means ongoing remote monitoring through a device designed to signal trained alarm monitoring personnel in an emergency situation.

#### **8.7520.C Electronic Monitoring Inclusions**

1. Electronic monitoring services shall include personal emergency response systems, medication reminder systems, or other devices which comply with the definition above and are not included in the non-benefit items below at Section 8.7520.D.

#### **8.7520.D Electronic Monitoring Exclusions and Limitations**

1. Electronic Monitoring 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.
2. Electronic Monitoring services shall be authorized ~~only~~ for Members who have the physical and mental capacity to utilize the particular system requested for that Member.
3. Electronic Monitoring services shall not be authorized as an ~~HCBS~~ CFC benefit if the service or device is available elsewhere as a state plan Medicaid benefit.
4. The following are not benefits of electronic monitoring services:
  - a. Augmentative communication devices and communication boards;
  - b. Hearing aids and accessories;
  - c. Phonic ears;
  - d. Environmental control units, unless required for the medical safety of a Member living alone unattended; or as part of Remote Supports;
  - e. Computers and computer software unrelated to the provision of Remote Supports;

- f. Wheelchair lifts for automobiles or vans
- g. Exercise equipment, such as exercise cycles; or
- h. Hot tubs, Jacuzzis, or similar items.

#### **8.7520.E Electronic Monitoring Provider Agency Requirements**

1. Electronic Monitoring Provider Agencies shall conform to the following standards for electronic monitoring services:
  - a. All equipment, materials or appliances used as part of the electronic monitoring service shall carry a UL (Underwriter's Laboratory) number or an equivalent standard. All telecommunications equipment shall be Federal Communications Commission (FCC) registered.
  - b. All equipment, materials or appliances shall be installed by properly trained individuals, and the installer and/or Provider Agency of Electronic Monitoring shall train the Member in the use of the device as requested by the Member.
  - c. 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.
  - d. All telephone calls generated by monitoring equipment shall be toll-free, and all Members shall be allowed to run unrestricted tests on their equipment.
  - e. Electronic Monitoring Provider Agencies shall send written information to each Member's Case Manager about the system, how it works, and how it will be maintained.

#### **8.7520.F Electronic Monitoring Reimbursement**

1. Payment for Electronic Monitoring services shall be the lower of the billed charges or the prior authorized amount.
2. For Electronic Monitoring the unit of reimbursement shall be one unit per service for non-recurring services, or one unit per month for services recurring monthly.
3. No reimbursement is available for Electronic Monitoring in Provider-owned, -Controlled, or Congregate Facilities.

#### **8.7522 Extraordinary Cleaning**

##### **8.7522.A Extraordinary Cleaning Eligibility**

1. Extraordinary Cleaning Services is a covered benefit available to Members enrolled in one of the following HCBS waivers:

- a. Children's Extensive Support Waiver
- b. Supported Living Services Waiver

##### **8.7522.B Extraordinary Cleaning Definitions**

1. Extraordinary Cleaning means specialized cleaning, disinfection, and sanitization services necessary to ensure a safe, hygienic living environment and prevent the spread of infectious diseasesdisease or pathogens. Extraordinary cleaning includes the use of commercial-grade products, infection control protocols, handling and disposal of biohazard materials, and specialized materials or equipment.
2. Personal Protective Equipment (PPE) is equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses. Personal protective equipment may include items such as gloves, safety glasses and shoes, well-fitting masks or NIOSH-approved respirators, gowns, shoe covers, etc.
3. Commercial-Grade Product means a cleaning substance or mixture of substances registered with the Environmental Protection Agency (EPA) that destroys or irreversibly inactivates bacteria, fungi, and viruses. The product must be clearly labeled and registered with the EPA and must be stored in a location sufficiently secure to deny access to children, pets, or at-risk adults.
4. Standard Precautions means an infection-control principle that treats all blood, bodily fluids and other potentially infectious materials as infectious.

#### **8.7522.C      Extraordinary Cleaning Inclusions**

1. Service shall be for the benefit of the Member and not for the benefit of other persons living in the home. Extraordinary Cleaning services must be completed within spaces a Member frequents such as their home or vehicle.
2. Extraordinary Cleaning tasks are beyond routine homemaking tasks and are necessary to ensure a safe and hygienic living environment due to or as a result of a Member's disability.
3. Services include professional and specialized cleaning, disinfection, and/or sanitization. Tasks require specialized knowledge, training, and use of Commercial-Grade Products and equipment. Providers must use standard precautions and personal protective equipment in the provision of services, when applicable.
4. Extraordinary Cleaning services may be authorized due to a member's disabilities/behaviors causing an unsafe and unsanitary living environment for the Member which requires extraordinary cleaning to mitigate. The Member's needs must be documented in the Person-Centered Support plan and then outlined in the Provider Care Plan or included in sub-contractor documentation, along with details on how the service frequency and scope is appropriate to address concerns.
5. Extraordinary Cleaning tasks may include:
  - a. Cleaning floors and other household surfaces including wood, laminate, engineered flooring materials, vinyl, tile, carpets or rugs, counters, and/or walls using Commercial-Grade Products and equipment.
    - i. Cleaning, sanitization and disinfection of mattresses, surfaces, furniture, upholstery, and other household items requiring use of Commercial-Grade Products and equipment.
  - b. Laundrying and disinfecting a member's clothing, towels, bedding or linens soiled with blood or other bodily fluids. Laundry services or commercial/professional laundering may be appropriate to manage the laundering needs.

- c. Air duct cleaning that is essential for the health and safety of the member that mitigates disability-related health complications.

#### **8.7522.D Extraordinary Cleaning Exclusions and Limitations**

##### **1. Extraordinary Cleaning service may NOT include:**

- a. Personal care services.
- b. Homemaker services.
- c. Services the member can perform independently.
- d. Adaptations or improvements to the home that are considered to be on-going home maintenance and are not of direct medical or remedial benefit to the Member.
- e. Services that are not essential to the health and safety of the Member.
- f. Services that do not meet the task definition for Extraordinary Cleaning may not be approved.
- g. Services that are deemed typical parental responsibility may not be approved.
- h. Services that do not follow Age- Appropriate Guidelines may not be approved.
- i. Extraordinary cleaning services provided in Uncertified Congregate Facilities may not be approved.
- j. In the case a Member resides in a rental property, the responsibility of the landlord, pursuant to the lease agreement, must be examined prior to the authorization of service.

#### **8.7522.E Extraordinary Cleaning Case Management Agency Responsibilities:**

- 1. Detailed, task-related goals shall be documented by the case manager in the Person-Centered Support Plan, including documentation and goals of extraordinary cleaning projects as it relates to improving the health and safety of the Member.
- 2. Requests for costs that exceed an amount equal to 700 15-minute units over the course of a Support Plan year may be approved by the Department, as prescribed by the Department, - if it:
  - a. -Ensures the health and safety of the Member in the home;
  - b. -Decreases the need for paid assistance in another HCBS waiver service or CFC on a long-term basis.
- 3. Case Management Agency approval for a higher amount shall include a thorough review of the current request to ensure cost effectiveness and no unnecessary duplication.

#### **8.7522.F Extraordinary Cleaning Provider Agency Requirements**

- 1. A provider enrolled with Colorado Medicaid or contracting with a Case Management Agency to provide the Extraordinary Cleaning service must be a legally constituted domestic or foreign business entity registered with the Colorado Secretary of State Colorado and hold a Certificate of Good Standing to do business in Colorado.

## **8.7522.G Extraordinary Cleaning Provider Services Reimbursement Requirements**

1. HCBS Supported Living Services (SLS) Waiver; Children's Extensive Support (CES) Waiver:
  - a. Payment does not include travel time to or from the Member's residence. a. Payment does not include travel time to or from the Member's residence.
  - b. Reimbursement shall not exceed an amount equal to 700 15-minute units and may be billed as a 15-minute unit and/or project total for services rendered.
  - c. Work that was completed prior to authorization by the Department or Case Management Agency is not eligible for reimbursement.}

## **8.7523 Health Maintenance Activities Self-Directed**

### **8.7523.A Health Maintenance Activities Eligibility**

1. Health Maintenance is available to Members eligible for Consumer Directed Attendant Support Services (CDASS) or In-Home Support Services (IHSS) within CFC. within the following HCBS waivers:
  - a. ~~Brain Injury Waiver~~
  - b. ~~Community Mental Health Supports Waiver~~
  - c. ~~Complementary and Integrative Health Waiver~~
  - d. ~~Elderly, Blind, and Disabled Waiver~~
  - e. ~~Supported Living Services Waiver~~
2. ~~Health Maintenance is available to Members eligible for In-Home Support Services within the following HCBS waivers:~~
  - a. ~~Children's Home and Community-Based Services Waiver~~
  - b. ~~Complementary and Integrative Health Waiver~~
  - c. ~~Elderly, Blind, Disabled Waiver~~

### **8.7523.B Health Maintenance Activities Definition**

1. Health Maintenance 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.
  - a. Health Maintenance Activities requires a skilled acuity assessment to be completed by the authorized Nurse Assessor Vendor, as defined in 8.520.1.V prior to the completion of a PAR.
2. Home Exercise Plan is an exercise plan that is developed by a Licensed Medical Professional, an occupational therapist, a speech language pathologist, a Registered Nurse, or physical therapist that instructs the Member what exercises must be completed in the home or in the community. The exercises identified in the Home Exercise Plan must not replace the services

that are traditionally received through Occupational Therapy, Physical Therapy, and/or Speech Therapy services.

#### **8.7523.C Health Maintenance Activities Inclusions**

1. Services may include:
  - a. Skin care, when the skin is broken, or a chronic skin condition is active and could potentially cause infection and the 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 (LMP).
  - b. Hair care includes shampooing, conditioning, drying, and combing when performed in conjunction with health maintenance level bathing, dressing, or skin care. Hair care may be performed when:
    - i. The Member is unable to complete task independently;
    - ii. Application of a prescribed shampoo/conditioner which has been dispensed by a pharmacy; or
    - iii. The Member has open wound(s) or neck stoma(s).
  - c. Nail care in the presence of medical conditions that may involve peripheral circulatory problems or loss of sensation; includes soaking, filing, and trimming.
  - d. Mouth care performed when health maintenance level skin care is required in conjunction with the task, or:
    - i. There is injury or disease of the face, mouth, head, or neck;
    - ii. In the presence of communicable disease;
    - iii. When the Member is unable to participate in the task;
    - iv. Oral suctioning is required;
    - v. There is decreased oral sensitivity or hypersensitivity;
    - vi. The Member is at risk for choking and aspiration.
  - e. Shaving performed when health maintenance level skin care is required in conjunction with the shaving, or:
    - i. The Member has a medical condition involving peripheral circulatory problems;
    - ii. The Member has a medical condition involving loss of sensation;
    - iii. The Member has an illness or takes medications that are associated with a high risk for bleeding;
    - iv. The Member has broken skin at/near shaving site or a chronic active skin condition.



- f. Dressing performed when health maintenance-level skin care or transfers are required in conjunction with the dressing, or:
  - i. Assistance with the application of prescribed anti-embolic or pressure stockings is required;
  - ii. Assistance with the application of prescribed orthopedic devices such as splints, braces, or artificial limbs is required.
- g. Feeding is considered a health maintenance task when the Member requires health maintenance-level skin care or dressing in conjunction with the task, or:
  - i. Oral suctioning is needed on a stand-by or intermittent basis;
  - ii. The Member is on a prescribed modified texture diet;
  - iii. The Member has a physiological or neurogenic chewing or swallowing problem;
  - iv. Syringe feeding or feeding using adaptive utensils is required;
  - v. Oral feeding when the Member is unable to communicate verbally, non-verbally or through other means.
- h. 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 Home Exercise Plan must be developed by a Licensed Medical Professional, Occupational Therapist, a speech language pathologist, a Registered Nurse, or Physical Therapist.  
~~Exercise including passive range of motion. Exercises must be specific to the Member's documented medical condition and require hands-on assistance to complete.~~
  - i. Registered nurses who are affiliated with the Home Care Agency in which the member receives services are not permitted to develop the home exercise plan for the member in which they are serving. For CDASS, a home exercise plan must be prescribed by a Licensed Medical Professional, Occupational Therapist, or Physical Therapist.
- i. Transferring a Member when they are not able to perform transfers independently due to illness, injury, or disability, or:
  - i. The Member lacks the strength and stability to stand, maintain balance or bear weight reliably;
  - ii. The Member has not been deemed independent with Adaptive Equipment or assistive devices by a Licensed Medical Professional;
  - iii. The use of a mechanical lift is needed.
- j. Bowel care performed when health maintenance-level skin care or transfers are required in conjunction with the bowel care, or:
  - i. The Member is unable to assist or direct care;
  - ii. Administration of a bowel program including but not limited to digital stimulation, enemas, or suppositories;

- iii. Care of a colostomy or ileostomy that includes emptying and changing the ostomy bag and application of prescribed skin care products at the site of the ostomy.
- k. Bladder care performed when health maintenance-level skin care or transfers are required in conjunction with bladder care, or;
  - i. The Member is unable to assist or direct care;
  - ii. Care of external, indwelling, and suprapubic catheters;
  - iii. Changing from a leg to a bed bag and cleaning of tubing and bags as well as perineal care.
- l. 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.
- m. 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.
- n. Bathing assistance is considered a health maintenance task when the Member requires health maintenance-level skin care, transfers or dressing in conjunction with bathing.
- o. Medication assistance, which may include setup, handling and administering medications.
  - i. For In-Home Support Services (IHSS) only, The IHSS Agencies 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.
- p. 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 may also include providing one or more health maintenance tasks as needed during the trip. Attendants must assist with communication, documentation, verbal prompting and/or hands on assistance when the task may not be completed without the support of the Attendant.
- q. Mobility assistance is considered a health maintenance task when health maintenance-level transfers are required in conjunction with the mobility assistance, or:

- i. The Member is unable to assist or direct care;
    - ii. 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
    - iii. The Member has not been deemed independent with Adaptive Equipment or assistive devices ordered by a Licensed Medical Professional
  - r. 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
2. Additional HMA inclusion criteria for children are available within the Health Maintenance Activities Documentation Guide.

## **8.7526 Home Delivered Meals**

### **8.7526.A Home Delivered Meals Eligibility**

1. Home Delivered Meals is a covered benefit available to Members enrolled in CFC. ~~one of the following HCBS waivers:~~
- a. ~~Brain Injury Waiver~~
  - b. ~~Community Mental Health Supports Waiver~~
  - c. ~~Complementary and Integrative Health Waiver~~
  - d. ~~Elderly, Blind, and Disabled Waiver~~
  - e. ~~Supported Living Services Waiver~~
  - f. ~~Developmental Disability Waiver~~

### **8.7526.B Home Delivered Meals Definition**

1. ~~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.~~ Home Delivered Meals means 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. At the Member's request, this service may also include nutritional counseling and meal planning

### **8.7526.C Home Delivered Meals Inclusions**

1. Home Delivered Meals may include:

a. Meals intended to support member wellness, which may include meals tailored to the member's nutritional needs.

b. Meal planning developed for the Member's individual needs which may include nutritional meal planning, nutritional counseling, selected meal types, and instructions for meal preparation and delivery.

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

a. The member is transitioning from an institutional setting to a home and community-based setting; and/or

b. The member demonstrates the following:

i. The Member lacks or has limited access to outside assistance, services, or resources through which they can access meals; and

ii. The Member is unable to prepare meals to sustain health, or has dietary restrictions, or has specific nutritional needs; and

iii. The Member's inability to access and/or prepare nutritious meals demonstrates a risk to the member's health or safety, or institutionalization; decreasing independence and increasing the need for human intervention or assistance.

~~a. The Member demonstrates a need for nutritional counseling, meal planning, and preparation;~~

~~b. The Member shows documented dietary restrictions or specific nutritional needs;~~

~~c. 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;~~

~~d. The Member is unable to prepare meals with the type of nutrition vital to meeting their dietary restrictions or special nutritional needs;~~

~~e. The Member's inability to access and prepare nutritious meals demonstrates a need-related risk to health, safety, or institutionalization~~

~~2. To establish eligibility for Home Delivered Meals, for Members transitioning into the community, the Member must satisfy general criteria for accessing service:~~

~~a. 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;~~

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

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

~~d. Members accessing Home Delivered Meals post-hospital discharge must have been discharged from the hospital following a 24-hour admission.~~

## 8.7526.D Home Delivered Meals Service Requirements

1. The Member's Provider Care Plan must specifically identify:
  - a. ~~The Member's need for individualized nutritional counseling and development of a Nutritional Meal Plan. Any individualized nutritional counseling or nutritional meal plan requested by the Member,~~ which describes the Member's nutritional needs and selected meal types, and provides instructions for meal preparation and delivery; and
  - b. The Member's specifications for preparation and delivery of meals, and any other detail necessary to effectively implement the individualized meal plan.
2. The service must be provided in the home or community and in accordance with the Member's Person-Centered Support Plan. All Home Delivered Meal services shall be documented in the Provider Care Plan.
3. ~~For Members transitioning into the community, the~~ The assessed need is documented in the Member's service plan 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.
4. 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. Home Delivered Meals may be authorized past 365 days on a case-by-case basis if there is a demonstrated need.~~
5. ~~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.~~
56. Meals are to be delivered up to two meals per day, with a maximum of 14 meals delivered per week.
67. Meals may include liquid, mechanical soft, or other medically necessary types.
78. Meals may ~~include ethnic or cultural options.~~ ~~be ethnically or culturally tailored.~~
89. 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.
940. The Provider Agency shall confirm meal delivery, ~~by attestation of the deliverer or carrier proof of 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.
1044. ~~For Members transitioning into the community, the~~ ~~The providing Agency's certified RD or RDN~~ ~~The Home Delivered Meals provider~~ 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.
1142. ~~For Members transitioning into the community, the~~ ~~The RD or RDN~~ ~~case manager~~ will review a Member's progress toward the nutritional goal(s) described in the Member's Provider Care Plan no less frequently than once per calendar quarter, and more frequently, as needed. ~~If the case manager has concerns regarding the Member's progress toward the nutritional goal(s), they should refer back to the Home Delivered Meals provider to schedule a nutritional counseling session with a RD or RDN.~~

1213. ~~For Members transitioning into the community, the~~ The RD or RDN shall make changes to the Nutritional Meal Plan if the quarterly assessment results show changes are necessary or appropriate.

- a. ~~For Members transitioning into the community, the~~ ~~RD or RDN~~ Home Delivered Meals provider 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. ~~The case manager will~~ and to make corresponding updates to the Person-Centered Support Plan, as needed.

#### **8.7526.E Home Delivered Meals Exclusions and Limitations**

1. Home Delivered Meals are not available when the Member resides in a provider-owned or controlled setting.
2. Delivery must not constitute a full nutritional regimen and includes no more than two meals per day or 14 meals per week.
3. Items or services through which the Member's need for Home Delivered Meal services may otherwise be met, including any item or service available under the State Plan, applicable HCBS waiver, or other resources are excluded.
4. Meals not identified in the Nutritional Meal Plan or any item outside of the meals not identified in the meal plan, such as additional food items or cooking appliances are excluded.
5. Meal plans and meals provided are reimbursable when they benefit the Member, only. Services provided to someone other than the Member are not reimbursable.

#### **8.7526.F Home Delivered Meals Provider Agency Requirements**

1. 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.
2. Home Delivered Meal Provider Agencies must conform to all general Certification standards, conditions, and processes established in Section 8.7400.
3. The Provider Agency 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.
4. The Provider Agency must maintain a Registered Dietitian (RD) OR Registered Dietitian Nutritionist (RDN) on staff or under contract.
5. The Provider Agency shall maintain meals documentation in accordance with Section 8.7405 and shall provide documentation to supervisor(s), program monitor(s) and auditor(s), and CDPHE surveyor(s) upon request. Required documentation includes:
  - a. Documentation pertaining to the Provider Agency, including employee files, claim submission documents, program and financial records, insurance policies, and licenses, including a Retail Food License and Food Handling License for Staff, or, if otherwise applicable, documentation of compliance and good standing with the City and County municipality in which this service is provided; and

- b. Documentation pertaining to services, including:
  - i. Documentation of any professionally recommended 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 (e.g. through documented driver attestation or proof of carrier delivery);
  - vii. Monitoring and follow-up (contacting the Member after meal delivery to ensure the Member is satisfied with the meal); and
  - viii. Provision of nutrition counseling or documentation of Member declination.

#### **8.7526.G Home Delivered Meals Provider Agency Reimbursement**

- 1. Home Delivered Meals services are reimbursed based on the number of units of service provided, with one unit equal to one meal.
- 2. Payment for Home Delivered Meals shall be the lower of the billed charges or the maximum rate of reimbursement.
- 3. Reimbursement is limited to services described in the Provider Care Plan.

#### **8.7527 Homemaker Services**

##### **8.7527.A Homemaker Services Eligibility**

- 1. Homemaker Services is a covered benefit available to Members enrolled in CFC. one of the following HCBS waivers:
  - a. ~~Brain Injury Waiver when the Member is receiving Personal Care as defined at 8.7537~~
  - b. ~~Children's Extensive Support Waiver~~
  - c. ~~Community Mental Health Supports Waiver~~
  - d. ~~Complementary and Integrative Health Waiver~~
  - e. ~~Elderly, Blind, and Disabled Waiver~~
  - f. ~~Supported Living Services Waiver~~

##### **8.7527.B Homemaker Services Definitions**

1. Homemaker Provider Agency means a Provider Agency that is certified by the state fiscal agent to provide Homemaker Services.
2. Homemaker means services provided to an eligible Member that include general household activities to maintain a healthy and safe home environment for a Member.

#### **8.7527.C Homemaker Services Inclusions**

1. ~~HCBS Elderly, Blind, and 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;~~  
a. Service shall be for the benefit of the Member and not for the benefit of other persons living in the home. Homemaker services, except for laundry, and shopping, and Acquisition, Maintenance, and Enhancement of Skills (AME) must be completed within the permanent living space.
2. ~~b. Homemaker tasks may include:~~
  - ~~a.i. Routine light house cleaning, such as dusting, vacuuming, mopping, and cleaning bathroom and kitchen areas.~~
  - ~~b.ii. Meal preparation and menu planning.~~
  - ~~c.iii. Dishwashing.~~
  - ~~d.iv. Bedmaking.~~
  - ~~e.v. Laundry.~~
  - ~~f.vi. Shopping.~~
  - ~~g.vii. Banking/Money Management. Teaching the skills listed above to Members who are capable of learning to do such tasks for themselves. Teaching shall result in a required reevaluation of the teaching task every ninety days. If the Member has increased independence, the weekly units should decrease accordingly.~~
    - ~~i. For CDASS: caregivers cannot be reimbursed to provide money management tasks that would typically be completed by an authorized representative as defined in 8.7515.H.~~
  - ~~h. Appointment Management.~~
  - ~~i. Homemaker Services includes the option for the Acquisition, Maintenance, and Enhancement of Skills (AME) task when the support is related to functional skills training and is desired by the member to accomplish Homemaker tasks to increase their independence and reduce supports needed in the home and community.~~
    - ~~i. Detailed, task-related goals shall be documented by case manager in the Person-Centered Support Plan, including documentation monitoring progress and any decrease in human assistance previously authorized.~~
    - ~~ii. AME services shall include direct training and instruction to the Member in performing homemaker tasks.~~



iii. ~~The provider or attendant shall be physically present to provide step-by-step verbal or physical instructions throughout the entire task.~~

2. ~~HCBS Children's Extensive Support (CES) Waiver; Supported Living Services (SLS) Waiver:~~

a. ~~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.~~

b. ~~There are two types of homemaker services: Basic and Enhanced~~

i. ~~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.~~

1) ~~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 such as dusting, vacuuming, mopping, and cleaning bathroom and kitchen areas.~~

ii. ~~Enhanced homemaker services include basic homemaker services with the addition of either procedures for habilitation or procedures to perform extraordinary cleaning~~

1) ~~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.~~

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

a) ~~When such support is incidental to the habilitative services being provided, and~~

b) ~~To increase the independence of the Member,~~

3) ~~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.~~

4) ~~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.~~

**8.7527.D Homemaker Services Exclusions and Limitations**

1. ~~HCBS Elderly, Blind, and 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. The CFC~~ Homemaker service may NOT include:

a. Personal care services.

- b. Services the person can perform independently.~~c. Homemaker services provided by Family Members:~~
  - ~~i. In no case shall any person be reimbursed to provide services to his or her spouse.~~
  - ~~ii. CES only: This service is limited to 2080 units per support plan year when provided by a legally responsible person(s).~~
  - ~~iii. CDASS only: a Family Member or Member of the Member's household may only be paid to furnish extraordinary care as defined in 8.7515.02.~~
- ~~cd.~~ Homemaker services provided in Uncertified Congregate Facilities are not a benefit.
- ~~de.~~ Lawn care, snow removal, routine air duct cleaning, and animal care are specifically excluded and shall not be reimbursed.
- ~~ef.~~ Billing for travel time is prohibited. Accompaniment of a Member by a Direct Care Worker in the community is reimbursable. Provider Agencies must follow all Department of Labor and Employment guidelines on time worked.
- ~~fg.~~ Services that do not meet the task definition for Homemaker may not be approved.

2. When Homemaker services are provided by a legally responsible person:

- a. A legally responsible person or Member of the Member's household may only be paid to furnish extraordinary care as defined in 8.7514.B.11.02.
- b. Legally Responsible Persons shall not be reimbursed for more than 520 hours of homemaker services annually.

**8.7527.E Homemaker Services Provider Agency Requirements**

- 1. ~~HCBS Elderly, Blind, and 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; Supported Living Services (SLS) Waiver;a.~~  
All providers shall be certified by the Department as a Homemaker Provider Agency.
- 2. ~~b.~~ 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:
  - ~~a.i.~~ Tasks included in Section 8.7527.C Homemaker Inclusions.
  - ~~b.ii.~~ Proper food handling and storage techniques.
  - ~~c.iii.~~ Basic infection control techniques including Universal Precautions.
  - ~~d.iv.~~ Informing staff of policies concerning emergency procedures.
- 3. ~~c.~~ 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:
  - ~~a.i.~~ Train staff on Agency policies and procedures.

- ~~b.ii.~~ Arrange and document training.
- ~~c.iii.~~ Oversee scheduling and notify Members of schedule changes.
- ~~d.iv.~~ 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.
  - ~~i.~~ 1)—Supervision should be flexible to the needs of the member and may be conducted via phone, video conference, telecommunication, or in-person.
    - 1) ~~a)~~—If there is a safety concern with the services, the Provider Agency must make every effort to conduct an in-person Assessment.
    - 2) ~~b)~~—The Provider Agency must conduct Direct Care Worker (DCW) supervision to ensure that Member care and treatment are delivered in accordance with a plan of care that addresses the Member status and needs.

#### **8.7527.F Homemaker Provider Services Reimbursement Requirements:**

- 1. ~~HCBS Elderly, Blind, and 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; Supported Living Services (SLS) Waiver;~~
- ~~a.~~—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.
- ~~2.b.~~ Payment does not include travel time to or from the Member's residence.
- ~~3.e.~~ 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.
- ~~4.d.~~ 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.
- 5. Legally Responsible Persons shall not be reimbursed for more than 520 hours of homemaker services annually.

#### **8.7528 In-Home Support Services (IHSS)**

##### **8.7528.A In-Home Support Services Eligibility**

- 1. In-Home Support Services (IHSS) is a covered benefit available to Members enrolled in CFC. in ~~one of the following HCBS waivers:~~
  - ~~a. Children's Home and Community-Based Services Waiver~~
  - ~~b. Complementary and Integrative Health Waiver~~
  - ~~c. Elderly, Blind, Disabled Waiver~~

##### **8.7528.B In-Home Support Services Definitions**

1. Attendant means a person who is directly employed by an In-Home Support Services (IHSS) Agency to provide IHSS. A Family Member, including a spouse, may be an Attendant.
2. Authorized Representative means an individual designated by the Member, or by the Parent or Guardian of the Member, if appropriate, who has the judgment and ability to assist the Member in acquiring and receiving services under Title 25.5, Article 6, Part 12, C.R.S. The Authorized Representative shall not be the eligible person's service provider.
3. Care Plan means a written plan of care developed between the Member or the Member's Authorized Representative, In-Home Support Services (IHSS) Agency and Case Management Agency that is authorized by the Case Manager.
4. Extraordinary Care means a service that exceeds the range of care a [Family Memberlegally responsible person](#) 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.
5. Inappropriate Behavior means documented verbal, sexual, or physical threats or abuse committed by the Member or Authorized Representative toward Attendants, Case Managers, or the In-Home Support Services (IHSS) Agency.
6. Independent Living Core Services means services that advance and support the independence of individuals with disabilities and to assist those individuals to live outside of Institutions. These services include but are not limited to information and Referral services, independent living skills training, peer and cross-disability peer counseling, individual and systems advocacy, transition services or diversion from nursing homes and Institutions to Home and Community-Based living, or upon leaving secondary education.
7. In-Home Support Services (IHSS) means services that are provided in the home and in the community by an Attendant under the direction of the Member or Member's Authorized Representative, including Health Maintenance Activities and support for Activities of Daily Living or Instrumental Activities of Daily Living, Personal Care services and Homemaker services.
8. In-Home Support Services (IHSS) Agency means an Agency that is certified by the Colorado Department of Public Health and Environment, enrolled in the Medicaid program and provides Independent Living Core Services.
9. Licensed Health Care Professional means a state-licensed Registered Nurse (RN) who contracts with or is employed by the In-Home Support Services (IHSS) Agency.

#### **8.7528.C In-Home Support Services Member Eligibility**

1. To be eligible for In-Home Support Services (IHSS) the Member shall meet the following eligibility criteria:
  - a. Be enrolled in [CFC-a Medicaid program approved to offer IHSS](#).
  - b. Provide a signed Physician Attestation of Consumer Capacity form at enrollment and following any change in condition stating that the Member has sound judgment and the ability to self-direct care. If the Member is in unstable health with an unpredictable progression or variation of disability or illness, the Physician Attestation of Consumer Capacity form shall also include a recommendation regarding whether additional supervision is necessary and if so, the amount and scope of supervision requested.

- c. Members who elect or are required to have an Authorized Representative must appoint an Authorized Representative who has the judgment and ability to assist the Member in acquiring and using services.
  - d. Demonstrate a current need for covered Attendant support services.
2. In-Home Support Services (IHSS) eligibility for a Member will end if:
- a. The Member is no longer enrolled in ~~a Medicaid program approved to offer IHSS.CFC~~
  - b. The Member's medical condition deteriorates causing an unsafe situation for the Member or the Attendant as determined by the Member's Licensed Medical Professional.
  - c. The Member refuses to designate an Authorized Representative when the Member is unable to direct their own care as documented by the Member's Licensed Medical Professional on the Physician Attestation of Consumer Capacity form.
  - d. The Member provides false information or false records.
  - e. The Member no longer demonstrates a current need for Attendant support services.

#### **8.7528.D In-Home Support Services (IHSS) Inclusions and Covered Services**

1. Services are for the benefit of the Member. Services for the benefit of other persons are not reimbursable.

~~2. Services available for eligible adults (as defined in EBD and CIH waivers):~~

- ~~a. Homemaker~~
- ~~b. Personal Care~~
- ~~c. Health Maintenance Activities~~

~~3. Services available for eligible children (as defined in the CHCBS waiver):~~

- ~~a. Health Maintenance Activities~~

24. Service Inclusions:

- a. Homemaker inclusions are set forth at Section 8.7527.C.
- b. Personal Care inclusions are set forth at Section 8.7538.C.
- c. Health Maintenance Activities inclusions are set forth at Section 8.7523.C.

#### **8.7528.E In-Home Support Services (IHSS) Exclusions and Limitations**

1. In-Home Support Services (IHSS) is a covered benefit for ~~CFC members; the HCBS Elderly, Blind, and Disabled (EBD), Complementary Integrative Health (CIH), and Children's Home and Community-Based Services (CHCBS) Waivers:~~
- a. IHSS services must be documented on an approved IHSS Care Plan and prior authorized before any services are rendered. The IHSS Care Plan and Prior Authorization Request (PAR) must be submitted and approved by the Case Manager and

received by the IHSS Agency prior to services being rendered. Services rendered in advance of approval and receipt of these documents are not reimbursable.

- b. Services rendered by an Attendant who shares living space with the Member or Family Members are reimbursable only when the Case Manager determines, prior to the services being rendered, that the services meet the definition of Extraordinary Care.
- c. Health Maintenance Activities may include related Personal Care and/or Homemaker services if such tasks are completed in conjunction with the Health Maintenance Activity and are secondary or contiguous to the Health Maintenance Activity.
  - i. Secondary means in support of the main task(s). Secondary tasks must be routine and regularly performed in conjunction with a Health Maintenance Activity. The Case Manager must document evidence that the secondary task is necessary for the health and safety of the Member. Secondary tasks do not add units to the care plan.
  - ii. Contiguous means before, during or after the main task(s). Contiguous tasks must be completed before, during, or after the Health Maintenance Activity. The Case Manager must document evidence that the contiguous task is necessary for the health and safety of the Member. Contiguous tasks do not add units to the care plan.
  - iii. The IHSS Agency shall not submit claims for Health Maintenance Activities when only Personal Care and/or Homemaking services are completed.
- d. Independent Living Core Services, Attendant training, and oversight or supervision provided by the IHSS Agencies Licensed Health Care Professional are not separately reimbursable. No additional compensation is allowable to IHSS Agencies for providing these services.
- e. Billing for travel time is prohibited. Accompaniment of a Member by an Attendant in the community is reimbursable. IHSS Agencies must follow all Department of Labor and Employment guidelines on time worked.
- f. Companionship is not a benefit of IHSS and shall not be reimbursed.~~2. HCBS Children's Home and Community-Based (CHCBS) Waiver:
  - a. In Home Support Services (IHSS) for CHCBS shall be limited to tasks defined as Health Maintenance Activities.
  - b. Family Members of a Member can only be reimbursed for extraordinary care.~~  
~~3. HCBS Elderly, Blind, and Disabled (EBD), Complementary Integrative Health (CIH) Waivers:
  - a. Family Members shall not be reimbursed for more than forty (40) hours of Personal Care services in a seven (7) day period.
  - b. Restrictions on allowable Personal Care units shall not apply to Parents who provide Attendant services to their eligible adult children through In Home Support Services.~~

**8.7528.F In-Home Support Services (IHSS) Member and Authorized Representative Participation and Self-Direction**

1. A Member or their Authorized Representative may self-direct the following aspects of service delivery:
  - a. Present a person(s) of their own choosing to the In-Home Support Services (IHSS) Agency as a potential Attendant. The Member must have adequate Attendants to assure compliance with all tasks in the Care Plan.
  - b. Train Attendant(s) to meet their needs.
  - c. Dismiss Attendants who are not meeting their needs.
  - d. Schedule, manage, and supervise Attendants with the support of the IHSS Agency.
  - e. Determine, in conjunction with the IHSS Agency, the level of in-home supervision as recommended by the Member's Licensed Medical Professional.
  - f. Transition to alternative service delivery options at any time. The Case Manager shall coordinate the transition and Referral process.
  - g. Communicate with the IHSS Agency and Case Manager to ensure safe, accurate and effective delivery of services.
  - h. Request a Reassessment, as defined at Section 8.7200.B.27, if Level of Care or service needs have changed.
2. An Authorized Representative is not allowed to be reimbursed for In-Home Support Services (IHSS) Attendant services for the Member they represent.
3. If the Member is required to or elects to have an Authorized Representative, the Authorized Representative shall meet the requirements:
  - a. Must be at least 18 years of age.
  - b. Has not been convicted of any crime involving exploitation, abuse, neglect, or assault on another person.
4. The Authorized Representative must attest to the above requirement on the Shared Responsibilities Form.
5. In-Home Support Services (IHSS) Members who personally require an Authorized Representative may not serve as an Authorized Representative for another IHSS Member.
6. The Member and their Authorized Representative must adhere to In-Home Support Services (IHSS) Agency policies and procedures.

**8.7528.G In-Home Support Services Agency Eligibility**

1. The In-Home Support Services (IHSS) Agency must be a licensed home care Agency. The IHSS Agency shall comply with all requirements of their Certification and licensure, in addition to requirements described in Section 8.7400.
2. Administrators or managers as defined at 6 C.C.R. 1011-1 Chapter 26 shall satisfactorily complete the Department authorized training on In-Home Support Services (IHSS) rules and regulations prior to Medicaid Certification and annually thereafter. Provider Agencies must upload the certificate of completion annually into the Medicaid Provider Portal.

## **8.7528.H In-Home Support Services (IHSS) Agency Responsibilities**

1. The In-Home Support Services (IHSS) Agency shall assure and document that all Members are provided the following:
  - a. Independent Living Core Services
    - i. An IHSS Agency must provide a list of the full scope of Independent Living Core Services provided by the Agency to each Member on an annual basis. The IHSS Agency must keep a record of each Member's choice to utilize or refuse these services, and document services provided.
  - b. Attendant training, oversight and supervision by a licensed healthcare professional.
  - c. The IHSS Agency shall provide 24-hour back-up service for scheduled visits to Members at any time an Attendant is not available. At the time the Care Plan is developed the IHSS Agency shall ensure that adequate staffing is available. Staffing must include backup Attendants to ensure necessary services will be provided in accordance with the Care Plan.
2. The In-Home Support Services (IHSS) Agency shall adhere to the following:
  - a. If the IHSS Agency admits Members with needs that require care or services to be delivered at specific times or parts of day, the IHSS Agency shall ensure qualified staff in sufficient quantity are employed by the Agency or have other effective back-up plans to ensure the needs of the Member are met.
  - b. The IHSS Agency shall only accept Members for care or services based on a reasonable assurance that the needs of the Member can be met adequately by the IHSS Agency in the individual's temporary or permanent home or place of residence.
    - i. There shall be documentation in the Care Plan or Member record of the agreed upon days and times of services to be provided based upon the Member's needs that is updated at least annually.
  - c. If an IHSS Agency receives a Referral of a Member who requires care or services that are not available at the time of Referral, the IHSS Agency shall advise the Member or their Authorized Representative and the Case Manager of that fact.
    - i. The IHSS Agency shall only admit the Member if the Member or their Authorized Representative and Case Manager agree the recommended services can be delayed or discontinued.
  - d. The IHSS Agency shall ensure orientation is provided to Members or Authorized Representatives who are new to IHSS or request re-orientation through the Department's prescribed process. Orientation shall include instruction in the philosophy, policies, and procedures of IHSS and information concerning Member rights and responsibilities.
  - e. The IHSS Agency will keep written service notes documenting the services provided at each visit.
3. The In-Home Support Services (IHSS) Agency is the legal employer of a Member's Attendants and must adhere to all requirements of federal and state law, and to the rules, regulations, and practices as prescribed by the Department.



4. The In-Home Support Services (IHSS) Agency shall ensure that no attendant provides more than sixteen (16) hours of care per day for one or more members collectively.

54. The In-Home Support Services (IHSS) Agency shall assist all Members in interviewing and selecting an Attendant when requested and maintain documentation of the IHSS Agency's assistance and/or the Member's refusal of such assistance.

65. The In-Home Support Services (IHSS) Agency will complete an intake Assessment following Referral from the Case Manager. Utilizing the authorized units provided on the IHSS Care Plan Calculator provided by the Case Manager, the IHSS Agency will develop a Care Plan in coordination with the Case Manager and Member. Any proposed services described in the Care Plan that differ from the authorized services and units must be submitted to the Case Manager for review. The Care Plan must be approved prior to the start of services.

76. The In-Home Support Services (IHSS) Agency shall ensure that a current Care Plan is in the Member's record, and that Care Plans are updated with the Member at least annually or more frequently in the event of a Member's change in condition. The IHSS Agency will send the Care Plan to the Case Manager for review and approval.

a. The Care Plan will include a statement of allowable Attendant hours and a detailed listing of frequency, scope, and duration of each service to be provided to the Member for each day and visit. The Care Plan shall be signed by the Member or the Member's Authorized Representative and the IHSS Agency.

i. Secondary or contiguous tasks must be described on the care plan as required in Section 8.7528.E.3.a-b.

b. In the event of the observation of new symptoms or worsening condition that may impair the Member's ability to direct their care, the IHSS Agency, in consultation with the Member or their Authorized Representative and Case Manager, shall contact the Member's Licensed Medical Professional to receive direction as to the appropriateness of continued care. The outcome of that consultation shall be documented in the Member's revised Care Plan, with the Member and/or Authorized Representative's input and approval. The IHSS Agency will submit the revised Care Plan to the Case Manager for review and approval.

87. The In-Home Support Services (IHSS) Agencies Licensed Health Care Professional is responsible for the following activities:

a. Administer a skills validation test for Attendants who will perform Health Maintenance Activities. Skills validation for all assigned tasks must be completed prior to service delivery unless postponed by the Member or Authorized Representative to prevent interruption in services. The reason for postponement shall be documented by the IHSS Agency in the Member's file. In no event shall the skills validation be postponed for more than thirty (30) days after services begin to prevent interruption in services.

b. Verify and document Attendant skills and competency to perform IHSS and basic Member safety procedures.

c. Counsel Attendants and staff on difficult cases and potentially dangerous situations.

d. Consult with the Member, Authorized Representative or Attendant in the event a medical issue arises.

- e. Investigate Complaints and Incidents within ten (10) calendar days as required in Section 8.7411.
- f. Verify the Attendant follows all tasks set forth in the Care Plan.
- g. Review the Care Plan and Physician Attestation for Consumer Capacity form upon initial enrollment, following any change of condition, and upon the request of the Member, their Authorized Representative, or the Case Manager.
- h. Provide in-home supervision for the Member as recommended by their Licensed Medical Professional and as agreed upon by the Member or their Authorized Representative.

98. At the time of enrollment and following any change of condition, the In-Home Support Services (IHSS) Agency will review recommendations for supervision listed on the Physician Attestation of Consumer Capacity form. This review of recommendations shall be documented by the IHSS Agency in the Member record.

- a. The IHSS Agency shall collaborate with the Member or Member's Authorized Representative to determine the level of supervision provided by the IHSS Agency's Licensed Health Care Professional beyond the requirements set forth at Section 25.5-6-1203, C.R.S.
- b. The Member may decline recommendations by the Licensed Medical Professional for in-home supervision. The IHSS Agency must document this choice in the Member record and notify the Case Manager. The IHSS Agency and their Licensed Health Care Professional, Case Manager, and Member or their Authorized Representative shall discuss alternative service delivery options and the appropriateness of continued participation in IHSS.

109. The In-Home Support Services (IHSS) Agency shall assure and document that all Attendants have received training in the delivery of IHSS prior to the start of services. Attendant training shall include:

- a. Development of interpersonal skills focused on addressing the needs of persons with disabilities.
- b. Overview of IHSS as a service-delivery option of consumer direction.
- c. Instruction on basic first aid administration.
- d. Instruction on safety and emergency procedures.
- e. Instruction on infection control techniques, including Universal Precautions.
- f. Mandatory reporting and Incident reporting procedures.
- g. Skills validation test for unskilled tasks assigned on the care plan.

10. The In-Home Support Services (IHSS) Agency shall allow the Member or Authorized Representative to provide individualized Attendant training that is specific to their own needs and preferences.

11. With the support of the In-Home Support Services (IHSS) Agency, Attendants must adhere to the following:

- a. Must be at least 16 years of age and demonstrate competency in caring for the Member to the satisfaction of the Member or Authorized Representative.
    - i. Minor attendants ages 16 to 17 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).
  - b. May be a Family Member subject to the reimbursement and service limitations in 8.7528.J.
  - c. Must be able to perform the assigned tasks on the Care Plan.
  - d. Shall not, in exercising their duties as an In-Home Support Services (IHSS) Attendant, represent themselves to the public as a licensed nurse, a certified nurse's aide, a licensed practical or professional nurse, a registered nurse or a registered professional nurse pursuant to Section 25.5-6-1203(3), C.R.S.
  - e. Shall not have had their license as a nurse or certified nurse aide suspended or revoked or their application for such license or certification denied.
12. The In-Home Support Services (IHSS) Agency shall provide functional skills training to assist Members and their Authorized Representatives in developing skills and resources to maximize their independent living and personal management of health care.

**8.7528.I In-Home Support Services (IHSS) Case Management Agency Responsibilities**

- 1. The Case Manager shall provide information and resources about In-Home Support Services (IHSS) to eligible Members, including a list of IHSS Agencies in their service area and an introduction to the benefits and characteristics of participant-directed programs.
- 2. The Case Manager will initiate a Referral to the In-Home Support Services (IHSS) Agency of the Member or Authorized Representative's choice, including an outline of approved services as determined by the Case Manager's most recent Assessment. The Referral must include the Physician Attestation, Assessment information, and other pertinent documentation to support the development of the Care Plan.
- 3. The Case Manager must ensure that the following forms are completed prior to the approval of the Care Plan or start of services:
  - a. The Physician Attestation of Consumer Capacity form shall be completed upon enrollment and following any change in condition.
  - b. The Shared Responsibilities Form shall be completed upon enrollment and following any change of condition. If the Member requires an Authorized Representative, the Shared Responsibilities Form must include the designation and attestation of an Authorized Representative.
- 4. Upon the receipt of the Care Plan, the Case Manager shall:
  - a. Review the Care Plan within five business days of receipt to ensure there is no disruption or delay in the start of services.
  - b. Ensure all required information is in the Member's Care Plan and that services are appropriate given the Member's medical or functional condition. If needed, request

additional information from the Member, their Authorized Representative, the In-Home Support Services (IHSS) Agency, or Licensed Medical Professional regarding services requested.

- c. Review the Care Plan to ensure there is delineation for all services to be provided; including frequency, scope, and duration.
  - d. Review the Licensed Medical Professional's recommendation for in-home supervision as requested on the Physician Attestation of Consumer Capacity form. The Case Manager will document the status of recommendations and provide resources for services outside the scope of the Member's eligible benefits.
  - e. Collaborate with the Member or their Authorized Representative and the In-Home Support Services (IHSS) Agency to establish a start date for services. The Case Manager shall discontinue any services that are duplicative with IHSS.
  - f. Authorize cost-effective and non-duplicative services via the Prior Authorization Request (PAR). Provide a copy of the Prior Authorization Request (PAR) to the IHSS Agency in accordance with procedures established by The Department prior to the start of IHSS services.
  - g. Work collaboratively with the IHSS Agency, Member, and their Authorized Representative to mediate Care Plan disputes following The Department's prescribed process.
    - i. Case Managers will complete the Long-Term Care ~~Waiver~~ Program Notice of Action (LTC-803) and provide the Member or the Authorized Representative with the reasons for denial of requested service frequency or duration, information about the Member's rights to fair hearing, and appeal procedures.
5. The Case Manager shall ensure cost-effectiveness and non-duplication of services by:
- a. Documenting the discontinuation of previously authorized Agency-based care, including Homemaker, Personal Care, and long-term home health services that are being replaced by In-Home Support Services (IHSS).
  - b. Documenting and justifying any need for additional in-home services including but not limited to acute or long-term home health services, hospice, traditional HCBS services, and private duty nursing.
    - i. A Member may receive non-duplicative services from multiple Attendants or agencies if appropriate for the Member's Level of Care and documented service needs.
  - c. Ensuring the Member's record includes documentation to substantiate all Health Maintenance Activities on the Care Plan and requesting additional information as needed.
  - d. Coordinating transitions from a hospital, nursing facility, or other Agency to IHSS. Assisting Members with transitions from IHSS to alternate services if appropriate.
  - e. Collaborating with the Member or their Authorized Representative and the IHSS Agency in the event of any change in condition. The Case Manager shall request an updated Physician Attestation of Consumer Capacity form. The Case Manager may revise the Care Plan as appropriate given the Member's condition and functioning.

- f. Completing a Reassessment as defined at Section 8.7200.B.27 if requested by the Member if Level of Care or service needs have changed.
- 6. The Case Manager shall not authorize more than one consumer-directed program on the Member's Prior Authorization Request (PAR).
- 7. The Case Manager shall participate in training and consultative opportunities with the Department's Consumer-Directed Training ~~& Operations and Support~~ Contractor.
- 8. Additional requirements for Case Managers:
  - a. Contact the Member or Authorized Representative once a month during the first three months of receiving In-Home Support Services (IHSS) to assess their IHSS management, their satisfaction with Attendants, and the quality of services received.
  - b. Contact the Member or Authorized Representative quarterly, after the first three months of receiving IHSS, to assess their implementation of Care Plans, IHSS management, quality of care, IHSS expenditures and general satisfaction.
  - c. Contact the Member or Authorized Representative when a change in Authorized Representative occurs and continue contact once a month for three months after the change takes place.
  - d. Contact the IHSS Agency semi-annually to review the Care Plan, services provided by the Agency, and supervision provided. The Case Manager must document and keep record of the following:
    - i. In-Home Support Services (IHSS) Care Plans;
    - ii. In-home supervision needs as recommended by the Physician;
    - iii. Independent Living Core Services offered and provided by the IHSS Agency; and
    - iv. Additional supports provided to the Member by the IHSS Agency.
- 9. Start of Services
  - a. Services may begin only after the requirements of Sections 8.7528.C, 8.7528.H.5, 8.7528.H.9, and 8.7528.I.3 of this rule have been met.
  - b. The Case Manager shall follow the Department's ~~assessment utilization management review~~ process and receive authorization prior to authorizing a start date for Attendant services for Person-Centered Support Plans that;
    - i. Contain Health Maintenance Activities; or
    - ii. Exceed the cost of care received in an institutional setting.
  - c. The Case Manager shall establish a service period and submit a Prior Authorization Request (PAR), providing a copy to the In-Home Support Services (IHSS) Agency prior to the start of services.

**8.7528.J In-Home Support Services (IHSS) Reimbursement and Service Limitations**

1. In-Home Support Services (IHSS) Personal Care services must comply with the rules for reimbursement set forth at Section 8.7538 Personal Care. IHSS Homemaker services must comply with the rules for reimbursement set forth at Section 8.7527 Homemaker Services.
2. The In-Home Support Services (IHSS) Agency shall not submit claims for services missing documentation of the services rendered, for services which are not on the Care Plan, or for services which are not on an approved Prior Authorization Request (PAR). The IHSS Agency shall not submit claims for more time or units than were required to render the service regardless of whether more time or units were prior authorized. Reimbursement for claims for such services is not allowable.
3. The In-Home Support Services (IHSS) Agency shall request a reallocation of previously authorized service units for 24-hour back-up care prior to submission of a claim.
4. Services by an Authorized Representative to represent the Member are not reimbursable. In-Home Support Services (IHSS) services performed by an Authorized Representative for the Member that they represent are not reimbursable.
5. An In-Home Support Services (IHSS) Agency shall not be reimbursed for more than ~~twenty-four~~sixteen (16) hours of IHSS service in one day by an Attendant for one or more Members collectively.
6. A Member cannot receive In-Home Support Services (IHSS) and Consumer Directed Attendant Support Services (CDASS) at the same time.
7. Legally Responsible Persons shall not be reimbursed for more than 520 hours of homemaker services annually.
87. Payment does not include travel time to or from the Member's residence.

#### **8.7528.K In-Home Support Services (IHSS) Discontinuation and Termination**

1. A Member may elect to discontinue In-Home Support Services (IHSS) or use an alternate service-delivery option at any time.
2. A Member may be discontinued from In-Home Support Services (IHSS) when equivalent care in the community has been secured.
3. The Case Manager may terminate a Member's participation in In-Home Support Services (IHSS) for the following reasons:
  - a. The Member or their Authorized Representative fails to comply with IHSS program requirements as defined in Section 8.7528.F, or
  - b. A Member no longer meets program criteria, or
  - c. The Member provides false information, false records, or is convicted of fraud, or
  - d. The Member or their Authorized Representative exhibits Inappropriate Behavior, and The Department has determined that the IHSS Agency has made adequate attempts at dispute resolution and dispute resolution has failed.
    - i. The IHSS Agency and Case Manager are required to assist the Member or their Authorized Representative to resolve the Inappropriate Behavior, which may include the addition of or a change of Authorized Representative. All attempts to

resolve the Inappropriate Behavior must be documented prior to notice of termination.

4. When an In-Home Support Services (IHSS) Agency discontinues services, the Agency shall give the Member and the Member's Authorized Representative written notice of at least thirty days. Notice shall be provided in person, by certified mail or another verifiable-receipt service. Notice shall be considered given when it is documented that the Member or Authorized Representative has received the notice. The notice shall provide the reason for discontinuation. A copy of the 30-day notice shall be given to the Case Management Agency.
  - a. Exceptions will be made to the requirement for advanced notice when the In-Home Support Services (IHSS) Agency has documented that there is an immediate threat to the Member, IHSS Agency, or Attendants.
  - b. Upon In-Home Support Services (IHSS) Agency discretion, the Agency may allow the Member or their Authorized Representative to use the 30-day notice period to address conflicts that have resulted in discontinuation.
5. If continued services are needed with another Agency, the current In-Home Support Services (IHSS) Agency shall collaborate with the Case Manager and Member or their Authorized Representative to facilitate a smooth transition between agencies. The IHSS Agency shall document due diligence in ensuring continuity of care upon discharge as necessary to protect the Member's safety and welfare.
6. In the event of discontinuation or termination from In-Home Support Services (IHSS), the Case Manager shall:
  - a. Complete the Long-Term Care ~~Waiver~~ Program Notice of (LTC-803) and provide the Member or the Authorized Representative with the reasons for termination, information about the Member's rights to fair hearing, and appeal procedures. Once notice has been given, the Member or Authorized Representative may contact the Case Manager for assistance in obtaining other home care services or additional benefits if needed.

## **8.7538 Personal Care**

### **8.7538.A Personal Care Eligibility**

1. Personal Care is a covered benefit available to Members enrolled in CFC ~~one of the following HCBS waivers:~~
  - a. ~~Brain Injury Waiver~~
  - b. ~~Community Mental Health Supports Waiver~~
  - c. ~~Complementary and Integrative Health Waiver~~
  - d. ~~Elderly, Blind, and Disabled Waiver~~
  - e. ~~Supported Living Services Waiver~~

### **8.7538.B Personal Care Definition**

1. Personal Care means services provided to an eligible Member to meet the Member's physical, maintenance, and supportive needs through hands-on assistance, supervision and/or cueing. These services do not require a nurse's supervision or physician's orders.

#### **8.7538.C Personal Care Inclusions**

1. Tasks included in Personal Care:
  - a. Eating/feeding which includes assistance with eating by mouth using common eating utensils such as spoons, forks, knives, and straws;
  - b. Respiratory assistance with cleaning or changing oxygen equipment tubes, filling distilled water reservoirs, and moving a cannula or mask to or from the Member's face;
  - c. Preventative skin care when skin is unbroken, including the application of non-medicated/non-prescription lotions, sprays and/or solutions, and monitoring for skin changes.
  - d. Bladder/Bowel Care:
    - i. Assisting Member to and from the bathroom;
    - ii. Assistance with bed pans, urinals, and commodes;
    - iii. Changing incontinence clothing or pads;
    - iv. Emptying Foley or suprapubic catheter bags, but only if there is no disruption of the closed system;
    - v. Emptying ostomy bags; and
    - vi. Perineal care.
  - e. Personal hygiene:
    - i. Bathing including washing, shampooing;
    - ii. Grooming;
    - iii. Shaving with an electric or safety razor;
    - iv. Combing and styling hair;
    - v. Filing and soaking nails; and
    - vi. Basic oral hygiene and denture care.
  - f. Dressing assistance with ordinary clothing and the application of non-prescription support stockings, braces and splints, and the application of artificial limbs when the Member is able to assist or direct.
  - g. Transferring a Member when the Member has sufficient balance and strength to reliably stand and pivot and assist with the transfer. Adaptive and safety equipment may be used in transfers, provided that the Member and Direct Care Worker are fully trained in the use of the equipment and the Member can direct and assist with the transfer.



- h. Mobility assistance when the Member has the ability to reliably balance and bear weight or when the Member is independent with an assistive device.
- i. Positioning when the Member is able to verbally or nonverbally identify when their position needs to be changed including simple alignment in a bed, wheelchair, or other furniture.
- j. Medication Reminders when medications have been preselected by the Member, a Family Member, a nurse or a pharmacist, and the medications are stored in containers other than the prescription bottles, such as medication minders, and:
  - i. Medication reminders are clearly marked with the day, time, and dosage and kept in a way as to prevent tampering;
  - ii. Medication reminding includes only inquiries as to whether medications were taken, verbal prompting to take medications, handing the appropriately marked medication minder container to the Member and opening the appropriately marked medication minder if the Member is unable to do so independently.
- k. ~~Accompanying includes the following: going with the Member, as indicated on the care plan, to medical appointments and errands such as banking and household shopping. Accompanying the Member may include providing one or more personal care services as needed during the trip. A Direct Care Worker may assist with communication, documentation, verbal prompting, and/or hands-on assistance when the task cannot be completed without the support of the Direct Care Worker.~~
  - i. Going with the Member to medical appointments, as indicated on the support plan, to provide one or more personal care tasks, or assist with communication, documentation, verbal prompting, and/or hands-on assistance when the task cannot be completed without the support of the Direct Care Worker; and/or
  - ii. Going with the Member to run errands such as grocery shopping or banking and providing one or more personal care tasks as needed during the trip.
- l. Homemaker Services, as described at Section 8.7527, may be provided by personal care staff, if provided during the same visit as personal care.
- m. Cleaning and basic maintenance of durable medical equipment.
- n. Protective Oversight is allowed when the Member requires supervision to prevent or mitigate disability, memory, or cognitive functioning-related behaviors or impairment, that may result in imminent harm to self, people, or property.:
  - i. ~~In the HCBS Elderly, Blind, and Disabled (EBD); Brain Injury (BI); Complementary and Integrative Health (CIH); Community Mental Health Supports (CMHS) Waivers: is allowed when the Member requires stand-by assistance with any of the unskilled personal care described in these regulations, or when the Member must be supervised at all times to prevent wandering.~~
  - ii. ~~For In-Home Support Services (IHSS) and Consumer Directed Attendant Support Services (CDASS): is allowed when the Member requires supervision to prevent or mitigate disability-related behaviors that may result in imminent harm to people or property.~~
  - iii. ~~In the HCBS Supported Living Services (SLS) Waiver: is not allowed.~~

o. Personal Care Services includes the option for the Acquisition, Maintenance, and Enhancement of Skills (AME) task when the support is related to functional skills training and is desired by the member to accomplish Personal Care tasks to increase their independence and reduce supports needed in the home and community.

i. Detailed, task-related goals shall be documented by case manager in the Person-Centered Support Plan, including documentation monitoring progress and any decrease in human assistance previously authorized.

ii. AME services shall include direct training and instruction to the Member in performing Personal Care tasks.

iii. The provider or attendant shall be physically present to provide step-by-step verbal or physical instructions throughout the entire task.

o. Exercise:

i. In the HCBS Elderly, Blind, and Disabled (EBD) Waiver; Brain Injury (BI) Waiver; Complementary and Integrative Health (CIH) Waiver; Community Mental Health Supports (CMHS); Supported Living Services (SLS) Waiver; is allowed when not prescribed by a Licensed Medical Professional and limited to the encouragement of normal bodily movement, as tolerated, on the part of the Member.

p. For In-Home Support Services (IHSS) and Consumer Directed Attendant Support Services (CDASS); is not allowed as a personal care service.2. Supported Living Services (SLS) Waiver:

a. In addition to the inclusions at Section 8.7538.C, personal care provided under the SLS Waiver also includes:

i. Assistance with money management,

ii. Assistance with menu planning and grocery shopping, and

iii. Assistance with health-related services including first aid, medication administration, assistance scheduling or reminders to attend routine or as needed medical, dental, and therapy appointments, support that may include accompanying Members to routine or as needed medical, dental, or therapy appointments to ensure understanding of instructions, doctor's orders, follow up, diagnoses or testing required, or skilled care that takes place out of the home.

#### **8.7538.D Personal Care Exclusions and Limitations**

1. The following exclusions and limitations apply to the HCBS Brain Injury (BI); Elderly, Blind, and Disabled (EBD); Complementary and Integrative Health (CIH); Community Mental Health Supports (CMHS); Supported Living Services (SLS) Waivers:

a. Personal care services shall not include any skilled care. Skilled care as defined under Section 8.7523, shall not be provided as personal care services under HCBS, regardless of the level of the training, certification, or supervision of the personal care employee.

2.b. The amount of personal care that is prior authorized is only an estimate. The prior authorization includes the number of hours a Member may need for their care; the Member is not required to utilize all units, however, units over the maximum authorized are not eligible for reimbursement, All hours provided and reimbursed by Medicaid must be for covered services and must be necessary to meet the Member's needs.

- ~~3.e.~~ Personal Care Provider Agencies may decline to perform any specific task, if the supervisor or the personal care staff feels uncomfortable about the safety of the Member or the personal care staff, regardless of whether the task may be included in the definition above.
- ~~4.d.~~ ~~Family Members shall not be reimbursed for providing only homemaker services.~~ Family Members must provide ~~relative~~ personal care in accordance with the following:
- ~~ai.~~ Family Members may be employed by ~~certified~~ Personal Care Agencies that are licensed and certified, as applicable to programs offered by the agency, to provide Personal Care Services to relatives enrolled a waiver subject to the conditions below.
  - ~~bii.~~ The Family Member shall meet all requirements for employment by a ~~certified p~~Personal ~~e~~Care Agency that is licensed and certified, as applicable to programs offered by the agency, and shall be employed and supervised by the personal care Agency.
  - ~~ciii.~~ The Family Member providing personal care shall be reimbursed, an hourly rate, by the personal care Agency which employs the Family Member, with the following restrictions:
    - ~~i.1)~~ ~~The total number of Medicaid personal care units for a Member of the Members Family shall not exceed the equivalent of 444 hours per support plan year which is equivalent to an average of 1.2164 hours a day (as indicated on the Member's support plan).~~
    - ~~a)~~ ~~If the support plan year for the waiver is less than one year, the maximum reimbursement for relative personal care shall be calculated by multiplying the number of days the Member is receiving care by the average hours per day of personal care for a full year.~~
    - ~~b)~~ ~~The reimbursement for personal care units shall cover the personal care Agency's costs for unemployment insurance, worker's compensation, FICA, training and supervision, and all other administrative costs.~~
    - ~~c)~~ ~~The above restrictions on allowable personal care units shall not apply to Members who receive personal care through Consumer Directed Attendant Support Services (CDASS), whose parents provide Attendant services to their eligible adult children through In-Home Support Services (IHSS), or who receive Personal Care through the SLS Waiver.~~
    - ~~2)~~ ~~If two or more waiver Members reside in the same household, Family Members may be reimbursed up to the maximum for each Member if the services are not duplicative and are appropriate to meet the Member's needs.~~
    - ~~ii.3)~~ When ~~waiver CFC~~ funds are utilized for reimbursement of personal care services provided by the Member's family, the home care allowance may not be used to reimburse the family.
- ~~d.iv.~~ Documentation of services provided shall indicate that the provider is a relative when services are provided by a Family Member.
- ~~54.~~ Billing for travel time is prohibited. Accompaniment of a Member by a Direct Care Worker in the community is reimbursable. Provider Agencies must follow all Department of Labor and Employment guidelines on time worked.

6. Individual caregivers may not be reimbursed for more than sixteen (16) hours of care per day for one or more members collectively.

#### **8.7538.E Personal Care Provider Agency Requirements**

1. ~~For the HCBS Brain Injury (BI); Elderly, Blind, and Disabled (EBD); Complementary and Integrative Health (CIH); Community Mental Health Supports (CMHS); and Supported Living Services (SLS) Waivers:~~
  - a. In addition to the training requirements described in Section 8.7400 HCBS Provider Agency Requirements, Personal Care Provider Agencies must be licensed and certified, as applicable to programs offered by the agency, through Colorado Department of Public Health and Environment. Personal Care Provider Agencies shall assure and document that all personal care staff have received at least twenty hours of training, or have passed a skills validation test, in the provision of unskilled personal care as described above. Training, or skills validation, shall include the areas of bathing, skin care, hair care, nail care, mouth care, shaving, dressing, feeding, assistance with ambulation, exercises and transfers, positioning, bladder care, bowel care, medication reminding, homemaking, and Protective Oversight. Training shall also include instruction in basic first aid, and training in infection control techniques, including Universal Precautions. Training or skills validation shall be completed prior to service delivery, except for components of training that may be provided in the Member's home, in the presence of the supervisor.
    - ba. All employees providing personal care shall be supervised by a person who, at a minimum, has received the training, or passed the skills validation test, required of personal care staff, as specified above. Supervision shall include, but not be limited to, the following activities:
      - i. Orientation of staff to Agency policies and procedures.
      - ii. Arrangement and documentation of training.
      - iii. Informing staff of policies concerning advance directives and emergency procedures.
      - iv. Oversight of scheduling, and notification to Members of changes; or close communication with scheduling staff.
      - v. Written assignment of duties on a Member-specific basis.
      - vi. Meetings and conferences with staff as necessary.
      - vii. Supervisory visits to Member's homes at least every three months, or more often as necessary, for problem resolution, skills validation of staff, Member-specific or procedure-specific training of staff, observation of Member's condition and care, and Assessment of Member's satisfaction with services. At least one of the assigned personal care staff must be present at supervisory visits at least once every three months.
        - 1) Supervision should be flexible to the needs of the member and may be conducted via phone, video conference, telecommunication, or in-person.

- a) If there is a safety concern with the services, the Provider Agency must make every effort to conduct an in-person Assessment.
- b) The Provider Agency must conduct Direct Care Worker (DCW) supervision to ensure that Member care and treatment are delivered in accordance with a plan of care that addresses the Member status and needs.

viii. Investigation of Complaints and Incidents.

ix. Counseling with staff on difficult cases, and potentially dangerous situations.

x. Communication with the Case Managers, the physician, and other providers on the care plan, as necessary to assure appropriate and effective care.

xi. Oversight of record keeping by staff.

eb. A Personal Care Agency may be denied or terminated from participation in Colorado Medicaid, according to Section 8.7403. Additionally, personal care agencies may be terminated for the following:

i. Improper Billing Practices:

- 1) Billing for visits without documentation to support the claims billed. Acceptable documentation for each visit billed shall include the nature and extent of services, the care provider's signature, the month, day, year, and the exact time in and time out of the Member's home. Providers shall submit or produce requested documentation in accordance with rules at Section 8.7400.
- 2) Billing for excessive hours that are not justified by the documentation of services provided, or by the Member's medical or functional condition. This includes billing all units prior authorized when the allowed and needed services do not require as much time as that authorized.
- 3) Billing for time spent by the personal care provider performing any tasks that are not allowed according to regulations in Section 8.7538. This includes but is not limited to companionship, financial management, transporting of Members, skilled personal care, or delegated nursing tasks.
- 4) Unbundling of home health aide and personal care or homemaker services, which is defined as any and all of the following practices by any personal care/homemaker Agency that is also certified as a Medicaid Home Health Agency, for all time periods during which regulations were in effect that defined the unit for home health aide services as one visit up to a maximum of two and one-half hours:
  - a) One employee makes one visit, and the Agency bills Medicaid for one home health aide visit and bills all the hours as personal care or homemaker.
  - b) One employee makes one visit, and the Agency bills for one home health aide visit, and bills some of the hours as personal

care or homemaker, when the total time spent on the visit does not equal at least 2 1/2 hours plus the number of hours billed for personal care and homemaker.

- c) Two employees make contiguous visits, and the Agency bills one visit as home health aide and the other as personal care or homemaker, when the time spent on the home health aide visit was less than 2 1/2 hours.
  - d) One or more employees make two or more visits at different times on the same day, and the Agency bills one or more visits as home health aide and one or more visits as personal care or homemaker, when any of the aide visits were less than 2 1/2 hours and there is no reason related, to the Member's medical condition or needs that required the home health aide and personal care or homemaker visits to be scheduled at different times of the day.
  - e) One or more employees make two or more visits on different days of the week, and the Agency bills one or more visits as home health aide and one or more visits as personal care or homemaker, when any of the aide visits were less than 2 1/2 hours and there is no reason related to the Member's medical condition or needs that required the home health aide and personal care or homemaker visits to be scheduled on different days of the week.
  - f) Any other practices that circumvent these rules and result in excess Medicaid payment through unbundling of home health aide and personal care or homemaker services.
- 5) For all time periods during which the unit of reimbursement for home health aide is defined as hour and/or half-hour increments, all the practices described in 4 above shall constitute unbundling if the home health aide does not stay for the maximum amount of time for each unit billed.
- 6) Billing for travel time Accompaniment of a Member by a Direct Care Worker in the community is reimbursable. Provider Agencies must follow all Department of Labor and Employment guidelines on time worked.
- ii. Refusal to Provide Necessary and Allowed Personal Care or Homemaker Services Without Also Receiving Payment for Home Health Services.
  - 1) A personal care/homemaker agency that is also certified as a Medicaid Home Health Agency may be terminated from Medicaid participation if the agency refuses to provide necessary and allowed HCBS personal care or homemaker services to Members who do not need Home Health services or who receive their Home Health services from a Home Health Agency not affiliated with the personal care/homemaker agency.
- iii. Prior Termination from Medicaid Participation.
  - 1) A personal care/homemaker agency shall be denied or terminated from Medicaid participation if the agency or its owner(s) have been previously

involuntarily terminated from Medicaid participation, regardless of the provider type of the entity that was terminated.

iv. Abrupt Prior Closure.

- 1) A personal care/homemaker agency may be denied or terminated from Medicaid participation if the agency or its owner(s) have abruptly closed without proper prior Member notification regardless of the provider type of the entity that closed abruptly.

#### 8.7538.F Personal Care Reimbursement Requirements

1. ~~HCBS Brain Injury (BI) Waiver; Elderly, Blind, and Disabled (EBD) Waiver; Complementary and Integrative Health (CIH) Waiver; Community Mental Health Supports (CMHS) Waiver;~~
- a. Payment for personal care services shall be the lower of the billed charges or the maximum rate of reimbursement. Reimbursement shall be per unit of ~~one hour~~ 15 minutes. The maximum unit rate shall be adjusted by the State as funding becomes available.
- ~~2.b.~~ Payment does not include travel time to or from the Member's residence.
- ~~3.e.~~ When personal care services are used to provide respite for unpaid primary caregivers, the exact services rendered must be specified in the documentation.
- ~~4.~~ ~~d.~~ If a visit by a personal care staff includes some homemaker and personal care services, the ~~entire~~ visit shall be ~~billed~~ billed separately in accordance with services provided as personal care services. ~~If the visit includes only homemaker services, and no personal care is provided, the entire visit shall be billed as homemaker services.~~
- ~~5.e.~~ If a visit by a Home Health Aide from a Home Health Agency includes unskilled personal care, as defined in this section, only the Home Health Aide visit shall be billed.~~f.~~
6. There shall be no reimbursement under this section for personal care services provided in certified, uncertified, licensed, or unlicensed Congregate Facilities.

#### 8.7544 Remote Supports

##### 8.7544.A Remote Supports Eligibility

1. Remote Supports is a covered benefit available to Members enrolled in CFC ~~one of the following HCBS waivers:~~
- a. ~~Brain Injury Waiver~~
- b. ~~Community Mental Health Supports Waiver~~
- c. ~~Complementary and Integrative Health Waiver~~
- d. ~~Elderly, Blind, and Disabled Waiver~~
- e. ~~Supported Living Services Waiver~~

##### 8.7544.B Remote Support Definitions

1. 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.
2. Monitoring Base means the off-site location from which the Remote Supports Provider monitors the Member.
3. Remote Supports means the provision of support by staff at a HIPAA compliant Monitoring Base who engage with a Member 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 in other HCBS services.
4. Remote Supports Service Plan means a document that describes the Member's need for remote support, devices that will be used, number of service hours, emergency contacts, and a safety plan developed between the Member and Remote Supports Provider Agency in consultation with their Case Manager.
5. Remote Supports Provider means the Provider Agency selected by the Member to provide Remote Supports. This provider supplies the monitoring base, the remote support staff who monitor a Member from the monitoring base, and the remote support technology equipment necessary for the receiving Remote Supports,
6. 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.

#### **8.7544.C Remote Supports Inclusions**

1. Remote Supports that help a Member with Activities of Daily Living and ~~I~~instrumental ~~A~~activities of ~~D~~daily ~~L~~iving tasks that can be completed through virtual two-way live communication with prompts, supervision, or coaching~~ing~~ from a Remote Supports Provider are a covered benefit.
2. Remote Supports includes prompting, coaching, and virtual supervision with Activities of Daily Living and Instrumental Activities of Daily Living either in a Member's home or community that are documented in the Member's Remote Supports Service Plan.
3. Remote Supports Technology services shall include but are not limited to the following technology options:
  - a. Motion sensing system;
  - b. Radio frequency identification;
  - c. Live audio feed;
  - d. Web-based system; or,
  - e. Another device that facilitates two-way communication.
4. Remote Supports includes the following general provisions:
  - a. Remote Supports shall only be approved when it is the Member's preference and will reduce the assessed need for in-person care.



- b. 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.
- c. Remote Supports shall be provided in real time by awake staff at a Monitoring Base using the appropriate technology. While Remote Supports is being provided, the Remote Supports staff shall not have duties other than the provision of Remote Supports.

**8.7544.D- Remote Supports Exclusions and Non-Benefit Items**

- 1. Remote Supports shall be authorized ~~only~~ for Members who have the physical and mental capacity to utilize the particular system(s) that meet needs identified during the person-centered planning process, and which the Member prefers to be met with virtual support. ~~requested for that Member.~~
- 2. Remote Supports shall not be authorized under CFC HCBS if the service or device is available as a state plan Medicaid benefit.
- 3. Remote Supports shall not be performed concurrently or be duplicative of any other HCBS benefit or service.
- 4. Remote Supports shall not provide any service that is authorized for Telehealth at Section 8.7562.
- 5. Remote Supports Technology shall only be used for the delivery of Remote Supports.
- 6. Remote Supports is available to Members to foster developmentally appropriate independence and not to replace informal support.
- 7. Video or audio monitoring and recording is not allowed. Interactions between the Remote Support Provider and the Member should be through live, two-way communication that is on-demand, scheduled, or alerted by a sensor as agreed to by the Member in the Remote Supports Service Plan.
- 8. Devices used for communication shall not be mounted in a bedroom or bathroom and must be able to be moved by the Member to a location of their choice.
- 9. The following are not benefits of Remote Supports:
  - a. The cost of meals, household supplies, cell phones, internet access, landline telephone lines, and cellular phone voice or data plans.
  - b. Augmentative communication devices and communication boards;
  - c. Hearing aids and accessories;
  - d. Phonic ears;
  - e. Environmental control units;
  - f. Computers and computer software unrelated to the provision of Remote Supports;
  - g. Wheelchair lifts for automobiles or vans;
  - h. Exercise equipment, such as exercise cycles;

- i. Hot tubs, Jacuzzis, or similar items.

**8.7544.E Remote Supports Provider Agency Requirements**

1. The Remote Supports Provider must comply with the Provider Agency Regulations at Section 8.7400 et seq. and the provider enrollment agreement.
2. The Remote Supports Provider shall meet with the Member to identify Remote Supports service needs and develop services in a Remote Supports Service Plan that will be sent to the Member's Case Manager. The Remote Supports Care Plan must include:
  - a. The location(s) where the Member will receive the service,
  - b. A description of tasks/services the Remote Supports Provider will perform for the Member,
  - c. The technology devices determined necessary to help the Member meet their identified need
  - d. Family or providers with whom the Member has authorized the Remote Supports Provider to share information with and a safety plan that includes emergency contact information and medical conditions, if any, that should be shared with emergency response personnel if the provider must contact them, and
  - e. An up-to-date list of Backup Support Person(s). 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.
3. Remote Supports Providers shall conform to the following standards for electronic monitoring services:
  - a. Properly trained individuals shall install all equipment, materials, or appliances, and the installer and/or provider of electronic monitoring shall train the Member in the use of the device.
  - b. All equipment, materials, or appliances shall be tested for proper functioning at the time of installation, and at periodic intervals after that, and be maintained based on the manufacturer's recommendations. Any malfunction shall be promptly repaired, and equipment replaced when necessary, including buttons and batteries.
  - c. All telephone calls generated by monitoring equipment shall be toll-free, and all Members shall be allowed to run unrestricted tests on their equipment.
  - d. Remote Supports Providers shall send written information to each Member's Case Manager about the system, how it works, and how it will be maintained in the Remote Support Plan.
  - e. 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) including regular confirmation that the Member knows how to turn systems on and off.
4. The Remote Supports Provider shall provide initial and ongoing training to its staff to ensure they know how to use the Monitoring Base System.

5. 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.
6. The Remote Support Provider shall have an effective system for notifying emergency personnel in the event of an emergency.
7. 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.
8. 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.
9. When a Member requests in-person assistance, the Backup Support Person shall arrive at the Member's location within a reasonable amount of time based on team agreement to be specified in documentation maintained by the Remote Support Provider.
10. When a Member needs assistance, but the situation is not an emergency, the Remote Supports Provider shall:
  - a. Address the situation from the Monitoring Base, or,
  - b. Contact the Member's Backup Support Person if necessary.
11. 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.
12. 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.
13. The Remote Supports Provider shall maintain daily service provision documentation that shall include the following:
  - a. Type of Service,
  - b. Date of Service,
  - c. Place of Service,
  - d. Name of Member receiving service,
  - e. Medicaid identification number of Member receiving service,
  - f. Name of Remote Supports Provider,
  - g. Identify the Backup Support Person and their contact information, if/when utilized.
  - h. Begin and end time of the Remote Supports service,

- i. Begin and end time of the Remote Supports service when a Backup Support Person is needed on site,
- j. Begin and end time of the Backup Support Person when on site, whether paid or unpaid,
- k. Number of units of Remote Supports service delivered per calendar day,
- l. Description and details of the outcome of providing Remote Supports, and any new or identified needs that are outside of the Member's current Person-Center Support Plan, which shall be communicated to the Member's Case Manager.

#### **8.7544.F Remote Supports Reimbursement**

- 1. For Remote Supports, the reimbursement unit 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.
- 2. Remote Supports in Provider -Owned, -Controlled, or Congregate Facility settings are not eligible for reimbursement by the Colorado Medicaid program.

#### **8.7552 Transition Setup**

##### **8.7552.A Transition Setup Eligibility**

- 1. Transition Setup is a covered benefit available to Members enrolled in CFC. ~~one of the following HCBS waivers:~~
  - a. ~~Brain Injury Waiver~~
  - b. ~~Community Mental Health Supports Waiver~~
  - c. ~~Complementary and Integrative Health Waiver~~
  - d. ~~Developmental Disabilities Waiver~~
  - e. ~~Elderly, Blind, and Disabled Waiver~~
  - f. ~~Supported Living Services Waiver~~

##### **8.7552.B Transition Setup Definition**

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

##### **8.7552.C Transition Setup Inclusions**

- 1. Transition Setup assists the Member by coordinating the purchase of items or services needed to establish a basic household and to ensure the home environment is ready for move-in with all applicable furnishings set up and operable; and
- 2. Transition Setup allows up to \$2000 in reimbursement for the purchase of one-time, non-recurring expenses necessary for a Member to establish a basic household as they transition from an

institutional setting to a community setting. The Department may authorize additional funds above the \$2,000 limit, not to exceed a total value of \$2,500, when it is demonstrated as a necessary expense to ensure the health, safety, and welfare of the member. Allowable expenses include:

- a. Security deposits that are required to obtain a lease on an apartment or home.
- b. Setup fees or deposits to access basic utilities or services (telephone, internet, electricity, heat, and water).
- c. Services necessary for the individual's health and safety such as pest eradication or one-time cleaning prior to occupancy.
- d. Essential household furnishings required to occupy, including furniture, window coverings, food preparation items, or bed or bath linens.
- e. Expenses incurred directly from the moving, transport, provision, or assembly of household furnishings to the residence.
- f. Housing application fees and fees associated with obtaining legal and/or identification documents necessary for a housing application such as a birth certificate, state ID, or criminal background check.

#### **8.7552.D Transition Setup Service Access and Authorization**

1. To access Transition Setup, a Member must be transitioning from an institutional setting or Regional Center to a community living arrangement and participate in a needs-based Assessment through which they demonstrate a need for the service based on the following:
  - a. The Member demonstrates a need for the coordination and purchase of one-time, non-recurring expenses necessary for a Member to establish a basic household in the community;
  - b. The need demonstrates risk to the Member's health, safety, or ability to live in the community; or
  - c. Other services/resources to meet need are not available.
2. The Member's assessed need must be documented in the Member's Transition Plan and Person-Centered Support Plan.

#### **8.7552.E Transition Setup Exclusions and Limitations**

1. Transition Setup may be used to coordinate or purchase one-time, non-recurring expenses up to thirty (30) days post-transition.
2. Transition Setup does not substitute for services available under the Medicaid State Plan, other Waiver Services, or other resources.
3. Transition Setup is not available to a Member transitioning to, or residing in, a provider-owned or provider-controlled setting.
4. Transition Setup does not include payment for room and board.
5. Transition Setup does not include rental or mortgage expenses, ongoing food costs, regular utility charges, cable or satellite services.

6. Transition Setup is not available for a transition to a living arrangement that does not match or exceed HUD certification criteria.
7. Transition Setup does not include appliances or items that are intended for purely diversional, recreational, or entertainment purposes (e.g. television, gaming, or video equipment).

#### **8.7552.F Transition Setup Provider Agency Requirements**

1. The Provider Agency shall ensure all products and services delivered to the Member shall meet all applicable manufacturer specifications, state and local building codes, and Uniform Federal Accessibility Standards.

#### **8.7552.G Transition Setup Documentation**

1. The Provider Agency must maintain receipts for all services and/or items procured for the Member. These must be attached to the claim and noted on the Prior Authorization Request.
2. Provider Agencies must submit to the Case Management Agency the minimum documentation of the transition process, which includes:
  - a. A Transition Services Referral Form,
  - b. Release of Information (confidentiality) Forms, and
  - c. A Transition Setup Authorization Request Form.
3. The Provider Agency must furnish to the Member a receipt for any services or durable goods purchased on the Member's behalf.

#### **8.7552.H Transition Setup Provider Agency Reimbursement**

1. Transition Setup Coordination is reimbursed according to the number of units billed, with one unit equal to 15-minutes of service. The maximum number of Transition Setup units eligible for reimbursement is 40 units per eligible Member.
2. Transition Setup Expenses must not exceed \$2000 per eligible Member. The Department may authorize additional funds above the \$2000 limit, up to \$2,500, when the Member demonstrates additional needs, and if the expense(s) would ensure the Member's health, safety and welfare.
3. Reimbursement shall be made only for items or services described in the Provider Care Plan with accompanying receipts.
4. When Transition Setup is furnished to individuals returning to the community from an institutional setting through enrollment in a waiver, the costs of such services are billable when the person leaves the institutional setting and is enrolled in the waiver.

### 8.7600 Community First Choice

#### 8.7600.A Community First Choice (CFC) Program

1. The Community First Choice Program is funded through an appropriation from the Colorado General Assembly and the Federal government. The CFC program is designed to provide select Home and Community-Based Services and Supports to eligible members on the State Plan.

2. Legal authority as defined in 8.7000.A.

### **8.7601 General CFC Provisions**

1. CFC must be provided to individuals on a statewide basis and in a manner that provides services and supports in the most integrated setting appropriate to meet individuals' needs, and without regard for the individual's age, type or nature of disability, severity of disability, or the form of home and community-based services and supports that the individual requires to lead an independent life.
2. Individuals receiving services through CFC will not be precluded from receiving other home and community-based or long-term care services and supports through other Medicaid state plan, waiver, grant or demonstration authorities, as long as there is no duplication of services.
3. For the duration of the first year of CFC implementation, Case Managers shall assess current HCBS waiver members for CFC eligibility and services at the time of Continued Stay Review. Case Managers may assess current HCBS waiver members prior to the scheduled Continued Stay Review as warranted by a documented change in the member's needs, diagnosis, or condition.

### **8.7602 CFC Member Rights and Responsibilities**

1. CFC must adhere to all requirements in Home and Community-Based Services Member Rights and Responsibilities as defined in 8.7001 et seq.

### **8.7603 CFC Definitions**

1. Activities of Daily Living is as defined at Section 8.7100.A.1.
2. Assessment is as defined at Section 8.7200.B.1
3. Case Management is as defined at Section 8.7100.A.7.
4. Case Management Agency (CMA) is as defined at Section 8.7100.A.8.
5. Member, for purposes of this Section 8.7600, et seq. means an individual who has met CFC eligibility requirements and has been offered and agreed to receive CFC Services.
6. Community First Choice (CFC) is as defined at Section 8.7001.A.1-A.
7. Continued Stay Review is as defined at Section 8.7100.A.14.
8. Institution is as defined at Section 8.7100.A.39.
9. Level of Care (LOC) is as defined at Section 8.7100.A.43.
10. Level of Care Assessment is as defined at Section 8.7100.A.44.
11. Long-Term Services and Supports (LTSS) is as defined at Section 8.7100.A.47.
12. Medicaid Eligible is as defined at Section 8.7100.A.48.
13. Reassessment is as defined at Section 8.7100.A.55.
14. Referral is as defined at Section 8.7100.A.56.

## 8.7604 CFC Member Eligibility

1. Individuals of all ages shall be eligible for CFC if they meet Level of Care and financial eligibility criteria.
  - a. CFC is available to individuals who, absent the provision of home and community-based attendant services and supports provided under CFC, would require the level of care furnished in a:
    - i. Nursing Facility;
    - ii. Intermediate Care Facility;
    - iii. In Patient Psychiatric Facility for Individuals under 21; or
    - iv. Hospital
  - b. Financial Eligibility Criteria: To be eligible for the CFC Benefit, an individual shall meet one of the following eligibility groups:
    - i. Members shall meet Medicaid Assistance eligibility criteria as stated at Section 8.100 and be enrolled in a Medicaid eligibility group that includes nursing facility services.
      - 1) CFC does not qualify as a Health First Colorado eligibility group.
    - ii. Members eligible for, and enrolled in, an HCBS Waiver and enrolled in, as defined in 8.7000401.H, will be eligible for CFC.
2. Level of Care determination process
  - a. Individuals shall be referred to the Case Management Agency for an initial Long-Term Services and Supports (LTSS) eligibility determination. The LTSS Level of Care (LOC) eligibility determination screen as defined in 8.401 is used to determine an individual's need for institutional Level of Care.
  - b. The state-prescribed Assessment instrument as defined in 8.401 shall measure six defined Activities of Daily Living (ADLs) and the need for supervision for behavioral, executive or cognitive dysfunction. ADLs include bathing, dressing, toileting, mobility, transferring, and eating.
  - c. Level of Care Assessments and Reassessments shall be performed by Case Management Agencies and utilize the same instrument in determining the Level of Care for all LTSS programs.
  - ~~d. For initial Level of Care eligibility determinations, the Professional Medical Information Page (PMIP) shall be completed by a treating medical professional who verifies the individual's qualifying diagnosis or conditions.~~
  - d. The individual must require Long-Term Services and Supports to remain in their own home, in the family residence, or in the community.
  - e. To utilize CFC Services, the individual must choose to receive services in their home or community.



- f. The Case Management Agency shall certify CFC eligibility only for those individuals determined by a Level of Care Assessment to require the Level of Care available in an Institution according to Section 8.401.

### 3. Institutional Status

- a. Members who are residents of Institutions are not eligible for CFC Services while residing in such Institutions.
- b. A Member enrolled in CFC and who is admitted to a hospital may not receive CFC Services while residing in the hospital.
  - i. Providers shall not be reimbursed for CFC Services provided while the member is in a hospital.
- c. A Member enrolled in CFC and who is admitted to a nursing facility or ICF-IID may not receive CFC Services while in the nursing facility or Intermediate Care Facilities.

### 4. Maintenance of CFC Eligibility

- a. Reevaluation of the Member to verify Medicaid, financial, and program eligibility is required within twelve months following any previous Assessment. The Continued Stay Review will follow the same procedures set forth at Section 8.401.11-.17(H).

### 5. Termination

- a. The Department shall discontinue a member's enrollment in the CFC benefit when one of the following occurs:
  - i. The Member no longer meets the CFC Benefit Level of Care and/or Financial eligibility criteria,
  - ii. The member dies,
  - iii. The member is admitted for a long-term stay beyond one month in an Institution, or
  - iv. The member voluntarily withdraws from the CFC program.

### **8.7605 CFC Case Management Agency Requirements**

- 1. Case Management Agencies must adhere to all Home and Community-based Services requirements as defined at Section 8.7200, et seq.

### **8.7606 CFC Provider Requirements**

- 1. CFC providers must adhere to all Home and Community-Based Services Provider Agency Requirements as defined at 8.7400, et seq.

### **8.7607 CFC Covered Services**

- 1. CFC includes the following Home and Community-Based Services as defined at Section 8.7500, et seq. Services include:
  - a. Electronic Monitoring as defined at Section 8.7520, et seq.

- b. Health Maintenance Activities as described at Section 8.7523, et seq.
- c. Home Delivered Meals as defined at Section 8.7526, et seq.
- d. Homemaker as defined at Section 8.7527, et seq.
- e. Personal Care as defined at Section 8.7538, et seq.
- f. Remote Supports as defined at Section 8.7544, et seq.
- g. Transition Setup as defined at Section 8.7552, et seq.

#### **8.7608 CFC Service Delivery Models**

1. CFC members may utilize a Provider Agency defined at 8.7001.A.12-B. to receive Personal Care and Homemaker.
2. CFC members may utilize one of the following self-directed service delivery models to receive Personal Care, Homemaker, and/or Health Maintenance Activities:
  - a. Consumer Directed Attendant Support Services defined at 8.7515., or
  - b. In-Home Support Services defined at 8.7528.
3. CFC members cannot utilize Consumer Directed Attendant Support Services and In-Home Support Services/Provider Agency services simultaneously. In-Home Support and Services can be used in conjunction with Provider Agency services, as long as there is no duplication.

## **DO NOT PUBLISH THIS PAGE**

Title of Rule: Revision to the Medical Assistance Act Rule concerning the Children  
with Complex Health Needs Waiver, Sections 8.401, 8.500, and 8.7000  
Rule Number: MSB 24-07-11-C  
Division / Contact / Phone: Office of Community Living/ Eileen Saunders/ 303-866-2354

## **SECRETARY OF STATE**

### **RULES ACTION SUMMARY AND FILING INSTRUCTIONS**

#### **SUMMARY OF ACTION ON RULE(S)**

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: Revision to the Medical Assistance Act Rule concerning the Children  
with Complex Health Needs Waiver, Sections 8.401, 8.500, and  
8.7000.
3. This action is an adoption of: An amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number  
and page numbers affected):  
Sections(s) Sections 8.400, 8.401, 8.550, 8.7100, and 8.7500
5. Does this action involve any temporary or emergency rule(s)? No No  
If yes, state effective date:  
Is rule to be made permanent? (If yes, please attach notice of hearing). Yes  
Yes

#### **PUBLICATION INSTRUCTIONS\***

Replace the current text at 8.400 with the proposed text beginning at 8.400 through  
the end of 8.401.1.16.B. Replace the current text at 8.550.3.A with the proposed text  
beginning at 8.550.3.A.1 through the end of 8.550.3.A.1. Replace the current text at  
8.7100.A with the proposed text beginning at 8.7100.A.46 through the end of  
8.7101.D.6.a. Replace the current text at 8.7200.B through the end of 8.7200.B.  
Replace the current text at 8.7511 with the proposed text beginning at 8.7511 through  
the end of 8.7511.E. Replace the current text at 8.7521 with the proposed text  
beginning at 8.7521 through the end of 8.7521.A. Replace the current text at 8.7531  
with the proposed text beginning at 8.7531.A.1 through the end of 8.7531.D.3. Replace  
the current text at 8.7536 with the proposed text beginning at 8.7536.A through the  
end of 8.7536.B.1. Replace the current text at 8.7546 with the proposed text beginning

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at 8.7546.E.2. Replace the current text at 8.7551 with the proposed text beginning at 8.7551.A.1 through the end of 8.7551.A.1. This rule is effective June 30, 2025.

## DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning the Children with Complex Health Needs Waiver, Sections 8.401, 8.500, and 8.7000  
Rule Number: MSB 24-07-11-C  
Division / Contact / Phone: Office of Community Living/ Eileen Saunders/ 303-866-2354

### STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

The Children's Home and Community-Based Services (CHCBS) Waiver is merging with the Children with Life-Limiting Illness (CLLI) Waiver and is being renamed as the Children with Complex Health Needs (CwCHN) Waiver. The purpose of the CwCHN waiver is to streamline home and community-based services (HCBS) for children's waiver programs, expand access to services, and ensure current and future CHCBS members have continued access to waiver services. The CwCHN waiver consists of the existing services on the CLLI waiver, with the addition of the Wellness Education Benefit, and includes eligibility criteria to capture both the CHCBS and CLLI waiver populations. Thus, all members who are eligible for the CHCBS waiver and the CLLI waiver will be eligible for the CwCHN waiver and have access to the same services currently available for CLLI waiver members.

This rule amends existing CLLI eligibility criteria to reflect the new eligibility criteria for the CwCHN waiver, places the new CwCHN waiver requirements and regulations in rule, and changes the name of the CLLI waiver throughout rule to reflect the new name.

2. An emergency rule-making is imperatively necessary

- ☐ to comply with state or federal law or federal regulation and/or  
☐ for the preservation of public health, safety and welfare.

Explain: N/A

3. Federal authority for the Rule, if any:

42 U.S.C. 1396n.

Federal Waiver Amendment C0.0450.R04.00, approval expected July 2025.

4. State Authority for the Rule:

C.R.S. Sections 25.5-1-301 through 25.5-1-303 (2024);

Initial Review

**[date]**

Final Adoption

**[date]**

Proposed Effective Date

**[date]**

Emergency Adoption

**[date]**

**DOCUMENT #**

## **DO NOT PUBLISH THIS PAGE**

Title of Rule: Revision to the Medical Assistance Act Rule concerning the Children with Complex Health Needs Waiver, Sections 8.401, 8.500, and 8.7000  
Rule Number: MSB 24-07-11-C  
Division / Contact / Phone: Office of Community Living/ Eileen Saunders/ 303-866-2354

### **REGULATORY ANALYSIS**

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

This rule affects Children's Home and Community-Based (CHCBS) Waiver members, and service providers on the Children With Life Limiting Illness (CLLI) waiver. There are no classes of persons anticipated to bear costs of this proposed rule. CHCBS members will benefit from this proposed rule as they will have increased access to services. CLLI service providers will benefit from this proposed rule as they will have more waiver members they can potentially serve. CLLI waiver members will experience no changes from the increased number of members using the service providers because the shift of CHCBS members to CwCHN will happen gradually and the Department is taking steps to recruit and prepare providers.

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

Children on the CHCBS Waiver will experience a positive change as they will now have access to a new set of Home and Community-Based (HCBS) services such as Music Therapy and Respite Services. CLLI service providers will benefit from this proposed rule as they will have more waiver members they can potentially serve. The Department will continue conducting targeted provider outreach, including provider communications and provider recruitment, to inform and prepare providers of the increase in waiver members they may be able to serve.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

The Department has obtained budget approval for the costs associated with this rule in the FY23/24 Community-Based Access to Services Budget Request, which are estimated to be \$2,672,646. The Department estimates an increase in service utilization from the members transitioning from the CHCBS waiver to the CLLI waiver, based on the current number of members on the CHCBS waiver, and the projected increase in service options available on the CLLI waiver.

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

CHCBS currently has two benefits: the Wellness Education Benefit and In-Home Support Services (IHSS)- Health Maintenance Activities (HMA). The implementation of Community First Choice will transition the IHSS-HMA service from the waiver and into CFC. The Department will not have federal authority to operate the CHCBS waiver with only one waiver service available, but current CHCBS waiver participants will still require assistance with the tasks for which they currently receive support through the IHSS-HMA and Wellness Education benefits.

In addition, the CHCBS waiver provides members with access to all Health First Colorado benefits, such as Long-Term Home Health and Private Duty Nursing. These benefits can be critical to this medically fragile waiver population. Without maintaining waiver eligibility, these members are at risk of losing access to Health First Colorado benefits as they would not meet State Plan financial eligibility without the waiver. If this proposed rule is not acted upon, over 2,000 members on the CHCBS waiver risk losing waiver eligibility and access to critical services when CFC is implemented on July 1, 2025. The loss of waiver support for day-to-day health maintenance and simultaneous loss of health care benefits such as Long Term Home Health and Private Duty Nursing place these vulnerable members at risk for deterioration in their health and well-being.

Adopting the proposed rule will allow current CHCBS members to remain stable on their current services, and will give them access to additional services to support their health and well-being. As described above, the impact on CLLI members will be negligible, and CLLI providers will benefit from having more members to serve.

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

Merging the CLLI and CHCBS waivers to create the CwCHN waiver is the least costly and least intrusive method to ensure continuity of service. This approach provides CHCBS waiver members with several new services that they may benefit from receiving. Furthermore, this approach only minimally impacts CHCBS waiver members, as they will transition gradually on to the new waiver during their annual review; a process that takes place regardless of this change. CLLI waiver members will experience no impact, only a waiver name change to CwCHN upon the effective date.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

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To ensure that CHCBS waiver members have continued access to waiver services and waiver eligibility, the Department considered adding new services to the CHCBS waiver or merging the CHCBS waiver with another existing waiver. Many of the waiver services currently available to CLLI waiver members had applicability to the population served on the CHCBS waiver. The Department determined that the best approach was to consolidate the CHCBS and CLLI waivers into a new CwCHN waiver. This approach also allows the Department to address and correct outdated policies on the CHCBS waiver.



## 8.400 LONG-TERM CARE

- .10 Long-term care includes nursing facility care as part of the standard Medicaid benefit package, and Home and Community Based Services provided under waivers granted by the Federal government.
- .101 Nursing facility services and Home and Community Based Services are benefits only under Medicaid. Nursing Facility Services and Home and Community Based Services are non-benefits under the Modified Medical Program.
- .102 State only funding will pay for nursing facility services for October 1988 and November 1988 for clients under the Modified Medical Program who were residing in a nursing facility October 1, 1988. This is intended to give clients time to qualify for Medicaid.
- .11 Standard Medicaid long-term care services are services provided in:
- Skilled care facilities (SNF)
  - ~~Intermediate care facilities (ICF)~~
  - Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)
  - Long-Term Care Hospitals
  - Inpatient Psychiatric Institution for Individuals under 21.
- .12 Home and Community Based Services under the Medicaid Waivers include distinct service programs designed as alternatives to standard Medicaid nursing facility or hospital services for discrete categories of clients. These waivers are Home and Community Based Services Waiver for Persons Who Are Elderly, Blind and Disabled (HCBS-EBD), Home and Community Based Services Waiver for Complementary and Integrative Health (HCBS-CHI), Community Mental Health Supports Waiver (HCBS-CMHS), Home and Community Based Services Waiver for Persons With Brain Injury (HCBS-BI); Home and Community Based Services Waiver for Persons with Developmental Disabilities (HCBS-DD), Supportive Living Services Waiver (HCBS-SLS); Children with Complex Health Needs Waiver (HCBS-CwCHN), Home and Community Based Services Waiver for Children with Autism (HCBS-CWA), Children with Life-limiting Illness Waiver (HCBS-CLLI), Children's Habilitation Residential Program Waiver (HCBS-CHRP), Children Extensive Supports Waiver (HCBS-CES), and Children's Home and Community Based Services Waiver (HCBS-CHCBS) and Home and Community Based Services for those inappropriately residing in nursing facilities (OBRA '87).
- .13 Unless specified by reference to the specific programs described above, the term Home and Community Based Services where it appears in these rules and regulations shall refer to the programs described herein above, and the rules and regulations within this section shall be applicable to all Home and Community Based Services programs.
- .14 Nursing facilities are prohibited from admitting any new client who has mental illness or intellectual or developmental disability, as defined in Section 8.401.18 Determination Criteria for Mentally Ill or Individuals with an Intellectual or Developmental Disability unless that client has been determined to require the level of services provided by a nursing facility as defined in Section 8.401.19.
- .15 Clients eligible for Home and Community Based Services are eligible for all Medicaid services including home health services.

.16 Target Population Definitions. For purposes of determining appropriate type of long-term services, including home and community-based services, as well as providing for a means of properly referring clients to the appropriate community agency, the following target group designations are established:

- A. Developmentally Disabled - includes all clients whose need for long-term care services is based on a diagnosis of Developmental Disability and Related Conditions, as defined in Section 8.401.18.
- B. Mentally Ill - includes all clients whose need for long-term care is based on a diagnosis of mental disease as defined in Section 8.401.18.
- C. Functionally Impaired Elderly - includes all clients who meet the level of care for SNF or ICF care, as determined by the LOC Screen and who are age 65 or over.
- D. Physically Disabled or Blind Adult - includes all clients who meet the level of care for SNF or ICF care, as determined by the LOC Screen and who are age 18 through 64.
- E. Persons Living with AIDS - includes all clients of any age who meet either the nursing home level of care or acute level of care for nursing facilities or hospitals and have the diagnosis of Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS). Clients who are diagnosed with HIV or AIDS may alternatively request to be designated as any other target group for which they meet the definitions above.

.17 Services in Home and Community Based Services programs established in accordance with federal waivers shall be provided to clients in accordance with the URC determined target populations as defined herein above.

#### **8.401 LEVEL OF CARE SCREEN**

The Level of Care Screen assesses whether applicants require an institutional level of care typically provided in the following settings:

- Nursing Facility
- Hospital
- Inpatient Psychiatric Institution for Individuals under the age of 21
- ~~Intermediate Care Facility~~
- Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)

.01 The client must have been found by the Case Management Agency to meet the applicable level of care for the type of services to be provided.

.02 The Case Management Agency shall not make a Level of Care Eligibility Determination unless the recipient has been determined to be Medicaid eligible or an application for Medicaid services has been filed with the County Department of Social/Human services.

.03 Payment for skilled (SNF) and intermediate nursing home care (ICF) Payment for skilled (SNF) and intermediate nursing home care (ICF) will only be made for clients whose Level of Care Eligibility Determination and frequency of need for skilled and maintenance services meet the level of care for long-term care.

.04 Payment for care in an intermediate care facility for individuals with intellectual disabilities (ICF/IID) will only be made for developmentally disabled clients whose programmatic and/or health care needs meet the level of care for the appropriate class of ICF/IIDs.

.05 Services provided by nursing facilities are available to those individuals who meet the level of care below and are not identified as mentally ill or individuals with an intellectual or developmental disability by the Determination Criteria for Mentally Ill or Individuals with an Intellectual or Developmental Disability in Section 8.401.18.

**8.401.1 GUIDELINES FOR LONG TERM CARE SERVICES (~~CLASS I SNF AND ICF FACILITIES, HCBS-EBD, HCBS-CMHS, HCBS-BI, Children's HCBS, HCBS-CES, HCBS-DD, HCBS-SLS, HCBS-CHRP, and Long-term Home Health~~)**

**.16 LONG-TERM CARE ELIGIBILITY ASSESSMENTS**

**B. COLORADO SINGLE ASSESSMENT (CSA) LEVEL OF CARE SCREEN**

The Level of Care Eligibility Determination outcome is based on an individual's performance level as documented in the LOC Screen, in areas including, but not limited to, completing Activities of Daily Living, memory and cognition, sensory and communication, and behavior, as well as other criteria specific to applicable program. The eligibility criteria and thresholds are as follows:

**1. Nursing Facility Level of Care Eligibility for ages four (4) and older**

a. Participants four (4) years of age or older must meet the Nursing Facility Level of Care criteria and thresholds outlined in 10 CCR 2505-10 Section 8.401.16.B.1 to be determined eligible for Long-Term Services and Supports.

**i. Eligibility Criteria**

1. Meets one or more ADL and Health Condition criteria thresholds in at least two areas to include Mobility, Transferring, Bathing, Dressing, Toileting, Eating (ADLs) or Health Condition; or
2. Meets one or more Behavior threshold(s); or
3. Meets one or more Memory and Cognition threshold(s); or
4. Meets the Sensory & Communication threshold.

**ii. Criteria Thresholds**

1. ADL and Health Condition criteria thresholds are as follows:

a. Mobility threshold is met with either of the following:

- i. Participant does not walk but walking is indicated in the future or Participant does not walk and walking is not indicated in the future; or
- ii. Participant requires a cane or walker during all mobility activities; or
- iii. Participant uses a wheelchair or scooter as their primary mechanism for mobility; or

- iv. Participant requires, at minimum, partial/moderate assistance to walk (once standing) 10 feet indoors; or
  - v. Participant requires, at minimum, supervision or touching assistance to walk (once standing) 150 feet indoors; or
  - vi. Participant requires, at minimum, supervision or touching assistance to walk 10 feet outside of the home; or
  - vii. Participant requires, at minimum, supervision or touching assistance to walk 150 feet outside of the home.
- b. Transferring threshold is met with either of the following:
- i. Participant requires use of a cane or walker during all transfer activities; or
  - ii. Participant requires, at minimum, partial/moderate assistance for the ability to roll left and right: from lying on back to left and right side, and return to lying on back on the bed; or
  - iii. Participant requires, at minimum, partial/moderate assistance for the ability to complete a sit to stand transfer: safely come to a standing position from sitting in a chair or on the side of the bed.
- c. Bathing threshold is met with the following:
- i. Participant requires, at minimum, partial/moderate assistance for the ability to shower/bathe self in shower or tub, including washing, rinsing, and drying self. Does not include transferring in/out of tub/shower
- d. Dressing threshold is met with either of the following:
- i. Participant requires, at minimum, partial/moderate assistance with upper body dressing; or
  - ii. Participant requires, at minimum, partial/moderate assistance with lower body dressing; or
  - iii. Participant requires, at minimum, partial/moderate assistance with putting on/taking off footwear.
- e. Toileting threshold is met with either of the following:
- i. Participant requires, at minimum, partial/moderate assistance with toilet hygiene; or
  - ii. Participant requires, at minimum, partial/moderate assistance with toilet transfers; or
  - iii. Participant requires, at minimum, partial/moderate assistance with menses care; or

- iv. Participant requires assistance with managing equipment related to bladder incontinence; or
  - v. Participant is currently using a bladder program to manage participant's bladder continence; or
  - vi. Participant requires assistance with managing equipment related to bowel incontinence; or
  - vii. Participant is currently using a bowel program to manage the participant's bowel continence.
- f. Eating threshold is met with either of the following:
- i. Participant requires, at minimum, partial/moderate assistance for eating; or
  - ii. Participant requires, at minimum, partial/moderate assistance for tube feeding.
- g. Health Condition threshold is met with the following:
- i. Participant has a diagnosis of paralysis; or
  - ii. A missing limb.

2. **Behavior** criteria thresholds are as follows:

- a. Behavior threshold area one is as follows:
- i. Participant's behavior status previously or currently requires interventions or presents symptoms for Injury to Self, Physical Aggression or Property Destruction; and
  - ii. One or more of the following are met:
    - 1. Cueing frequency, at minimum, is required more than once per month and up to weekly; or
    - 2. Physical intervention frequency, at minimum, is required more than once per month up to weekly; or
    - 3. Planned intervention frequency, at minimum, is required less than monthly up to once per month.
- b. Behavior criteria threshold area two is as follows:
- i. Participant's behavior status for Verbal Aggression currently requires interventions or presents symptoms for this behavior; and
  - ii. Participant presents threat(s) to own or other's safety; and

- iii. One or more of the following are met:
      - 1. Cueing frequency, at minimum, is required more than once per month and up to weekly; or
      - 2. Physical intervention frequency, at minimum, is required more than once per month up to weekly; or
      - 3. Planned intervention frequency, at minimum, is required less than monthly up to once per month.
    - c. Behavior criteria threshold area three is as follows:
      - i. Injurious to Self, property destruction, physical aggression, or verbal aggression behavior status currently requires intervention and/or displays symptoms and
      - ii. Likelihood behavior would occur and/or escalate if HCBS services were withdrawn is likely or highly likely.
  - 3. Memory and Cognition criteria thresholds are as follows:
    - a. Participant has a Level of Impairment of moderately or higher in at least one area (Memory, Attention, Problem Solving, Planning, or Judgment); or
    - b. Participant has a level of impairment of mildly or higher in at least two areas (Problem Solving, Planning, Judgment).
  - 4. Sensory and Communication criteria threshold is as follows:
    - a. Participant frequently exhibits difficulty expressing needs and/or ideas with individuals they are familiar with; or
    - b. Participant rarely or never expresses themselves or is very difficult to understand.
- 2. Nursing Facility Level of Care Eligibility Criteria for individuals zero to three (0-3) years of age
  - a. Participants zero to three (0-3) years of age must meet the Nursing Facility Level of Care criteria and thresholds outlined in 10 CCR 2505-10 Section 8.401.16.B.2, according to age, to be determined eligible for Long-Term Services and Supports.
    - i. Eligibility Criteria
      - 1. The participant must meet the criteria threshold for two or more Activities of Daily Living, based on participant age.
      - 2. If the participant meets one or more of the two required ADL thresholds by selecting only "Other Concerns," a second level review is required to determine eligibility.

3. Participants may also meet LOC using the behavior criteria for adults in Section 8.401.16.B.1.ii.2.

ii. Activities of Daily Living thresholds by age 0-5 months

1. Bathing:

- a. Needs adaptive equipment, or
- b. Utilizes medical devices that make bathing very difficult, such as feeding tubes, breathing tubes, etc., or
- c. Other concerns that may affect the amount of support the child needs and
- d. at least one of the bathing impairments above is expected to last for at least one year from the date of assessment.

2. Dressing:

- a. Has physical characteristics that make dressing very difficult, such as contractures, extreme hypotonia, or extreme hypertonia., or
- b. Utilizes medical devices that make dressing very difficult, such as feeding tubes, breathing tubes, etc., or
- c. Other concerns that may affect the amount of support the child needs and
- d. at least one of the impairments above is expected to last for at least one year from the date of assessment.

3. Eating:

- a. Requires more than one hour per feeding, or
- b. Receives tube feedings or TPN, or
- c. Requires more than three hours per day for feeding or eating, or
- d. Other concerns that may affect the amount of support the child needs and
- e. at least one of the impairments above is expected to last for at least one year from the date of assessment.

iii. Activities of Daily Living thresholds by age 6-11 months

1. Bathing:

- a. Needs adaptive equipment, or
- b. Utilizes medical devices that make bathing very difficult, such as feeding tubes, breathing tubes, etc., OR

- c. Other concerns that may affect the amount of support the child needs AND
- d. at least one of the impairments above is expected to last for at least one year from the date of assessment.

2. Dressing:

- a. Has physical characteristics that make dressing very difficult, such as contractures, extreme hypotonia, or extreme hypertonia., OR
- b. Utilizes medical devices that make dressing very difficult, such as feeding tubes, breathing tubes, etc., OR
- c. Other concerns that may affect the amount of support the child needs AND
- d. at least one of the impairments above is expected to last for at least one year from the date of assessment.

3. Eating:

- a. Requires more than one hour per feeding, OR
- b. Receives tube feedings or TPN, OR
- c. Requires more than three hours per day for feeding or eating, OR
- d. Other concerns that may affect the amount of support the child needs AND
- e. at least one of the impairments above is expected to last for at least one year from the date of assessment.

4. Mobility:

- a. Unable to maintain a sitting position when placed, OR
- b. Unable to move self by rolling, crawling, or creeping, OR
- c. Other concerns that may affect the amount of support the child needs AND
- d. at least one of the impairments above is expected to last for at least one year from the date of assessment.

iv. Activities of Daily Living thresholds by age 12-17 months

1. Bathing:

- a. Needs adaptive equipment, OR



- b. Utilizes medical devices that make bathing very difficult, such as feeding tubes, breathing tubes, etc., OR
- c. becomes agitated requiring alternative bathing methods OR
- d. Other concerns that may affect the amount of support the child needs AND
- e. at least one of the impairments above is expected to last for at least one year from the date of assessment.

2. Dressing:

- a. Has physical characteristics that make dressing very difficult, such as contractures, extreme hypotonia, or extreme hypertonia., OR
- b. Utilizes medical devices that make dressing very difficult, such as feeding tubes, breathing tubes, etc., OR
- c. Other concerns that may affect the amount of support the child needs AND
- d. at least one of the impairments above is expected to last for at least one year from the date of assessment.

3. Eating:

- a. Requires more than one hour per feeding, OR
- b. Receives tube feedings or TPN, OR
- c. Requires more than three hours per day for feeding or eating, OR
- d. Other concerns that may affect the amount of support the child needs AND
- e. at least one of the impairments above is expected to last for at least one year from the date of assessment.

4. Mobility:

- a. Unable to sit alone, OR
- b. Requires a stander or someone to support the child's weight in a standing position, OR
- c. Unable to crawl or creep, OR
- d. Other concerns that may affect the amount of support the child needs AND

- e. at least one of the impairments above is expected to last for at least one year from the date of assessment.
- v. Activities of Daily Living thresholds by age 18-23 months
  - 1. Bathing:
    - a. Needs adaptive equipment, OR
    - b. Utilizes medical devices that make bathing very difficult, such as feeding tubes, breathing tubes, etc., OR
    - c. becomes agitated requiring alternative bathing methods OR Other concerns that may affect the amount of support the child needs AND
    - d. at least one of the impairments above is expected to last for at least one year from the date of assessment.
  - 2. Dressing:
    - a. Has physical characteristics that make dressing very difficult, such as contractures, extreme hypotonia, or extreme hypertonia., OR
    - b. Utilizes medical devices that make dressing very difficult, such as feeding tubes, breathing tubes, etc., Does not assist with dressing by helping to place arms in sleeves or legs into pants, OR
    - c. Other concerns that may affect the amount of support the child needs AND
    - d. at least one of the impairments above is expected to last for at least one year from the date of assessment.
  - 3. Eating:
    - a. Receives tube feedings or TPN, OR
    - b. Requires more than three hours per day for feeding or eating, OR
    - c. Other concerns that may affect the amount of support the child needs AND
    - d. at least one of the impairments above is expected to last for at least one year from the date of assessment.
  - 4. Mobility:
    - a. Requires a stander or someone to support the child's weight in a standing position, OR

- b. Uses a wheelchair or other mobility device not including a single cane, OR
- c. Unable to take steps holding on to furniture, OR
- d. other concerns that may affect the amount of support the child needs AND
- e. at least one of the impairments above is expected to last for at least one year from the date of assessment.

vi. Activities of Daily Living thresholds by age 24-35 months

1. Bathing:

- a. Needs adaptive equipment, OR
- b. Utilizes medical devices that make bathing very difficult, such as feeding tubes, breathing tubes, etc., OR
- c. becomes agitated requiring alternative bathing methods OR Other concerns that may affect the amount of support the child needs AND
- d. at least one of the impairments above is expected to last for at least one year from the date of assessment.

2. Dressing:

- a. Has physical characteristics that make dressing very difficult, such as contractures, extreme hypotonia, or extreme hypertonia., OR
- b. Utilizes medical devices that make dressing very difficult, such as feeding tubes, breathing tubes, etc., Does not assist with dressing by helping to place arms in sleeves or legs into pants, OR
- c. Unable to pull hats, socks, and mittens, OR
- d. Other concerns that may affect the amount of support the child needs AND
- e. at least one of the impairments above is expected to last for at least one year from the date of assessment.

3. Eating:

- a. Receives tube feedings or TPN, OR
- b. Requires more than three hours per day for feeding or eating, OR

- c. Cannot pick up appropriate foods with hands and bring them to his/her mouth, OR
- d. Other concerns that may affect the amount of support the child needs AND
- e. at least one of the impairments above is expected to last for at least one year from the date of assessment.

4. Mobility:

- a. Requires a stander or someone to support the child's weight in a standing position, OR
- b. Does not walk or needs physical help to walk, OR
- c. Uses a wheelchair or other mobility device not including a single cane, OR
- d. Other concerns that may affect the amount of support the child needs AND
- e. at least one of the impairments above is expected to last for at least one year from the date of assessment.

5. Transfers:

- a. Requires transfer assistance due to physical or cognitive deficits, OR
- b. Other concerns that may affect the amount of support the child needs AND
- c. at least one of the impairments above is expected to last for at least one year from the date of assessment.

vii. Activities of Daily Living thresholds by age 36-47 months

1. Bathing:

- a. Needs adaptive equipment, OR
- b. Utilizes medical devices that make bathing very difficult, such as feeding tubes, breathing tubes, etc., OR
- c. Is combative during bathing (e.g., flails, takes two caregivers to accomplish task), OR
- d. Other concerns that may affect the amount of support the child needs AND
- e. at least one of the impairments above is expected to last for at least one year from the date of assessment.

2. Grooming:

- a. Is combative during grooming (e.g., flails, clamps mouth shut, takes two caregivers to accomplish task), OR
- b. Has physical limitations that prevent completing the task (e.g. limited range of motion, unable to grasp brush), OR
- c. Other concerns that may affect the amount of support the child needs AND
- d. at least one of the impairments above is expected to last for at least one year from the date of assessment.

3. Dressing:

- a. Has physical characteristics that make dressing very difficult, such as contractures, extreme hypotonia, or extreme hypertonia., OR
- b. Utilizes medical devices that make dressing very difficult, such as feeding tubes, breathing tubes, etc., OR
- c. Is combative during dressing (e.g., flails, resists efforts to put clothes on, takes two caregivers to accomplish task), OR
- d. Does not or cannot assist with dressing by helping to place arms in sleeves or legs into pants, OR
- e. Unable to undress self independently, OR
- f. Other concerns that may affect the amount of support the child needs AND
- g. at least one of the impairments above is expected to last for at least one year from the date of assessment.

4. Eating:

- a. Is combative while eating (e.g., flails, throws food so will not have to eat, takes two caregivers to accomplish task), OR
- b. Receives tube feedings or TPN, OR
- c. Requires more than three hours per day for feeding or eating, OR
- d. Needs to be fed by another individual, OR
- e. Needs one-on-one monitoring to prevent choking, aspiration, or other serious complications, OR
- f. Other concerns that may affect the amount of support the child needs AND

- g. at least one of the impairments above is expected to last for at least one year from the date of assessment.

5. Toileting:

- a. Is combative during toileting (e.g., flails, takes two caregivers to accomplish task), OR
- b. Has no awareness of being wet or soiled, OR
- c. Requires caregiver assistance to be placed onto the toilet/potty chair, OR
- d. Does not use toilet/potty chair when placed there by a caregiver, OR
- e. Other concerns that may affect the amount of support the child needs AND
- f. at least one of the impairments above is expected to last for at least one year from the date of assessment.

6. Mobility:

- a. Does not walk or needs physical help to walk, OR
- b. Uses a wheelchair or other mobility device not including a single cane, OR
- c. Other concerns that may affect the amount of support the child needs AND
- d. at least one of the impairments above is expected to last for at least one year from the date of assessment.

7. Transfers:

- a. Needs physical help with transfers, OR
- b. Uses a mechanical lift, OR
- c. Other concerns that may affect the amount of support the child needs AND
- d. at least one of the impairments above is expected to last for at least one year from the date of assessment.

3. Nursing Facility Level of Care Eligibility Alternative Criteria

- a. Alternative ADL criteria shall be applicable for participants four (4) and older whose level of support for Activities of Daily Living (Mobility, Transferring, Bathing, Dressing Toileting, Eating) has varied over the last 30 days; and
  - i. Meet the following alternate ADL thresholds in two or more ADL areas (Mobility, Transferring, Bathing, Dressing Toileting, Eating):

1. Participant's performance level is, at minimum, scored at partial/moderate assistance or higher AND
      2. Frequency of enhanced support is scored, at minimum, 1-2 times per month in the past 30 days, or
    - ii. Meets at least one Nursing Facility Level of Care ADL (Mobility, Transferring, Bathing, Dressing Toileting, Eating) thresholds as required at 10 CCR 2505-10 Section 8.401.16.B.1.a.ii.1., and
    - iii. Meets the alternate ADL thresholds in at least one ADL area.
  - b. If the alternative LOC criteria is used, a second level review is required to determine eligibility.
4. Hospital Level of Care Eligibility Criteria
- a. Complementary and Integrative Health (CIH), Brain Injury (BI), Children's Home and Community Based Services (CHCBS), and [Children with Complex Health Needs \(CwCHN\)](#) ~~Children with Life Limiting Illness (CLLI)~~ have a Hospital Level of Care (H-LOC).
    - i. CIH and BI may be met through NF-LOC and H-LOC Criteria.
    - ii. CHCBS and ~~CLLI~~ [CwCHN](#) have distinct criteria.
  - b. H-LOC for SCI and BI participants must meet in at least one of the following areas:
    - i. Transfers:
      1. Participant has met Nursing Facility Level of Care (NF-LOC) AND
      2. Participant's performance level is, at minimum, substantial/maximum assistance for Chair/Bed -to-Chair Transfers-the ability to safely transfer to and from a bed to a chair.
    - ii. Bathing:
      1. Participant has met NF-LOC AND
      2. Participant's performance level is, at minimum, substantial/maximum assistance for Shower/bathe self-the ability to bathe self in shower or tub, including washing, rinsing, and drying self. Does not include transferring in/out of tub/shower.
    - iii. Dressing:
      1. Participant has met NF-LOC AND
      2. Participant's performance level is, at minimum, substantial/maximum assistance for Upper Body Dressing-the ability to put on and remove shirt or pajama top. Includes buttoning, if applicable OR
      3. Participant's performance level is, at minimum, substantial/maximum for Lower Body Dressing-the ability to dress and undress below the waist, including fasteners. Does not include footwear.

iv. Toileting:

1. Participant has met NF-LOC AND
2. Participant's performance level is, at minimum, substantial/maximum assist for Toilet hygiene-the ability to maintain perineal/feminine hygiene, adjust clothes before and after using toilet, commode, bedpan, urinal. If managing ostomy, include wiping opening but not managing equipment. OR
3. Participant's performance level is, at minimum, substantial/maximum assistance for Toilet Transfers: the ability to safely get on and off a toilet or commode.

v. Eating:

1. Participant has met NF-LOC AND
2. Participant's performance level is, at minimum, substantial/maximum assistance for Eating - the ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. This includes modified food consistency OR
3. Participant's performance level is, at minimum, substantial/maximum assistance for Tube feeding - the ability to manage all equipment/supplies related to obtaining nutrition.

c. H-LOC for CwCHN participants must be met in at least ONE of the following threshold areas:

i. Threshold Area 1:

1. Participant has met NF-LOC and has one or more ADL at the "substantial/maximal level" (scoring option related to assistance needed with ADL completion)

ii. Threshold Area 2:

1. Participant has met NF-LOC and one of the following conditions applies to the participant:

- a. Participant has been diagnosed with a life limiting illness
- b. Technologically dependent for life or health-sustaining functions, or
- c. Complex medication regimen or medical interventions to maintain or improve health status, or
- d. Need of ongoing assessment or intervention to prevent serious deterioration of health status or medical complications that place life, health or development at risk

iii. Threshold Area 3:

1. Participant has not met NF-LOC or Alt-LOC and one of the following conditions applies to the participant:

- a. Technologically dependent for life or health-sustaining functions, or
- b. Complex medication regimen or medical interventions to maintain or improve health status, or
- c. Need of ongoing assessment or intervention to prevent serious deterioration of health status or medical complications that place life, health or development at risk

iv. Threshold Area 4:

1. Participant has not met NF-LOC or Alt-LOC, and
2. Participant has been diagnosed with a life limiting illness by a licensed medical professional, and



3. One of the following conditions applies to the participant:

- a. Technologically dependent for life or health-sustaining functions, OR
- b. Complex medication regimen or medical interventions to maintain or improve health status, OR
- c. Need of ongoing assessment or intervention to prevent serious deterioration of health status or medical complications that place life, health or development at risk

c. H-LOC for CLLI participants must meet in at least ONE of the following threshold areas:

i. ~~Threshold Area 1:~~

- ~~1. Participant has met NF LOC or Alt LOC AND~~
- ~~2. Participant has been diagnosed with a life limiting illness by a medical professional.~~

ii. ~~Threshold Area 2:~~

- ~~1. Participant has NOT met NF LOC or Alt LOC AND~~
- ~~2. Participant has been diagnosed with a life limiting illness by a medical professional AND~~
- ~~3. ONE of the following conditions apply to the participant:~~
  - ~~a. Technologically dependent for life or health-sustaining functions OR~~
  - ~~b. Complex medication regimen or medical interventions to maintain or improve health status, OR~~
  - ~~c. Need of ongoing assessment or intervention to prevent serious deterioration of health status or medical complications that place life, health or development at risk~~
- ~~4. A second level review is required to verify whether the conditions documented justify a H-LOC.~~

d. H-LOC for CHCBS participants must meet in at least ONE of the following threshold areas:

i. Threshold Area 1:

- 1. Transferring:
  - a. Participant met NF-LOC or Alt-LOC AND
  - b. Participant's performance level is, at minimum, substantial/maximum assistance for Chair/Bed -to-Chair Transfer  
-The ability to safely transfer to and from a bed to a chair.
- 2. Bathing:

- a. Participant has met NF-LOC or Alt-LOC AND
  - b. Participant's performance level is, at minimum, substantial/maximum assistance for Shower/bathe self- The ability to bathe self in shower or tub, including washing, rinsing, and drying self. Does not include transferring in/out of tub/shower.
3. Dressing:
- a. Participant has met NF-LOC or Alt-LOC AND
  - b. Participant's performance level is, at minimum, substantial/maximum assistance for Upper Body Dressing - The ability to put on and remove shirt or pajama top. Includes buttoning, if applicable OR
  - c. Participant's performance level is, at minimum, substantial/maximum assistance for Lower Body Dressing - The ability to dress and undress below the waist, including fasteners. Does not include footwear.
4. Toileting:
- a. Participant has met NF-LOC or Alt-LOC AND
  - b. Participant's performance level is, at minimum, substantial/maximum assistance for toilet hygiene-The ability to maintain perineal/feminine hygiene, adjust clothes before and after using toilet, commode, bedpan, urinal. If managing ostomy, include wiping opening but not managing equipment. OR
  - c. Participant's performance level is, at minimum, substantial/maximum assistance for Toilet Transfer: The ability to safely get on and off a toilet or commode.
5. Eating:
- a. Participant has met NF-LOC or Alt-LOC AND
  - b. Participant's performance level is, at minimum, substantial/maximum assistance for Eating - The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. This includes modified food consistency OR
  - c. Participant's performance level is, at minimum, substantial/maximum assistance for Tube feeding - The ability to manage all equipment/supplies related to obtaining nutrition.

ii. Threshold Area 2:

- 1. Participant has not met NF-LOC or Alt-LOC AND
- 2. One of the following conditions apply to the participant:

- a. Technologically dependent for life or health-sustaining functions, OR
  - b. Complex medication regimen or medical interventions to maintain or improve health status, OR
  - c. Need of ongoing assessment or intervention to prevent serious deterioration of health status or medical complications that place life, health or development at risk.
3. A second-level review is required to verify whether the conditions documented justify a H-LOC.

## **8.550 HOSPICE BENEFIT**

### **8.550.3 HOSPICE RELATED TO HCBS WAIVERS**

#### **8.550.3.A. Provision of Services**

1. Hospice Services may be provided to a client who is enrolled in one of the Colorado Medicaid home and community-based services (HCBS) waivers, including the [children with life limiting illness waiver](#) [Children with Complex Health Needs Waiver](#).
2. HCBS waiver services may be provided for conditions unrelated to the client's terminal diagnosis. For children ages 20 and under, HCBS waivers services may be provided for conditions related or unrelated to the client's terminal diagnosis.
3. HCBS waiver services may also be provided to the client when these services are not duplicative of the services that are the responsibility of the Hospice Provider. HCBS waivers are those waivers as defined at Sections 8.500 through 8.599.

#### **8.550.3.B. Waiver Coordination**

1. The Hospice Provider must notify the HCBS waiver case manager or support coordinator of the client's Election of Hospice Services and the anticipated start date.
2. The Hospice Provider must coordinate Hospice Services and HCBS waiver services with the HCBS waiver case manager or support coordinator and must document coordination of these services in the Client Record. Documentation must include:
  - a. Identification of the Hospice Services that will be provided;
  - b. Identification of the HCBS waiver services that will be provided under the waiver; and

- c. Integration of Hospice Services and HCBS waiver services in the Hospice plan of care.
3. The Hospice Provider must invite the HCBS waiver case manager or support coordinator to participate in the Interdisciplinary Team meetings for the client when possible.

## **8.7100 Waiver/Program Eligibility Requirements**

### **8.7100.A Definitions**

46. Life-Limiting Illness means a medical condition or set of medical conditions that, in the opinion of the medical specialist involved, has a prognosis of death that is highly probable before the child reaches adulthood at age 19. A Life-Limiting Illness means a medical condition or set of condition that, in the opinion of the medical specialist involved, has a prognosis of death that is highly probable before the child reaches adulthood. Conditions that are incurable, irreversible, and that usually result in death are considered as one criterion for eligibility for the HCBS-[CLL-CwCHN](#) waiver.

## **8.7101 HCBS Waiver Program-Specific Member Eligibility**

### **8.7101.A Children's HCBS Waiver (CHCBS)**

1. Target Group Criteria:
2. To be eligible for the HCBS-CHCBS waiver, a child shall meet the following Target Group Criteria:
  - a. Is under 18 years of age.
  - b. Lives at home with Parent(s) or Guardian.
  - c. Meets Hospital Level of Care the state additionally limits the waiver to the subcategory of acute Hospital Level of Care or Nursing Facility Level of Care the State additionally limits the waiver to the subcategory of skilled nursing facilities Level of Care.
  - d. Meets federal SSI disability definition.
  - e. The child's Parent(s) or Guardian chooses to receive services in the home or community instead of an Institution.
  - f. The child is not otherwise eligible for Medicaid benefits or enrolled in other Medicaid waiver programs due to parental income and/or resources.
3. Medicaid Eligibility Groups Served in the Waiver

- a. CHCBS Waiver Services are available to eligible individuals who meet the criteria set forth at 42 C.F.R. § 435.217 (2024). ~~42 C.F.R. § 435.217 (2024) is hereby incorporated by reference. This incorporation by reference excludes later amendments to, or editions of the referenced material. Pursuant to C.R.S. § 24-4-403(12.5), the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 303 E. 17<sup>th</sup> Ave., Denver, CO 80203. Certified copies are provided at cost upon request. Incorporated materials may also be obtained from the original issuer at [www.federalregister.gov](http://www.federalregister.gov).~~ 42 CFR §435.217 2024 is hereby incorporated by reference. This incorporation of 42 CFR §435.217 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 303 E. 17<sup>th</sup> Ave., Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request. Incorporated materials may also be obtained from the original user.

4. Other

- a. To be eligible for the CHCBS waiver, the income and resources of the child shall not exceed 300% of the current maximum Social Security Insurance (SSI) standard maintenance allowance.
- b. Individuals who meet eligibility criteria for the CHCBS waiver and cannot be served within the federally approved waiver capacity limits shall be eligible for placement on a waiting list maintained by the Utilization Review Contractor (URC).
- c. A child on the waiting list shall be prioritized for enrollment in the waiver if they meet any of the following criteria:
- d. Have been in a hospital for one month or longer and require Waiver Services in order to be discharged from the hospital.
- e. Are on the waiting list for an organ transplant.
- f. Are dependent upon mechanical ventilation or prolonged intravenous administration of nutritional substances.
- g. Have received a terminally ill prognosis from their physician.

8.7101.D ~~Children with Complex Health Needs Waiver (HCBS-CwCHN) Children with Life-Limiting Illness Waiver (HCBS-CLLI)~~

1. Target Group Criteria:
2. To be eligible for the ~~HCBS-CLLI waiver~~ HCBS-CwCHN waiver, an individual shall meet the Target Group Criteria as follows:
- a. Is under 19 years of age,
- b. Meets a Level of Care, as determined by the state prescribed Level of Care Assessment instrument defined in 8.401.16, furnished in one of the following:
- i. Nursing Facility
- ii. Hospital

1. To meet Hospital Level of Care for CwCHN, a member must either:

a. Have a diagnosis of a Life-Limiting Illness (i.e. a life-limiting medical condition or set of life-limiting medical conditions) as certified by a licensed medical professional and documented as prescribed by the Department upon enrollment.

Or:

b. One of the following conditions applies to the participant, documented as prescribed by the Department upon initial enrollment:

i. Technologically dependent for life or health-sustaining functions, OR

ii. Complex medication regimen or medical interventions to maintain or improve health status, OR

iii. Need of ongoing assessment or intervention to prevent serious deterioration of health status or medical complications that place life, health, or development at risk.

ii.

~~ii. Has been diagnosed with a Life-Limiting Illness (i.e., a life-limiting medical condition or set of life-limiting medical conditions) as certified by a physician on the Department-prescribed form, the Professional Medical Information Page.~~

~~c. Meets Hospital Level of Care as determined by the Case Manager using the Long-Term Services and Supports Level of Care Screen, and~~

~~d. Lives at home with Parent(s) or Guardian. Lives in their Family home.~~

3. Medicaid Eligibility Groups Served in the Waiver:

4. HCBS-CwCHN Waiver ~~-GLLI Waiver~~ Services are available to eligible individuals in the following State Plan eligibility groups:

a. Meets federal SSI disability definition and/or is an SSI recipient ~~SSI recipients~~

b. Optional Sstate Pplan recipients

5. Waiting List

a. Individuals who are determined eligible for benefits under the HCBS-CwCHN Waiver ~~-GLLI waiver~~, and who cannot be served within the capacity limits of the federally approved waiver, shall be eligible for placement on a waiting list maintained by the Department.

b. A child on the waiting list shall be prioritized for enrollment in the waiver if they meet any of the following criteria:

- i. Have been in a hospital for one month or longer and require Waiver Services in order to be discharged from the hospital.
- ii. Are on the waiting list for an organ transplant.
- iii. Are dependent upon mechanical ventilation or prolonged intravenous administration of nutritional substances.
- iv. Have received a terminally ill prognosis from their physician.

6. Other

- a. To be eligible for the CwCHN waiver, the income and resources of the child shall not exceed 300% of the current maximum Social Security Insurance (SSI) standard maintenance allowance. Individuals who are determined eligible for benefits under the HCBS-CLLI waiver, and who cannot be served within the capacity limits of the federally approved waiver, shall be eligible for placement on a waiting list maintained by the Department.

**8.7200.B Definitions**

21. Long Term Services and Supports (LTSS) Program means any of the following: publicly funded programs, Medicaid Nursing Facility Care, Program for All-Inclusive Care for the Elderly (PACE) (where applicable), Hospital Back-up (HBU) and Adult Long-Term Home Health (LTHH).

- a. Children's Home and Community-Based Services (HCBS-CHCBS)
- b. Developmental Disabilities (HCBS-DD)
- c. Home and Community-Based Services for the Elderly, Blind and Disabled (HCBS-EBD)
- d. Home and Community-Based Services Complementary and Integrative Health (HCBS-CIH)
- e. Home and Community-Based Services for Persons with a Brain Injury (HCBS-BI)
- f. Home and Community-Based Services Community Mental Health Supports (HCBS-CMHS)
- g. Home and Community-Based Services for Children with Complex Health Needs Life Limiting Illness (HCBS-~~CLLI~~CwCHN), and
- h. Home and Community-Based Services Supported Living Services (HCBS-SLS)
- i. Children's Extensive Support Waiver (HCBS-CES)

- j. Children's Habilitative Residential Program (HCBS-CHRP)
31. Waiver Benefit means covered benefits offered in addition to or as an alternative to state plan benefits as authorized by 42 U.S.C. 1396n(c) and include the Waiver Benefits described in Section 8.7101 for the following programs: Children's Home and Community-Based Services Waiver (CHCBS); Children's Extensive Support Waiver (HCBS-CES); Children's Habilitation Residential Program Waiver (HCBS-CHRP); Children ~~Withwith Complex Health Needs Life Limiting Illness Waiver~~ (HCBS-~~CwCHNCLLI~~); Persons With Brain Injury Waiver (HCBS-BI); Community Mental Health Supports Waiver (HCBS-CMHS); Elderly, Blind and Disabled Waiver (HCBS-EBD); Complementary and Integrative Health Waiver (HCBS-CIH; Supported Living Services Waiver (HCBS -SLS); and Developmental Disabilities Waiver (HCBS-DD).

## **8.7511 Bereavement Counseling**

### **8.7511.A Bereavement Counseling Eligibility**

1. Bereavement Counseling is a covered benefit available to Members ~~and/or Family Members~~ enrolled in the HCBS ~~Children with Complex Health Needs (CwCHN) Waiver~~ ~~Children's with Life Limiting Illness Waiver~~.

### **8.7510.B Bereavement Counseling Definition**

1. 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 ~~complex or~~ life-threatening condition.

### **8.7510.C Bereavement Counseling Exclusions and Limitations**

1. Bereavement Counseling shall be a benefit only 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 from other sources.

### **8.7511.D Bereavement Counseling Provider Agency Requirements**

1. Bereavement Counseling shall be provided only by individuals licensed or certified in at least one of the following:
- a. Licensed Clinical Social Worker (LCSW)
  - b. Licensed Professional Counselor (LPC)
  - c. Licensed Social Worker (LSW)
  - d. Licensed Independent Social Worker (LISW)
  - e. Licensed Psychologist; or
  - f. Non-denominational spiritual counselor, if employed by a qualified Medicaid home health or hospice agency.
2. Providers shall be licensed and in good standing with their specific specialty practice act or with current state licensure statutes and regulations.



3. Each individual providing Bereavement Counseling shall enroll as a Medicaid provider or be employed by an enrolled Medicaid home health or hospice provider agency.

#### **8.7511.E Bereavement Counseling Reimbursement**

1. Bereavement Counseling may be initiated and reimbursed while the Member is on the [CLL/CwCHN](#) waiver but may continue for one year following the death of the Member.

### **8.7521 Expressive Therapy- Art, Music, Play Therapy**

#### **8.7521.A Expressive Therapy Eligibility**

1. Expressive Therapy is a covered benefit available to Members enrolled in the HCBS [Children with Complex Health Needs](#) ~~Children's with Life Limiting Illness~~ Waiver.

#### **8.7521.B Expressive Therapy Definition**

1. Expressive Therapy means creative art, music or play therapy which provides 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.

#### **8.7521.C Expressive Therapy Inclusions**

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

#### **8.7521.D Expressive Therapy Exclusions and Limitations**

1. Expressive Therapy is limited to the Member's assessed need up to a maximum of 39 hours per annual support plan year.

#### **8.7521.E Expressive Therapy Provider Agency Requirements**

1. Individuals providing Expressive Therapy shall enroll with the fiscal agent or be employed by a Medicaid enrolled home health or hospice Agency.
  - a. 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.
  - b. 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.

### **8.7531 Massage Therapy**

#### **8.7531.A Massage Therapy Eligibility**

1. Massage Therapy is a covered benefit available to Members enrolled in one of the following HCBS waivers:

- a. ~~Children with Life Limiting Illness~~[Children with Complex Health Needs Waiver](#)
- b. Children's Extensive Support Waiver
- c. Children's Habilitation Residential Program
- d. Complementary and Integrative Health Waiver
- e. Supported Living Services Waiver

#### **8.7531.B Massage Therapy Definition**

1. Massage Therapy means the systematic manipulation of the soft tissues of the body, (including manual techniques of gliding, percussion, compression, vibration, and gentle stretching) for the purpose of bringing about beneficial physiologic, mechanical, and psychological changes.

#### **8.7531.C Massage Therapy Inclusions**

1. Massage therapy shall only be used for the treatment of conditions related to the Member's illness, medical need, or behavioral need as identified on the Person-Centered Support Plan.
2. Massage therapy includes the physical manipulation of muscles to ease muscle contractures or spasms, increase extension and muscle relaxation and decrease muscle tension, and WATSU.
3. Massage Therapy shall be provided in a licensed massage therapist's office, an approved outpatient setting, or in the Member's residence.
4. HCBS Complementary and Integrative Health Waiver (CIH); Support Living Services (SLS)
  - a. Members receiving massage therapy services may be asked to participate in an independent evaluation to determine the effectiveness of the services.

#### **8.7531.D Massage Therapy Exclusions and Limitations**

1. Massage therapy is not available if it is available under the Medicaid State Plan, EPSDT or from a Third-Party Resource.
2. HCBS Support Living Services (SLS) Waiver; Children's Extensive Services (CES) Waiver; ~~Children with Life Limiting Illness (CLLI)~~[Children with Complex Health Needs \(CwCHN\)](#) Waiver; Children's Habilitation Residential Program (CHRP) Waiver:
  - a. The following items are excluded and are not eligible for reimbursement:
    - i. Acupuncture;
    - ii. Chiropractic care; and
    - iii. Experimental treatments or therapies.
3. Massage Therapy Service Limitations:
  - a. HCBS ~~Children with Life Limiting Illness~~[Children with Complex Health Needs](#) Waiver:
    - i. Massage Therapy shall be limited to the Member's assessed need up to a maximum of 24 hours per annual certification period.

- b. HCBS Complementary and Integrative Health Waiver:
  - i. A maximum of 408 combined units of Acupuncture, Chiropractic, and Massage Therapy Waiver Services may be covered as a benefit during the support plan year.

#### **8.7531.E Massage Therapy Provider Agency Requirements**

- 1. Massage Therapy providers shall be licensed and in good standing pursuant to § 12-235-101, et seq., (C.R.S.)
- 2. HCBS Supported Living Services (SLS) Waiver, HCBS Children's Extensive Services (CES) Waiver; Children's Habilitation Residential Program (CHRP) Waiver:
  - a. The Medicaid State Plan therapist or physician identifies the need for the service, establishes the goal for the treatment and monitors the progress of that goal at least quarterly.
- 3. HCBS Complementary and Integrative Health Waiver
  - a. Massage Therapy providers shall have at least year of experience practicing Massage Therapy at a rate of 520 hours per year; OR year of experience working with individuals with paralysis or other long term physical disabilities.
  - b. Massage Therapy Provider Agencies shall:
    - i. Determine the appropriate modality, amount, scope, and duration of the massage therapy service within the established limits at Section 8.7531.D.3.2.a.
    - ii. Recommend only services that are necessary and appropriate in a care plan.
    - iii. Provide only services in accordance with the Member's prior authorized units.

#### **8.7536 Palliative/Supportive Care**

##### **8.7536.A Palliative/Supportive Care Eligibility**

- 1. Palliative/Supportive Care is a covered benefit available to Members enrolled in the HCBS ~~Children with Life Limiting Illness~~Children with Complex Health Needs Waiver.

##### **8.7536.B Palliative/Supportive Care Definition**

- 1. Palliative/Supportive Care means a specific program of specialized medical care for Members ~~with life limiting illness~~ offered by a licensed healthcare facility or provider that is specifically focused on the provision of organized palliative care services. Palliative care shall be focused on providing Members with relief from the symptoms, pain, and stress of serious illness, whatever the diagnosis. The goal shall be to improve the quality of life for both the Member and the family. Palliative care may be provided to Members of any age and at any stage in a ~~life-limiting~~member's illness. Palliative care services shall be provided by a Hospice or Home Care Agency staff who have received additional training in palliative care concepts such as adjustment to illness, advance care planning, symptom management, and grief/loss. For the purpose of the CLLI-CwCHN waiver, Palliative Care shall include Care Coordination and Pain and Symptom Management.

### **8.7536.C Palliative/Supportive Care Inclusions**

1. Palliative/Supportive Care may be provided together with curative treatment and includes:
  - a. Care Coordination
    - i. Care Coordination includes development and implementation of a care plan, home visits for regular monitoring of the health and safety of the Member and central coordination of medical and psychological services.
    - ii. A Care Coordinator will organize an array of services. This approach will enable the Member to receive all medically necessary care in the community with the goal of avoiding institutionalization in an acute care hospital.
    - iii. Additionally, a key function of the Care Coordinator shall be to manage the majority of the responsibility, otherwise placed on the Parents, for condensing, organizing, and making accessible to providers critical information that is related to the care and necessary for effective medical management.
    - iv. Care Coordination does not include Case Management Agency or Case Manager responsibilities.
  - b. Pain and Symptom Management
    - i. Pain and Symptom Management means nursing care in the home by a registered nurse to manage the Member's symptoms and pain. Management includes regular, ongoing pain and symptom Assessments to determine efficacy of the current regimen and available options for optimal relief of symptoms.
    - ii. Management also includes as needed visits to provide relief of suffering, during which, nurses assess the efficacy of current pain management and modify the regimen if needed to alleviate distressing symptoms and side effects using pharmacological, non-pharmacological and complementary/supportive therapies.

### **8.7536.D Palliative/Supportive Care Provider Agency Requirements**

1. Individuals providing Palliative/Supportive Care services shall be employed by or working under a formal contract with a qualified Medicaid hospice or Home Health Agency.
2. The services shall be provided by Hospice or Home Care Agency staff who have received additional training in palliative care concepts such as adjustment to illness, advance care planning, symptom management, and grief/loss.

### **8.7546 Child Respite**

#### **8.7546.A Child Respite Eligibility**

1. Child Respite is a covered benefit available to Members enrolled in one of the following HCBS waivers:
  - a. [~~Children with Life Limiting Illness~~Children with Complex Health Needs Waiver](#)
  - b. Children's Extensive Support Waiver
  - c. Children's Habilitation Residential Program

#### **8.7546.B Child Respite Definition**

1. Child Respite care means services provided to an eligible Member on a short-term basis because of the absence or need for relief of those persons who normally provide the care.
2. Unskilled Respite means services provided to an eligible Member by a trained and unlicensed support staff.
3. Skilled Respite means services provided to an eligible Member by a licensed RN/LPN/or CNA. These services must qualify as skilled care as prescribed by a Licensed Medical Professional.
4. Therapeutic Respite means services provided to an eligible Member by a specially-trained and certified support provider for ongoing behavioral support needs.

#### **8.7546.C Child Respite Inclusions**

1. HCBS Children's Extensive Supports (CES) Waiver
  - a. Respite may be provided in the Member home or private residence;
  - b. The private residence of a respite care provider; or
  - c. In the community.
2. HCBS ~~Children with Life Limiting Illness (GLLI)~~Children with Complex Health Needs (CwCHN) Waiver
  - a. Respite care may be provided in the home;
  - b. In the community; or
  - c. In an approved respite center location of a Member.
3. HCBS Children's Habilitation Residential Program Waiver (CHRP) Waiver
  - a. Respite services may be provided in a certified Foster Care Home;
  - b. Kinship Foster Care Home;
  - c. Licensed Residential Child Care Facility;
  - d. Licensed Specialized Group Facility, Licensed Child Care Center (less than 24 hours);
  - e. in the Family home; or
  - f. or in the community.
  - g. Overnight or out of home Respite must be in a Foster Care Home, Kinship Home, Group Home, or Residential Child Care Facility (RCCF).

#### **8.7546.D Child Respite Exclusions and Limitations**

1. HCBS Children's Extensive Supports (CES) Waiver
  - a. Respite is to be provided in an age-appropriate manner. Respite is not a covered benefit for Member 11 years of age and younger during the time the primary caregiver is at work, pursuing continuing education or engaging in volunteer activities.

- b. When the cost of care during the time the caregiver at work is more for a Member 11 years of age or younger, than it is for same age peers, respite may be used to pay the difference in costs. Caregivers shall be responsible for the basic and typical costs of childcare.

2. HCBS ~~Children with Life Limiting Illness (CLLI)~~ Children with Complex Health Needs (CwCHN) Waiver

- a. Respite care shall not be provided at the same time as Home Health or Palliative/Supportive Care services.

**8.7546.E Child Respite Provider Reimbursement Requirements**

1. HCBS Children's Extensive Supports (CES) Waiver

- a. Respite shall be provided according to an individual or group rates as defined below: Individual: the Member receives respite in a one-on-one situation. There are no other Members in the setting also receiving respite services.
- b. Unskilled Individual day: the Member receives respite in a one-on-one situation for cumulatively more than 10 hours in a 24-hour period. A full day is 10 hours or greater within a 24-hour period.
- c. Skilled and Therapeutic Individual day: the Member receives respite in a one-on-one situation for cumulatively more than four hours in a 24-hour period. A full day is four hours or greater within a 24-hour period.
- d. Overnight group: the Member receives respite in a setting which is defined as a facility that offers twenty-four (24) hour supervision through supervised overnight group accommodations. The total cost of overnight group within a twenty-four (24) hour period shall not exceed the respite daily rate.
- e. Group: the Member receives care along with other individuals, who may or may not have a disability. The total cost of the group rate within a twenty-four (24) hour period shall not exceed the respite daily rate. The following limitations to respite service shall apply:
- f. The total amount of respite provided in one support plan year may not exceed an amount equal to 30 day units and 1,880 15-minute units. The Department may approve a higher amount based on a need due to the Member's age, disability or unique Family circumstances.
- g. Overnight group respite may not substitute for other services provided by the provider such as Personal Care, Behavioral Services or other services not covered by the HCBS-CES waiver.
- h. Respite shall be reimbursed according to a unit rate or daily rate whichever is less. The daily overnight or group respite rate shall not exceed the respite daily rate.
- i. The purpose of respite is to provide the primary caregiver a break from the ongoing daily care of a Member. Therefore, additional respite units beyond the service limit will not be approved for Members who receive skilled nursing, certified nurse aide services, or home care allowance from the primary caregiver.

2. HCBS ~~Children with Life Limiting Illness (CLLI)~~ Children with Complex Health Needs (CwCHN) Waiver

- a. Respite is not to exceed thirty (30) days per support plan year, as determined by the Department approved Assessment.
3. HCBS Children's Habilitation Residential Program Waiver (CHRP) Waiver
  - a. The total amount of respite provided in one support plan year may not exceed an amount equal to thirty (30) day units and one thousand eight hundred eighty (1,880) individual units, where one unit is equal to 15 minutes. The Department may approve a higher amount when needed due to the Member's age, disability or unique Family circumstances.
  - b. During the time when Respite care is occurring, the Foster Care Home or Kinship Care Home may not exceed six (6) foster children or a maximum of eight (8) total children, with no more than two (2) children under the age of two (2). The respite home must be in compliance with all applicable rules and requirements for Family Foster Care Homes.
  - c. Respite is available for children or youth living in the Family home and may not be utilized while the Member is receiving Habilitation services.

### **8.7551 Therapeutic Life Limiting Illness Support**

#### **8.7551.A Therapeutic Life Limiting Illness Support Eligibility**

1. Therapeutic Life Limiting Illness Support is a covered benefit available to Members enrolled in the HCBS [Children's with Life Limiting Illness](#) [Children with Complex Health Needs](#) Waiver.

#### **8.7551.B Therapeutic Life Limiting Illness Support Definition**

1. Therapeutic Life Limiting Illness Support is intended to help the Member and Family in the disease process. Support is provided to the Member to decrease emotional suffering due to health status and develop coping skills. Support is provided to the Member and/or Family Members in order to guide and help them cope with the Member's illness and the related stress that accompanies the continuous, daily care required by a terminally ill child.

#### **8.7551.C Therapeutic Life Limiting Illness Support Inclusions, Exclusions and Limitations**

1. Support includes but is not limited to counseling, attending physician visits, providing emotional support to the family/caregiver if the child is admitted to the hospital or having stressful procedures, and connecting the Family with community resources such as funding or transportation.
2. Therapeutic Life Limiting Illness Support may be provided in individual or group settings.
3. Therapeutic Life Limiting Illness Support 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.
4. Therapeutic Life Limiting Illness Support is limited to the Member's assessed need up to a maximum of 98 hours per annual certification period.

#### **8.7551.D Therapeutic Life Limiting Illness Support Provider Requirements**

1. Individuals providing Therapeutic Life Limiting Illness Support shall enroll with the fiscal agent or be employed by a qualified Medicaid home health or hospice Agency.
2. Individuals providing Therapeutic Life Limiting Illness Support shall be one of the following:

- a. Licensed Clinical Social Worker (LCSW)
  - b. Licensed Professional Counselor (LPC)
  - c. Licensed Social Worker (LSW)
  - d. Licensed Independent Social Worker (LISW)
  - e. Licensed Psychologist; or
3. Non-denominational spiritual counselor, if employed by a qualified Medicaid home health or hospice Agency.

### **8.7556 Wellness Education Benefit**

#### **8.7556.A Wellness Education Benefit Eligibility**

1. Wellness Education Benefit is a covered benefit available to Members enrolled Children's Home and Community Based Services (CHCBS) Waiver.

#### **8.7556.B Wellness Education Benefit Definitions**

1. Article means a written document that contains text related to health or wellness topics that a Member receives.
2. Article Topic means a health and wellness topic that relates to helping a Member manage health-related issues, achieve goals on their Person-Centered Support Plan, and address topics of community living.
3. Mail means the mechanism by which the benefit is sent to the Member through the United States Postal Service.
4. Plain language means friendly and clear, with a direct, conversational tone and active voice. The information is organized in logical order for the reader. Paragraphs are one-topic and brief, and sentences are simple and short. Plain language includes using common, everyday vocabulary consistently across correspondence, with few multi-syllable words and few technical or bureaucratic words.
5. Service rendered means the Provider Agency has sent the Wellness Education Benefit.
6. Provider Agency means the entity contracted with the Department to distribute the Wellness Education Benefit.
7. Verified Address means an address that mail can be sent to and received by a Member.
8. Wellness Education Benefit is individualized educational materials designed to reduce the need for a higher level of care by offering educational materials that provide members and their families with actionable tools that can be used to prevent the progression of a disability, increase community engagement, combat isolation, and improve awareness of Medicaid services. The Wellness Education Benefit helps Members and their unpaid caregivers to obtain, process, and understand information that assists with managing health-related issues, promoting community living, and achieving goals identified in their Person-Centered Support Plan. Wellness Education Benefit services include varied topics such as engaging in community activities, nutrition, adaptive exercise, balance training and fall prevention, money management, and developing social networks.



#### **8.7556.C Wellness Education Benefit Inclusions**

1. The Wellness Education Benefit shall be delivered to the Member's mailing address in a printed format.
2. Article topics can provide the information needed to: Navigate the Medicaid/medical system to achieve better health outcomes, successfully manage chronic conditions in order to decrease risk of nursing facility placement, effectively communicate health and wellness goals, effectively communicate with medical and social service professionals, provide unpaid caregivers with relevant information regarding best practices around support and care of the Member, achieve community living goals identified in the Person-Centered Support Plan by providing simple, actionable suggestions to help support the health and welfare of waiver Members.
3. Article topics shall be written in plain language.
4. The Wellness Education Benefit is delivered no less than once every month, with a maximum of 12 unique education materials per year.
5. Wellness Education Benefit shall be provided in a format that is accessible to the Member at the request of the Member and their support team including, but not limited to, preferred written language. For Members who cannot read standard print and would benefit from an alternative format, educational materials will be sent to Members in the requested accessible format, which may include larger print or braille.

#### **8.7556.D Wellness Education Benefit Restrictions and Exclusions**

1. Additional wellness reading materials, software, or subscriptions are excluded from the Wellness Education Benefit.
2. Article topics that do not address community living, Medicaid navigation, health-related issues, health care needs, mental health-related issues, or Person-Centered Support Plan goals shall be excluded from this benefit.
3. The Wellness Education Benefit does not duplicate services found in Early and Periodic Screening, Diagnostic, and Treatment.

#### **8.7556.E Wellness Education Benefit Provider Requirements**

1. Provider Agencies must be contracted with the Department to distribute the Wellness Education Benefit.
2. Wellness Education Benefit Provider Agency shall be responsible for the following tasks:
  - a. Receive and manage member data in compliance with all applicable Health Insurance Portability and Accountability Act (HIPAA) regulations and ensure Member confidentiality and privacy.
  - b. Translate materials into select languages, as directed by the Department.
  - c. Both the Department and Wellness Benefit Provider Agency shall ensure that professionally certified translators and reviewers complete article translations and that translations are linguistically accurate and consistent with the formatting and technical specifications of the original document. Translations will be reviewed for cultural appropriateness before delivery.

- d. Ensure that materials are Person-Centered and are formatted in an accessible format, which may include Braille, large print, or high contrast formats.
- e. Maintain records of articles sent to members to prevent duplication of materials.
- f. Conduct member outreach to gather information on how the service has helped Members thrive in the community and meet their health and wellness goals.
- g. Utilize information on the Member's Person-Centered Support Plan and updated health conditions to guide the subject matter of the educational materials.
- h. Identify any undeliverable Member addresses prior to each monthly mailing and manage any returned mail by sending the Department electronic, custom-formatted relevant address information. The Department will coordinate with case managers to update the Member's address and send updated addresses to the Provider Agency.
- i. Verify Member addresses data files through the United States Postal Service "National Change of Address" database and identify any addresses that are undeliverable by USPS.
  - i. The Department will be informed by the Wellness Education Benefit Provider Agency of the educational materials that are undeliverable or returned to sender. An attempt to deliver the following month's service will take place using the following procedure:
    - 1) The Department will notify the Member's Case Management Agencies of any returned or undeliverable mail.
    - 2) Case Management Agencies shall update addresses in accordance with Department guidance.

#### **8.7556.F Wellness Education Benefit Provider Reimbursement Requirements**

- 1. The Wellness Education Benefit is reimbursed based on the number of units of service provided, with one unit equal to one Article.
- 2. The Wellness Education Benefit will be delivered once every month, for twelve (12) units.
  - a. The Case Manager may authorize up to 12 additional units per support plan year for the following:
    - i. The Wellness Education Benefit was returned to sender as a non-deliverable, and the address is updated in time for the second round of monthly delivery.
    - ii. A Member has requested reasonable accommodation for an alternative format, such as braille.
    - iii. A Member requests that their representative receives a copy of the benefit to help them better utilize information provided in the benefit.
- 3. The annual total units that may be authorized for the Wellness Education Benefit shall not exceed 24 units per plan year.

#### **8.7556.G Wellness Education Benefit Case Management Agency Responsibilities**

- 1. Wellness Education Benefit Introduction and Education:

- a. The Case Manager shall provide Member information on the benefits of the Wellness Education Benefit, the types of articles included, and the frequency of delivery.
  - b. Through the person-centered planning process, the Case Manager will determine a format that is accessible to the Member including, but not limited to, preferred written language.
2. Case Management Agencies shall update addresses in accordance with Department guidance.
3. The Member may work with their Case Manager to request different subject matter for the educational materials.
4. The Case Manager may work with the Provider Agency to ensure the educational materials are being targeted to meet any new needs the Member may have.
5. Disenrollment
  - a. If a Member wants to opt out of the service, the Case Manager shall inform the Member of the possible implications of disenrollment. If a Member disenrolls, the Case Manager must revise the Prior Authorization Request to end-date the Wellness Education Benefit.
  - b. The Wellness Education Benefit is recognized as an HCBS service as it relates to Section 8.7101.35 and may be utilized to maintain waiver eligibility.
  - c. If services are decreased without the member's agreement, the Case Manager shall notify the Member of the adverse action and of appeal rights, according to Long-Term Care Waiver Program Notice of Action (LTC-803) regulations at Section 8.7206.18.

## **DO NOT PUBLISH THIS PAGE**

Title of Rule: Revision to CMS file names used for Inpatient Rebasing, Section 8.300  
Rule Number: MSB 25-02-03-B  
Division / Contact / Phone: Fee for Service Rates / Diana Lambe /  
diana.lambe@state.co.us

## **SECRETARY OF STATE**

### **RULES ACTION SUMMARY AND FILING INSTRUCTIONS**

#### **SUMMARY OF ACTION ON RULE(S)**

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 25-02-03-B, Revision to CMS file names used for Inpatient Rebasing, Section 8.300
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):  
Sections(s) 10 CCR 2505-10 8.300 Pages 16-18, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No  
If yes, state effective date:  
Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

#### **PUBLICATION INSTRUCTIONS\***

Replace the current text at 8.300 with the proposed text beginning at 8.300.1.L.8 through the end of 8.300.1.L.8. Replace the current text at 8.300.5 with the proposed text beginning at 8.300.5.A through the end of 8.300.5.A.3.e.1).ii. This rule is effective June 30, 2025.

## DO NOT PUBLISH THIS PAGE

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Rule Number: MSB 25-02-03-B  
Division / Contact / Phone: Fee for Service Rates / Diana Lambe / diana.lambe@state.co.us

## STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

Below is a list of the proposed amendments to Rule to address the change in naming conventions that we encountered this year with CMS Tables/IMPACT data file "adjustments," and other housecleaning items:

A) The Department is amending Colorado Rule 8.300.5.A.3.a with a new paragraph that describes what files will be used this year and in the future to the best of our ability. These changes will eliminate specific file naming in subsequent portions of rule describing the base rate methodology.

B) Additionally, we amended the date of January 1 to "the end of the first full week in January" since January 1st is a holiday.

C) We also made a correction in the rate methodology portions of rule to correctly reference the "Definitions" portion of Rule for hospital types located at 8.300.1.L instead of the incorrect reference of 8.300.1.K.

Below are 2 slides from our Hospital Stakeholder Engagement Meeting on March 7, 2025 which describes the nature of the rule changes summarized above.

### Examples showing nature of Rule Changes

a. Calculation of the Starting Point for the Medicaid Inpatient Base Rate

This screenshot shows the new paragraph deposited in 8.300.5.A.3.a: "Calculation for the Starting Point for the Medicaid Inpatient Base Rate."

The screenshot also shows the deleted portions of named files and timing since it is all now addressed in the overarching paragraph above.

b. Policy Adjustments

For PPS hospitals, Operating IME's will be multiplied by Adjusted Operating Federal Portion and the Capital IME's will be multiplied by the Adjusted Federal Capital Rate. The VBP Adjustment Factor and Readmission Adjustment Factor taken from CMS Final Rule Correcting Assessment Tables 10B and 11 respectively will be multiplied by the Adjusted Operating Federal Portion. The Hospital Acquired Conditions Reduction taken from the most recent CMS.gov Data Set as of January 1 will be applied against the Medicare Federal Base Rate with Wage Index/GAF Adjustments.

### Examples showing nature of Rule Changes cont'd

8.300.1 is the "Definitions" portion of rule and lists 12 different definitions related Hospital Services. Three of those definitions in 8.300.1.L are specific to Pediatric, Sole Community Hospitals (SCH) and Medicare Dependent Hospitals (MDH) which are detailed in the Mutually Exclusive Add-ons section of Rule.

This screenshot shows the reference for Sole Community Hospital (SCH) and Medicare Dependent Hospital (MDH) as well as the Pediatric Hospital definition being amended from K to L in the definitions portion of Rule.

c. Mutually Exclusive Medicaid Add-ons

Four Add-ons will be mutually exclusive and applied as described here and will be applied as a percentage against the Medicare Federal Base Rate w/Wage Index/GAF Adjustments as detailed below:

- 1) Critical Access Hospital (CAH) Add-on will be set at 25% and is only open to those hospitals categorized as CAH by Medicare.
- 2) Sole Community Hospital (SCH)/Medicare Dependent Hospital (MDH) will be set at 20% and is only open to those hospitals categorized as SCH/MDH in section 8.300.1.L.
- 3) Low Discharge Add-on based on the average of up to three years of Total Discharges of most recently available cost reports on HCRRS as of January 1 of the rebasing year and excludes hospitals that are classified as Pediatric, SCH/MDH or CAH. For hospitals with subunits of Psychiatric, Rehabilitation and other subunits discharges in those subunits will be added to total discharges. The percentage add-on is set at 10% and distributed on a sliding scale with a ceiling of 2,500 and floor of 500 discharges.
- 4) The Pediatric Add-on is open only to hospitals defined as Pediatric in Section 8.300.1.K.3 and the percentage add-on is set at 25%.

Initial Review  
Proposed Effective Date

**04/11/25**  
**06/30/25**

Final Adoption  
Emergency Adoption

**05/09/25**

**DOCUMENT #**

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2. An emergency rule-making is imperatively necessary

- ☐ to comply with state or federal law or federal regulation and/or  
☐ for the preservation of public health, safety and welfare.

Explain:

NA

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2024);

Initial Review  
Proposed Effective Date

**04/11/25**  
**06/30/25**

Final Adoption  
Emergency Adoption

**05/09/25**

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### **REGULATORY ANALYSIS**

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

Hospitals will neither benefit nor be hurt by the proposed rule changes.

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

Hospital rates will remain as intended and are not affected by these rule changes.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

There are no costs associated with the proposed rule changes.

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

Failure to make the proposed changes may result in ambiguous interpretations by hospitals as to which files are used as input to create their Inpatient Base Rates every other year.

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

There are no less costly or intrusive methods for achieving the purpose of the proposed rule.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

No alternative methods are available to our understanding.

## **8.300 HOSPITAL SERVICES**

### **8.300.1 Definitions**

- 8.300.1.A.** Abbreviated Client Stay means an Inpatient stay ending in client death or in which the client leaves against medical advice.
- 8.300.1.B.** Concurrent Review means a review of quality, Medical Necessity and/or appropriateness of a health care procedure, treatment or service during the course of treatment.
- 8.300.1.C.** Continued Stay Review means a review of quality, Medical Necessity and appropriateness of an Inpatient health care procedure, treatment or service.
- 8.300.1.D.** Corrective Action is a step-by-step plan approved by the Department to achieve targeted outcomes and address patterns of inappropriate behavior, including, but not limited to, improper billing, unwarranted utilization, or questionable quality of care. Corrective action may include, but is not limited to, Concurrent Review, Continued Stay Review, Prospective Review, Retrospective Review, requirement to self-audit, or any other action as determined appropriate by the Department.
- 8.300.1.E.** Department means the Department of Health Care Policy and Financing.
- 8.300.1.F.** Diagnosis Related Group (DRG) means a cluster of similar conditions within a classification system used for Hospital reimbursement. It reflects clinically cohesive groupings of Inpatient hospitalizations that utilize similar amounts of Hospital resources.
- 8.300.1.G.** DRG Hospital means a Hospital that is reimbursed by the Colorado Medicaid program based on a system of DRGs. Those Hospitals reimbursed based on a DRG system are: General Hospitals, Critical Access Hospitals, Pediatric Hospitals.
- 8.300.1.H.** Diagnostic Services means any medical procedures or supplies recommended by a licensed professional within the scope of his/her practice under state law to enable him/her to identify the existence, nature, or extent of illness, injury, or other health condition in a client.
- 8.300.1.I.** Disproportionate Share Hospital (DSH) Factor is a percentage add-on adjustment that qualified Hospitals receive for serving a disproportionate share of low-income clients.
- 8.300.1.J.** Emergency Care Services, for the purposes of this rule, means services for a medical condition, including active labor and delivery, manifested by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the client's health in serious jeopardy, (2) serious impairment to bodily functions or (3) serious dysfunction of any bodily organ or part.
- 8.300.1.K.** Enhanced Ambulatory Patient Group (EAPG) means a cluster of similar procedures within a classification system used for Hospital reimbursement. It reflects clinically cohesive groupings of services performed during Outpatient visits that utilize similar amounts of Hospital resources.
- 8.300.1.L.** Hospital means an institution that is (1) primarily engaged in providing, by or under the supervision of physicians, Inpatient medical or surgical care and treatment, including diagnostic, therapeutic and rehabilitation services, for the sick, disabled and injured; (2) licensed, when located in Colorado, as a Hospital by the Colorado Department of Public Health and Environment (CDPHE); and, when not located in Colorado, by the state in which it is located; and (3) certified



for participation in the Centers for Medicare and Medicaid Services (CMS) Medicare program. Hospitals can have multiple satellite locations as long as they meet the requirements under CMS. For the purposes of the Colorado Medicaid program, distinct part units and satellite locations are considered part of the Hospital under which they are licensed. Transitional Care Units (TCUs) are not considered part of the Hospital for purposes of the Colorado Medicaid program. Types of Hospitals are:

1. A General Hospital is licensed and CMS-certified as a General Hospital that, under an organized medical staff, provides Inpatient services, emergency medical and surgical care, continuous nursing services, and necessary ancillary services. A General Hospital may also offer and provide Outpatient services, or any other supportive services for periods of less than twenty-four hours per day.
2. A Critical Access Hospital (CAH) is licensed and CMS-certified as a Critical Access Hospital. CAHs offer emergency services and limited Inpatient care. CAHs may offer limited surgical services and/or obstetrical services including a delivery room and nursery.
3. A Pediatric Hospital is licensed as a General Hospital and CMS-certified as a children's Hospital providing care primarily to populations aged seventeen years and under.
4. A Rehabilitation Hospital is licensed and CMS-certified as a Rehabilitation Hospital which primarily serves an Inpatient population requiring intensive rehabilitative services including but not limited to stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, fracture of femur, brain injury, and other disorders or injuries requiring intensive rehabilitation.
5. A Long-Term Care Hospital is licensed as a General Hospital and CMS-certified as a Long-Term Care Hospital which primarily serves an inpatient population requiring long-term care services including but not limited to respiratory therapy, head trauma treatment, complex wound care, IV antibiotic treatment and pain management.
6. A Spine/Brain Injury Treatment Specialty Hospital licensed as a General Hospital and CMS-certified as a Long-Term Care Hospital OR CMS-certified as a Rehabilitation Hospital is a Not-for Profit Hospital as determined by the CMS Cost Report for the most recent fiscal year. A Spine/Brain Injury Treatment Specialty Hospital primarily serves an inpatient population requiring long term acute care and extensive rehabilitation for recent spine/brain injuries. To qualify as a Spine/Brain Injury Treatment Specialty Hospital, for at least 50% of Medicaid members discharged in the preceding calendar year the hospital must have submitted Medicaid claims including spine/brain injury treatment codes (previously grouped to APR-DRG 40, 44, 55, 56, and 57). The Department shall revoke the designation if the percentage of Medicaid members discharged falls below the 50% requirement for a calendar year. Designation is removed the calendar year following the disqualifying year.
7. A Psychiatric Hospital is licensed and CMS-certified as a Psychiatric Hospital to plan, organize, operate, and maintain facilities, beds, and treatment, including diagnostic, therapeutic and rehabilitation services, over a continuous period exceeding twenty-four (24) hours, to individuals requiring early diagnosis, intensive and continued clinical therapy for mental illness; and mental rehabilitation. A Psychiatric Hospital can qualify to be a state-owned Psychiatric Hospital if it is operated by the Colorado Department of Human Services.
8. A Medicare Dependent Hospital is defined as set forth at 42 C.F.R § 412.103 (2022). 42 C.F.R. § 412.108(1) (~~2018~~2022) is hereby incorporated by reference into this rule. Such

incorporation, however, excludes later amendments to or editions of the referenced material. This regulation is available for public inspection at the Department of Health Care Policy and Financing, 303 E. 17th Ave, Denver~~1570 Grant Street, Denver~~, CO 80203. Pursuant to C.R.S § 24-4-410(12.5)(V)(b), the Department shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule.

9. A Non-independent Urban Hospital is a hospital which reports a name of the home office of the chain with which they are affiliated on the CMS-2552-10 Cost Report in Worksheet S-2 Part 1, Line 141, Column 1, with the exception of individual hospitals reporting an affiliation not reported amongst other hospitals located in Colorado.
  10. A Sole Community Hospital (SCH) is defined by CMS which classifies a hospital as a sole community hospital if it is located more than 35 miles from other like hospitals, or it is located in a rural area (as defined in 412.64) and meets one of the following conditions. No more than 25 percent of residents who become hospital inpatients or no more than 25 percent of the Medicare beneficiaries who become hospital inpatients in the hospital's service area are admitted to other like hospitals located within a 35-mile radius of the hospital, or, if larger within its service area. The hospital has fewer than 50 beds and intermediary certifies that the hospital would have met the criteria in paragraph (a)(1)(i) of this section were it not for the fact that some beneficiaries or residents were forced to seek care outside the service area due to the unavailability of necessary specialty services at the hospital are inaccessible for at least 30 days in each 2 out of 3 years.
  11. For the purposes of Section 8.300: Hospital Services, Prospective Payment System (PPS) inpatient hospitals are categorized by CMS as hospitals which Medicare pays on a prospective basis and which provide data in the Medicare IPPS IMPACT file and supporting data files/tables from which to create their PPS rate. Conversely, non-Prospective Payment System (PPS) inpatient hospitals are categorized by CMS as Pediatric and Critical Access Hospitals for which Medicare does not pay on a prospective basis and which do not have data available on the Medicare IPPS IMPACT file or supporting data files/tables.
  12. Rebasing years are every other odd year starting in state fiscal year 2023-24. Non-rebasing years are every other even year starting in state fiscal year 2024-25.
- 8.300.1.M.** Inpatient is a person who has been admitted to a Hospital for purposes of receiving Inpatient Hospital Services.
- 8.300.1.N.** Inpatient Hospital Services means services that are furnished by a Hospital for the care and treatment of an Inpatient and are provided in the Hospital by or under the direction of a physician.
- 8.300.1.O.** Medical Necessity is defined at Section 8.076.1 and, for members ages 20 and under receiving Early and Periodic Screening, Diagnosis, and Treatment services, at Section 8.280.4.E.2.
- 8.300.1.P.** Non-DRG Hospital means a Hospital that is not reimbursed by the Colorado Medicaid program based on a system of DRGs. Psychiatric Hospitals, Long-Term Care Hospital, Rehabilitation Hospital and Spine/Brain Injury Treatment Specialty Hospital are considered Non-DRG Hospitals since their reimbursement is based on a per diem rate.

- 8.300.1.Q.** Observation Stay means Outpatient Hospital Services provided in a Hospital for the purposes of evaluating a person for Inpatient admission, stabilization, or extended recovery.
- 8.300.1.R.** Outlier Days mean the days in a Hospital stay that occur after the Trim Point Day.
- 8.300.1.S.** Outpatient means a person who is receiving professional services at a Hospital or an off-campus location of a Hospital but is not admitted as an Inpatient.
- 8.300.1.T.** Outpatient Hospital Services means services that are furnished to Outpatients; and are furnished by or under the direction of a physician or dentist.
- 8.300.1.U.** Prospective Review means a review of quality, Medical Necessity and/or appropriateness of a health care procedure, treatment, or service prior to treatment.
- 8.300.1.V.** Rehabilitative Services means any medical or remedial services recommended by a physician within the scope of his/her practice under state law, for maximum reduction of physical or mental disability and restoration of a client to his/her best possible functional level.
- 8.300.1.W.** Relative Weight (DRG weight or EAPG weight) means a numerical value which reflects the relative resource consumption for the DRG or EAPG to which it is assigned. Modifications to these Relative Weights are made when needed to ensure payments reasonably reflect the average cost for each DRG or EAPG. Relative Weights are intended to be cost effective and based upon the data sources applicable to the DRG version effective during the last date of the inpatient hospitalization.
- 8.300.1.X.** Retrospective Review means a review of quality, Medical Necessity and/or appropriateness of a health care procedure, treatment or service following treatment. A Retrospective Review can occur before or after reimbursement has been made.
- 8.300.1.Y.** Rural Hospital means a Hospital not located within a metropolitan statistical area (MSA) as designated by the United States Office of Management & Budget.
- 8.300.1.Z.** State University Teaching Hospital means a Hospital which provides supervised teaching experiences to graduate medical school interns and residents enrolled in a state institution of higher education; and in which more than fifty percent (50%) of its credentialed physicians are members of the faculty at a state institution of higher education.
- 8.300.1.AA.** Swing Bed Designation means designation of Hospital beds in a Rural Hospital with less than 100 beds for reimbursement under Medicare for furnishing post-hospital extended care services to Medicare beneficiaries in compliance with the Social Security Act, Sections 1883 and 1866. Such beds are called "swing beds."
- 8.300.1.BB.** Trim Point Day (Outlier Threshold Day) means the day during an inpatient stay after which Outlier Days are counted.. The Trim Point Day is based upon the data sources applicable to the DRG version effective during the last date of service of the inpatient hospitalization.
- 8.300.1.CC.** Urban Hospital means a Hospital located within a MSA as designated by the United States Office of Management & Budget.
- 8.300.1.DD.** Urban Safety Net Hospital means an Urban, General Hospital for which the Medicaid Inpatient eligible days plus Colorado Indigent Care Program (CICP) Inpatient days relative to total Inpatient days, rounded to the nearest percent are equal to or exceed sixty-five percent. To qualify as an Urban Safety Net Hospital, a Hospital must submit its most current information on Inpatient days by March 1 of each year for the Inpatient rates effective on July 1 of that same year. The Department may rely on other data sources for the calculation if there are

discrepancies between the data submitted by the Hospital and alternative data sources such as claims or cost report data.

### **8.300.5 Payment for Inpatient Hospital Services**

#### **8.300.5.A Payments to DRG Hospitals for Inpatient Hospital Services**

##### **1. Peer Groups**

For the purposes of Inpatient reimbursement, DRG Hospitals are assigned to one of the following peer groups. Hospitals which do not fall into the peer groups described in a and b shall default to the peer groups described in c and d based on geographic location.:

- a. Pediatric Hospitals
- b. Rural Hospitals
- c. Urban Hospitals

##### **2. Base Payment and Outlier Payment**

DRG Hospitals shall be reimbursed for Inpatient Hospital Services based on a system of DRGs and a hospital-specific Medicaid Inpatient base rate. The reimbursement for Inpatient Hospital Services shall be referred to as the DRG base payment.

- a. The DRG base payment shall be equal to the DRG Relative Weight multiplied by the Medicaid Inpatient base rate as calculated in Section 8.300.5.A.3 – 6.
- b. Outlier days shall be reimbursed at 80% of the DRG per diem rate. The DRG per diem rate shall be the DRG base payment divided by the DRG average length of stay.
- c. The DRG base payment plus any corresponding outlier payment is considered the full reimbursement for an Inpatient Hospital stay where the client was Medicaid-eligible for the entire stay.
- d. When a client was not Medicaid-eligible for an entire Inpatient Hospital stay, reimbursement shall be equal to the DRG per diem rate for every eligible day, with payment up to the full DRG base payment. If applicable, the Hospital shall receive outlier reimbursement.

##### **3. Medicaid Inpatient Base Rate for In-network Colorado DRG Hospitals**

a. Calculation of the Starting Point for the Medicaid Inpatient Base Rate

Medicaid Inpatient Base rates for DRG Hospitals are calculated based in part on CMS data. The CMS named files used from CMS are used as inputs to calculate the inpatient base rates. For the purpose of calculating the starting point for the Medicaid inpatient base rate, the CMS named files will ~~will be whatever file is the~~ most recently deposited "adjustment" of the CMS Tables and IMPACT file data effective October 1 and available as of the end of the first full week in January of rebasing years. Similarly, the most recently available Medicare and Medicaid full year cost reports on the CMS Healthcare Provider Cost Reporting Information System (HCRIS) will be utilized by the end of the first full week in January of rebasing years. One exception to the timeframe is the Hospital Acquired Conditions (HAC) Reduction file. The data for the current year is published within the first quarter of each calendar year. Since the reports available at the end of the first full week of January contain the previous year's HAC data, the Department will utilize the newest file available between January through March of rebasing years to assign HAC Reduction to Inpatient Base Rates.

For in-state Colorado DRG Hospitals (both PPS and non-PPS), the starting point shall be the hospital-specific Medicare Federal base rate with the specific adjustments listed. The Operating Federal Portion and Federal Capital Rate (source: CMS Tables 1A-1B & IE) will be adjusted by the Wage Index and Geographic Adjustment Factor (GAF) from the CMS IMPACT File.

For CAH and Pediatric hospitals (non-PPS Medicare hospitals), both adjustment factors as listed above will be set to 1.0 and the corresponding labor and non-labor related amounts will be applied because these factors are not available from CMS. Additionally, the Quality and Meaningful Electronic Health Records (EHR) User adjustments will be applied to all PPS hospitals as indicated on the CMS ~~corrected~~ IMPACT file, while all non-PPS hospitals are assumed to have submitted Quality Data and be meaningful EHR users since no data exists for them. The ~~corrected~~ Medicare base rate IMPACT File shall be used to set the Federal Base Rate and other adjustments detailed above. ~~effective on October 1 of the previous fiscal year.~~

b. Policy Adjustments

Indirect Medical Education (IME) / Value Based Purchasing Adjustment (VBP) Factor / Readmission Adjustment Factor and Hospital Acquired Conditions (HAC) Reduction:

- 1) For PPS hospitals, Operating IME% will be multiplied by Adjusted Operating Federal Portion and the Capital IME% will be multiplied by the Adjusted Federal Capital Rate. The VBP Adjustment Factor and Readmission Adjustment Factor taken from CMS ~~Final Rule Correcting Amendment~~ Tables 16B and 15 respectively will be multiplied by the Adjusted Operating Federal Portion. The Hospital Acquired Conditions Reduction taken from the ~~most recent~~ CMS.gov Data Set as detailed in 8.300.5.A.3.a as of January 1 will be applied against the Medicare Federal Base Rate with Wage Index/GAF Adjustments.

- 2) For non-PPS hospitals, Operating & Capital IME % are not calculated in the IMPACT File so the Department's Contractor will compute their Operating and Capital IME using the most recently available ~~cost report as of January 1~~ HCRIS cost report data in rebasing years and will require that hospitals have a CMS approved teaching program as detailed in Section 8.300.5.A.3.e. Additionally, non-PPS Hospitals will have the opportunity to review their calculated Operating and Capital IME percent during a 30-day review period and request changes if necessary. The VBP Adjustment Factor, Readmission Adjustment Factor and HAC Reduction will not be applied to non-PPS hospitals since they are not calculated by CMS.

c. Mutually Exclusive Medicaid Add-ons:

Four Add-ons will be mutually exclusive and applied as described here and will be applied as a percentage against the Medicare Federal Base Rate w/Wage Index/GAF Adjustments as detailed below.

- 1) Critical Access Hospital (CAH) Add-on will be set at 25% and is only open to those hospitals categorized as CAH by Medicare,
- 2) Sole Community Hospital (SCH)/Medicare Dependent Hospital (MDH) will be set at 20% and is only open those hospitals categorized as SCH/MDH in Section 8.300.1.KL,
- 3) Low Discharge Add-on based on the average of up to three years of Total Discharges ~~of most recently available from~~ cost reports on HCRIS as of January 1 of in rebasing years and excludes hospitals that are classified as Pediatric, SCH/MDH or CAH. For hospitals with subunits of Psychiatric, Rehabilitation and other subunits discharges in those subunits will be added to total discharges. The percentage add-on is set at 10% and distributed on a sliding scale with a ceiling of 2,500 and floor of 500 discharges,
- 4) The Pediatric Add-on is open only to hospitals defined as Pediatric in Section 8.300.1.KL.3 and the percentage add-on is set at 25%.

d. Remaining Medicaid Add-ons:

The remaining add-ons are open to all hospitals who qualify and are applied as a percentage of the Medicare Federal Base Rate with Wage Index/GAF Adjustments and distributed on a sliding scale between the respective ceiling and floor.

1. Payer Mix Add-on is based on the percentage of Medicaid patient days treated at the hospital using up to three years of the most recently available HCRIS cost reports. The add-on is set at up to 10% with a ceiling and floor of 50% and 35% respectively. For hospitals with subunits of Psychiatric, Rehabilitation and other subunits Payer Mix utilization in those subunits will be added to the calculations.
2. Operating Cash Flow Margin Percent Add-on (also known as the solvency metric) is set at 20% with a ceiling of 8% and floor of 0%. The source for this data is up to 3 years of Hospital Transparency Data that is generated by each hospital and sent into the Department. The Operating

Cash Flow Margin Percent Add-on is calculated for all hospitals and is based on the maximum of the hospital or the hospital system's operating cash flow margin percent. System hospital list can be found on the Department's website. Operating Cash Flow Margin Percent is calculated by taking (Total Operating Net Income + Depreciation Expense) / Total Operating Revenue.

e. Application of Graduate Medical Education (GME) Cost Add-on to Determine Medicaid Inpatient Base Rate:

- 1) The Medicaid Inpatient base rate shall be equal to the rate as calculated in Sections 8.300.5.A.3.a-b plus the GME Medicaid hospital-specific cost add-on. The GME Medicaid hospital-specific cost add-on is calculated from the most recently available HCRIS Medicare/Medicaid cost report (CMS 2552) worksheet B, Part I. Partial year cost reports shall not be used to calculate the GME cost add-on. The GME cost add-on shall not be applied to the Medicaid Inpatient base rates for State University Teaching Hospitals. State University Teaching Hospitals shall receive reimbursement for GME costs as described in Section 8.300.9.B.

The GME Medicaid hospital-specific cost add-on shall be an estimate of the cost per discharge for GME based on: Medicare approved GME program where legitimate GME expenses have been reported in accordance with Medicare's rules detailed in 42 C.F.R. § 413.75, et. seq. (2025) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. This regulation is available for public inspection at the Department of Health Care Policy and Financing, 303 E.17th Ave, Denver1570 Grant Street, Denver, CO 80203. Pursuant to C.R.S § 24-4-410(12.5)(V)(b), the Department shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule.

GME will be calculated when the following two criteria are met:

- i. Hospitals that appear on the most recent list as of the end of the first full week in January ~~4~~ of CMS qualified teaching hospitals on the CMS Open Payments website or the hospital will need to provide documentation to the State by proving Medicare approval of the GME program.
- ii. Have countable GME costs in the most recent HCRIS cost report available as of the end of the first full week in January ~~4~~ of rebasing years in worksheet B, part 1 and discharges from worksheet S-3, part I.

- 2) Ten percent of the GME Medicaid hospital-specific cost add-on shall be applied.

f. Application of Adjustment Based on General Assembly Funding

In rebasing years, for all in-state, Colorado DRG Hospitals (both PPS and non-PPS), the starting point for the Medicaid Inpatient base rate, as determined in Section 8.300.5.A.3.a - e, shall be adjusted by an equal percentage. This percentage shall be determined by the Department as required by the available funds appropriated by the General Assembly. Additionally, a 10% corridor has been implemented to prevent any hospital's inpatient base rate from increasing or decreasing more than 10% each rebasing year.

g. Annual Adjustments

The Medicaid Inpatient base rates are rebased every other year as described in Section 8.300.5.A.3.a - f and are effective each July 1. In non-rebasing years, the Medicaid Inpatient base rates will be adjusted by the State Budget Action as set by Legislature and are effective each July 1. The Medicaid base rate shall be adjusted during the fiscal year, if necessary, based on appropriations available to the Department and/or adjustments necessary to balance the DRG payment equation.

4. Medicaid Inpatient Base Rate for New In-State Colorado DRG Hospitals

The Medicaid Inpatient base rate for new in-state Colorado DRG Hospitals shall be the average Colorado Medicaid Inpatient base rate for their corresponding peer group. A Hospital is considered "new" until the next Inpatient rate rebasing year after the Hospital's contract effective date. For the next Inpatient rate rebasing year, the Hospital's Medicaid Inpatient base rate shall be equal to the rate as determined in Section 8.300.5.A.3-6. If the Hospital does not have a Medicare Inpatient base rate or a full year Medicare/Medicaid cost report to compute a starting point as described in Section 8.300.5.A.3.a, their initial rate shall be equal to the average Colorado Medicaid Inpatient base rate for their corresponding peer group.

5. Medicaid Inpatient Base Rate for Border-state Hospitals

The Medicaid Inpatient base rate for border-state Hospitals shall be equal to the average Medicaid Inpatient base rate for the corresponding peer group.

6. Medicaid Inpatient Base Rate for Out-of-state Hospitals

- a. The Medicaid Inpatient base rate for out of state Hospitals shall be equal to 90% of the average Medicaid Inpatient base rate for the corresponding peer group.
- b. The Department may reimburse an out-of-state Hospital for non-emergent services at an amount higher than the DRG base payment when the needed services are not available in a Colorado Hospital. Reimbursement to the out-of-state Hospital shall be made at a rate mutually agreed upon by the parties involved.

7. Reimbursement for Inpatient Hospital claims that (a) include serious reportable events identified by the Department in the Provider Bulletin with (b) discharge dates on or after October 1, 2009, may be adjusted by the Department.



## **DO NOT PUBLISH THIS PAGE**

Title of Rule: Revision to the Medical Assistance Act concerning changes to the Drug Utilization Review Board and Pharmacy and Therapeutics Committee, Section 8.800.9.D  
Rule Number: MSB 25-01-06-A  
Division / Contact / Phone: Pharmacy Office / Korri Conilogue / Korri.Conilogue@state.co.us

## **SECRETARY OF STATE**

### **RULES ACTION SUMMARY AND FILING INSTRUCTIONS**

#### **SUMMARY OF ACTION ON RULE(S)**

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 25-01-06-A, Revision to the Medical Assistance Act concerning changes to the Drug Utilization Review Board and Pharmacy and Therapeutics Committee, Section 8.800.9.D
3. This action is an adoption of: N/a
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):  
Sections(s) 8.800.9 and 8.800.17, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No  
If yes, state effective date:  
Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

#### **PUBLICATION INSTRUCTIONS\***

Replace the current text at 8.800.9.D with the proposed text beginning at 8.800.9.D through the end of 8.800.9.D.7. Replace the current text at 8.800.17 with the proposed language beginning at 8.800.17 through the end of 8.800.17.D.2. This rule is effective June 30, 2025.

## DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act concerning changes to the Drug Utilization Review Board and Pharmacy and Therapeutics Committee, Section 8.800.9.D  
Rule Number: MSB 25-01-06-A  
Division / Contact / Phone: Pharmacy Office / Korri Conilogue / Korri.Conilogue@state.co.us

### STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

The purpose of the proposed rule change is to update the composition of the Drug Utilization Review (DUR) Board and the Pharmacy and Therapeutics (P&T) Committee. The Department proposes eliminating the non-voting pharmaceutical industry representative position on the DUR Board due to challenges in maintaining this role. Additionally, the Department seeks to reduce the size of the P&T Committee to address difficulties in filling positions and achieving a quorum for meetings.

2. An emergency rule-making is imperatively necessary

☐ to comply with state or federal law or federal regulation and/or  
☐ for the preservation of public health, safety and welfare.

Explain:

N/a

3. Federal authority for the Rule, if any:

42 C.F.R. § 456.716

4. State Authority for the Rule:

Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2024);  
C.R.S. § 25.5-5-506; Executive Order D004-07

Initial Review  
Proposed Effective Date

**04/11/25**  
**06/30/25**

Final Adoption  
Emergency Adoption

**05/09/25**

**DOCUMENT #**

## **DO NOT PUBLISH THIS PAGE**

Title of Rule: Revision to the Medical Assistance Act concerning changes to the Drug Utilization Review Board and Pharmacy and Therapeutics Committee, Section 8.800.9.D  
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### **REGULATORY ANALYSIS**

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

This will primarily affect Department staff who work with the DUR Board and P&T Committee. There is no anticipated cost. The benefit is that these groups may continue to meet and complete their clinical work with less administrative barriers.

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

This has no effect quantitatively. Qualitatively, this will help to ensure that the operations of the DUR board and the P&T Committee will continue to move forward with less administrative barriers.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

There is no cost to the Department or any other agency and no impact on state revenue.

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

Without action, the DUR board and P&T Committee will continue to face administrative barriers as it relates to reaching a quorum and filling positions which could delay the clinical decisions that these groups make for the Pharmacy Office and the Department as a whole.

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

The proposed compositions were carefully considered and determined to be the least intrusive while still achieving the purpose.

**DO NOT PUBLISH THIS PAGE**

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

N/a

## 8.800 PHARMACEUTICALS

### 8.800.9 DRUG UTILIZATION REVIEW

#### 8.800.9.D. DRUG UTILIZATION REVIEW (DUR) BOARD

1. The DUR Board shall serve in an advisory capacity to the Department. The DUR Board's activities shall include but are not limited to the following:
  - a. Approving the application of standards;
  - b. Conducting retrospective DUR;
  - c. Conducting ongoing interventions with pharmacists and physicians concerning therapy problems identified in the course of the DUR program;
  - d. Making recommendations regarding certain Department policy issues as determined by the Department; however, the Department shall consider all such recommendations but shall not be bound by them; and
  - e. Engaging in any other activities as designated by the Department.
2. The DUR Board shall meet at least quarterly.
3. The DUR Board shall consist of ~~nine-eight~~ members appointed by the Executive Director of the Department based upon recommendations of relevant professional associations. Membership on the Board shall consist of four physicians and four pharmacists, all of whom are licensed and actively practicing in Colorado, ~~and one non-voting representative from the pharmaceutical industry~~. The physicians and pharmacists shall serve two-year terms and may be reappointed to additional terms at the discretion of the Executive Director. The terms shall be staggered so that in each year, there are two physician members and two pharmacist positions that are reappointed. ~~The pharmaceutical industry representative shall serve a one-year term and shall not be reappointed.~~
4. The membership of the DUR Board shall include health care professionals who have recognized knowledge and expertise in one or more of the following:
  - a. The clinically appropriate prescribing of covered outpatient drugs;
  - b. The clinically appropriate dispensing and monitoring of outpatient drugs;
  - c. Drug utilization review, evaluation and intervention; or
  - d. Medical quality assurance.
5. The DUR Board shall have those responsibilities as set forth in Title 42 of the Code of Federal Regulations, Section 456.716(d)(202~~40~~). Title 42 of the Code of Federal Regulations, Section 456.716(d)(202~~40~~-) -is hereby incorporated by reference into this

rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. This statute is available for public inspection at the Department of Health Care Policy and Financing, 303 E. 17th Ave., 1570 Grant Street, Denver, CO 80203. Pursuant to C.R.S. §24-4-103(12.5)(V)(b), the agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule.

6. The DUR Board is also responsible for preparing and submitting a report to the Department on an annual basis which shall include the following information:
  - a. A description of the activities of the DUR Board, including the nature and scope of the prospective and retrospective drug utilization review programs;
  - b. A summary of the interventions used;
  - c. An assessment of the impact of these educational interventions on quality of care; and
  - d. An estimate of the cost savings generated as the result of the program.
7. The DUR Board under the direction of the Department may delegate to a retrospective DUR contractor the responsibility of preparation of continuing education programs, the conduct of interventions and the preparation of any reports.

## **8.800.17 PHARMACY AND THERAPEUTICS COMMITTEE**

### **8.800.17.A. MEMBERSHIP**

1. The P&T Committee shall consist of at least nine-five members, but not more than thirteen-nine members, appointed by the Executive Director.
  - a. The P&T Committee membership shall include:
    - i) Four pharmacists;
    - ii) Two-One member representatives; and
    - iii) One-Four physicians who specializes in the practice of psychiatry;
    - iv) One physician who specializes in the practice of pediatrics;
    - v) One physician who specializes in the treatment of members with disabilities; and
    - vi) Four physicians from any other medical specialty.
  - b. Physicians and pharmacists must be licensed and actively practicing in the State of Colorado while a member of the P&T Committee.

- c. The Department shall solicit recommendations for P&T Committee members from professional associations, member advocacy groups and other Medical Assistance Program stakeholders.
  - d. The P&T Committee may meet and conduct business when at least any ~~nine~~<sup>five</sup> members are appointed to the P&T Committee. A majority of the appointed P&T Committee members constitutes a quorum for the transaction of business at any P&T Committee meeting.
  - e. All P&T Committee members may vote on P&T Committee business when a vote is required. The affirmative vote of the majority of the appointed P&T Committee members is required to take action.
  - f. P&T Committee members shall serve two-year terms and may be reappointed to additional terms at the discretion of the Executive Director.
  - g. The terms shall be staggered so that in each year at least two pharmacists ~~one~~<sup>two</sup> consumer representative and any ~~three~~<sup>two</sup> physicians are reappointed.
  - ~~h. The Executive Director may appoint initial P&T Committee members to serve less than two years to provide for staggered terms.~~
  - ~~h.i.~~ <sup>h.</sup> The Executive Director may terminate the appointment of any P&T Committee member for Good Cause.
  - ~~h.ii.~~ <sup>h.j.</sup> The Executive Director shall fill a vacancy occurring in the membership of the P&T Committee for the remainder of the unexpired term. Such replacement shall meet all applicable requirements as set forth in this section.
2. Physicians and pharmacists on the P&T Committee shall have knowledge and expertise in one or more of the following:
- a. The clinically appropriate prescribing of covered outpatient drugs;
  - b. The clinically appropriate dispensing of outpatient drugs;
  - c. Drug use review, evaluation and intervention;
  - d. Medical quality assurance; or
  - e. The treatment of Medical Assistance Program members.

8.800.17.B. CONFLICT OF INTEREST

- 1. P&T Committee members must complete and sign a conflict of interest disclosure form, prior to their appointment to the P&T Committee, which discloses any financial or other affiliation with organizations that may have a direct or indirect interest in business before the P&T Committee.
- 2. At any meeting, a P&T Committee member must recuse himself or herself from discussion and decision making for an entire Drug Class if he or she has a Conflict of Interest with any drug in that Drug Class.
- 3. At any meeting, if a P&T Committee member does not recuse themselves after the disclosure of a potential conflict, the P&T Committee will vote as to whether or not the

member has a Conflict of Interest. The Department then makes the final determination if the member has a Conflict of Interest.

#### 8.800.17.C. DUTIES

1. Among other duties, the P&T Committee shall:
  - a. Review drugs or Drug Classes selected by the Department.
  - b. Utilize scientific evidence, standards of practice and drug information.
  - c. Consider drug safety and efficacy and other review criteria requested by the Department.
  - d. Request information, recommendations or testimony from any health care professional or other person with relevant knowledge concerning a drug or Drug Class subject to P&T Committee review, at their discretion during the P&T Committee meeting.
  - e. Make clinical recommendations on drugs or Drug Classes. Such recommendations shall be considered by the Medical Director, when making final determinations on PDL implementation and maintenance.
  - f. Perform any other act requested by the Department necessary for the development and maintenance of the PDL as described in Section 8.800.16.A.
  - g. A Department approved policy and procedures manual shall be followed by the P&T Committee.
  - h. Meet at least quarterly and other times at the discretion of the Department or the P&T Committee.

#### 8.800.17.D. NOTICE/OPEN MEETINGS

1. P&T Committee meetings and the proposed agenda shall be posted publicly at least thirty days before the meeting.
2. The P&T Committee meetings shall be open to the public. If a P&T Committee meeting is required to be held in executive session pursuant to state or federal law, the executive session shall be convened after conclusion of the open meeting.



## **DO NOT PUBLISH THIS PAGE**

Title of Rule: Revision to Medical Assistance Act Concerning the Home Health Benefit, Section 8.520  
Rule Number: MSB 24-12-31-A  
Division / Contact / Phone: Benefits and Services Management / Paul Hutchings / 303-866-4944

## **SECRETARY OF STATE**

### **RULES ACTION SUMMARY AND FILING INSTRUCTIONS**

#### **SUMMARY OF ACTION ON RULE(S)**

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 24-12-31-A, Revision to Medical Assistance Act Concerning the Home Health Benefit, 10 CCR 2505-10-8.520
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):  
  
Section 8.520, Home Health Services, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No  
If yes, state effective date: N/A  
Is rule to be made permanent? (If yes, please attach notice of hearing).  
Yes. Notice of hearing attached.

#### **PUBLICATION INSTRUCTIONS\***

Replace the current text at 8.520 with the proposed text beginning at 8.520 through the end of 8.520.11.B.5. This rule is effective June 30, 2025.

## DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to Medical Assistance Act Concerning the Home Health Benefit, Section 8.520

Rule Number: MSB 24-12-31-A

Division / Contact / Phone: Benefits and Services Management / Paul Hutchings / 303-866-4944

### STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

The Department is revising the rules and regulations governing the Home Health benefit. The Home Health Rule (10 CCR 2505-10 Section 8.520) outlines the provision of home health services under Health First Colorado (Colorado's Medicaid Program), including criteria for services, provider eligibility, covered services, and provider services. This rule is designed to serve Health First Colorado Members, both children and adults, who require in-home skilled nursing, therapies, or certified nurse aide services due to medical conditions.

The updated Home Health Rule addresses outdated or unclear language, refines areas requiring edits, and improves overall readability. Changes include rephrasing, clarification, restructuring, and removing redundant sections where appropriate. For example, terminology adjustments, such as replacing "client" with "Member," were made to align with current standards. These modifications are essential to enhance the benefit for both Members and providers, ensuring clarity, accessibility, and effectiveness in delivering home health services.

The proposed updates to the Home Health Rule are designed to align with the recently revised Private Duty Nursing (PDN) Rules (Section 8.540), approved by the Medical Services Board on May 10, 2024. To maintain consistency between these benefits, many definitions and terms from the PDN Rules have been incorporated into the Home Health Rules. In addition, the Home Health Rule outlines using the Acuity Tool, developed in collaboration with For Health Consulting as part of the American Rescue Plan Act (ARPA) Project 6.01. This proprietary, evidence-based tool assesses medical necessity for skilled services within the Medicaid program.

2. An emergency rule-making is imperatively necessary

- ☐ to comply with state or federal law or federal regulation and/or  
☐ for the preservation of public health, safety and welfare.

Explain: N/A

3. Federal authority for the Rule, if any:

Initial Review  
Proposed Effective Date

**04/11/25**  
**06/30/25**

Final Adoption  
Emergency Adoption

**05/09/25**

**DOCUMENT #**

**DO NOT PUBLISH THIS PAGE**

42 CFR 456.6(a), 42 CFR 456.1(b)(1)

4. State Authority for the Rule:

Section 25.5-6-113, C.R.S. and Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2024)

Initial Review  
Proposed Effective Date

**04/11/25**  
**06/30/25**

Final Adoption  
Emergency Adoption

**05/09/25**

**DOCUMENT #**

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### **REGULATORY ANALYSIS**

5. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

Health First Colorado Members of all ages will experience improved quality of care and more effective service delivery under the updated rule. This includes those who receive or may qualify for in-home skilled nursing, therapy, or certified nurse aide services. Providers will benefit from enhanced clarity and consistency in the regulations, reducing compliance challenges and increasing operational efficiency. The proposed rule will help the Department's Utilization Management (UM) vendor, Acentra Health to improve the efficiency of their decision-making processes and reduce ambiguities in determining medical necessity.

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

The quantitative impact of the proposed rule revision is minimal and primarily involves one-time administrative costs for providers, such as staff training and updating documentation processes. The qualitative impact will likely be more significant for Health First Colorado Members. The proposed rule's emphasis on clarity will contribute to a more equitable and efficient healthcare delivery system for Members, especially those requiring complex or long-term care service. It will enhance their ability to access care, improve their experience within the Health First Colorado system, and promote better health outcomes through improved care coordination and satisfaction.

7. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

The Department will incur minimal costs for implementing the revised rule, such as creating educational materials and hosting provider training sessions. Key components of the Home Health Rule change, such as the Acuity Assessment Tool created in collaboration with ForHealth Consulting through the American Rescue Plan Act (ARPA) Project 6.01 and the Nurse Assessor approved in the FY 2024-25 Budget Request R-10, are already established and will not impact the budget further. Other agencies are

## **DO NOT PUBLISH THIS PAGE**

unlikely to incur significant costs since these revisions are specifically related to HCPF. Additionally, the proposed rule is not anticipated to significantly affect future state revenues.

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

The updated rule revision will improve clarity, functionality, and service delivery, ultimately enhancing Members' experience and simplifying provider compliance. Inaction would perpetuate outdated and unclear language, leading to possible confusion, inconsistent service delivery, and challenges with compliance.

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

Alternative methods like issuing guidance or FAQs would not fully address the structural issues in the current rule, leaving gaps in clarity and efficiency. A comprehensive rule update is necessary to resolve these problems.

10. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

No less costly or intrusive methods could achieve the same level of improvement. Partial updates or supplemental guidance would fall short of addressing the underlying issues in the existing rule, making the comprehensive revision process essential to achieving the intended benefits for both Members and providers.

These codes of regulation incorporate by reference (as indicated within) material originally published elsewhere. Such incorporation, however, 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 303 E. 17th Avenue Denver, CO 80203. The agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule.

## **8.520 HOME HEALTH SERVICES**

### **8.520.1. Definitions**

8.520.1.A. Activities of Daily Living (ADL) means daily tasks that are required to maintain a ~~client~~Member's health, which and includes but not limited to eating, bathing, dressing, toileting, grooming, transferring, walking, and continence. When a ~~client~~Member is unable to perform these activities independently, skilled or unskilled providers may be required for the ~~client~~Member's needs.

~~[8.520.1.B.]~~ 8.520.1.BG. Acute Medical Condition means a medical condition which has a rapid onset and short duration. A condition is considered acute only until it is resolved or until 60 calendar days after onset, whichever comes first.

~~[8.520.1.C.]~~ 8.520.1.CD. Alternative Care Facility means an ~~A~~ssisted ~~L~~iving ~~R~~esidence licensed by the Colorado Department of Public Health and Environment (CDPHE) and certified by the Department of Health Care Policy and Financing (Department) to provide Assisted Living Care Services and Protective Oversight to ~~client~~Members.

~~[8.520.1.D.]~~ 8.520.1.ED. Behavioral Intervention means techniques, therapies, and methods used to modify or minimize aggressive (verbal/physical), combative, destructive, disruptive, repetitious, resistive, self-injurious, or other inappropriate behaviors outlined on the CMS-485 Plan of Care, or a form that is of similar format to the CMS-485,-(defined below). Behavioral interventions exclude frequent verbal redirection or additional time to transition or complete a task, which are part of the general assessment of the ~~client~~Member's needs.

8.520.1.E. Brief Nursing Visit means those Skilled Nursing Services that are provided to a Member who requires multiple visits per day for skilled tasks that can be completed in a shorter or brief visit as compared to a Standard Nursing Visit (excluding the first regular nursing visit of the day).

8.520.1.F[G. 8.520.1.E.] Care Coordination means the deliberate organization of ~~ient~~Member care activities between two or more participants (including the ~~client~~Member) for the appropriate delivery of health care and health support services, and organization of personnel and resources needed for required ~~clientcare~~Member activities.

8.520.1.G[H. 8.520.1.F.] Certified Nurse Aide Assignment Form means the form used by the Home Health Agency to list the duties to be performed by the Certified Nurse Aide (CNA) at each visit as per the Department of Public Health and Environment Health Facilities Regulation Division Standards for Hospitals and Health Facilities Chapter 26, Home Care Agencies 6 CCR 1011-1 Chapter 26 Section 7.15.

8.520.1.H[I. Chronic Medical Condition means a medical condition that lasts more than one year ~~or more~~ and requires ongoing medical attention, or limits Activities of Daily Living, or both.

~~8.520.1.I. 8.520.1.G.] Department means the Colorado Department of Health Care Policy and Financing, the Single State Medicaid Agency, which is designated as the single State Medicaid agency for Colorado, or any divisions or sub-units within that agency.]~~

~~8.520.1.H.] 8.520.1.K.J.] Designee means the entity that has been contracted by the Department to review for the Medical Necessity and appropriateness of the requested services, including Home Health prior authorization requests (PARs). Designees may include case management entities such as Single Entry Points or Community Centered Boards who manage waiver eligibility and review.~~

~~8.520.1.L. Direct Care Worker means a non-administrative employee or independent Contractor of a Home Health Agency who provides hands-on care, services, and support to individuals with disabilities across the Long-Term Services and Supports continuum within Home and Community-Based settings.]~~

~~8.520.1.K.M.] Family/In-Home Caregiver means an individual who assumes a portion of the Member's care in the home in the absence of agency staff. A Family/In-Home Caregiver may either live in the Member's home or travel to the Member's home to provide care.~~

~~8.520.1.I. Home Care Agency means an entity which provides Home Health or Personal Care Services. When referred to in this rule without a 'Class A' or 'Class B' designation, the term encompasses both types of agencies.]~~

~~8.520.1.L.N.] 8.520.1.J.] Home Health Agency (HHA) means an agency or organization that is certified for participation as a Medicare Home Health Provider [under Title XVIII of the Social Security Act and licensed as a Class A Home Care Agency through the Colorado Department of Public Health and Environment.] pursuant to 42 U.S.C. § 1395bbb and licensed as a Class A Home Care Agency as required by § 25-27.5-103(1), C.R.S. Title XVIII of the Social Security Act is hereby incorporated by reference.] Home Health Agency means an agency that is licensed as a Class A Home Care Agency in Colorado, and is certified to provide skilled care services to Medicare and Medicaid-eligible clients. Agencies shall hold active and current Medicare and Medicaid provider IDs to provide services to Medicaid clients.]~~

~~8.520.1.M.Q.] 8.520.1.K.] Home Health Services means those services listed at Section 8.520.5, Service Types.~~

~~8.520.1.L. Home Health Telehealth means the remote monitoring of clinical data transmitted through electronic information processing technologies, from the client to the home health provider which meet HIPAA compliance standards.]~~

~~8.520.1.N.P.] 8.520.1.M.] Intermittent means visits that have a distinct start time and stop time, and are task oriented with the goal of meeting a [client] Member's specific needs for that visit.~~

~~8.520.1.O.Q.] Medical Necessity is defined in Program Integrity rules (40 CCR 2505-10 Section 8.076.1.8). For children 20 and younger, this is further defined to include the requirements outlined in the Early and Periodic Screening, Diagnosis, and Treatment rules (40 C.C.R. 2505-10 Section 8.280.1.).~~

~~8.520.1.P. Member means any person who is eligible for and is enrolled in the Colorado Medical Assistance Program.~~

~~8.520.1.N. Ordering Practitioner means the client's primary care physician, nurse practitioner, clinical nurse specialist, physician assistant, or other physician specialist. For clients in a hospital or nursing facility, the Ordering Practitioner is the appropriate qualified personnel responsible for writing discharge orders until such time as the client is discharged. This definition may include an alternate practitioner authorized by the Ordering Practitioner to care for the client in the Ordering Practitioner's absence.]~~

8.520.1.Q[P] Personal Care Worker means an employee of a licensed Home Care Agency who has completed the required training to provide Personal Care Services, or who has verified experience providing Personal Care Services to Members. A Personal Care Worker shall not perform tasks that are considered skilled Nursing or CNA services.

~~[8.520.1.O. Personal Care Worker means an employee of a licensed Home Care Agency who has completed the required training to provide Personal Care Services, or who has verified experience providing Personal Care Services for clients. A Personal Care Worker shall not perform tasks that are considered skilled CNA services.]~~

8.520.1.R.[Q] Nurse Assessor Vendor means a third-party vendor contracted by the Department to complete the Skilled Care Acuity Assessment for specific skilled care services.

8.520.1.S[RQ.] Physician or Allowed Practitioner means a physician, physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS) who oversees the delivery of skilled care to a Member within their scope of practice, in accordance with State law, and who is actively enrolled with Health First Colorado.

8.520.1.T. [S8.520.1.P.] Place of Residence means where the [client] Member lives. Includes temporary accommodations, homeless shelters or other locations for [client] Members who are homeless or have no permanent residence.

~~[8.520.1.Q. Plan of Care means a coordinated plan developed by the Home Health Agency, as ordered by the Ordering Practitioner for provision of services to a client at his or her residence, and periodically reviewed and signed by the practitioner in accordance with Medicare requirements. This shall be written on the CMS 485 ("485") or a document that is identical in content, specific to the discipline completing the plan of care.]~~

8.520.1.U[TS]. Plan of Care (POC) means a completed Centers for Medicare and Medicaid Services (CMS) Form 485, or a form that is of similar format to the CMS-485, also referred to as a care plan developed by the HHA in consultation with the Member, that has been ordered by the Physician or Allowed Practitioner for the provision of services to a Member at his/her residence or community setting, and is periodically reviewed and signed by the Physician or Allowed Practitioner in accordance with Medicare requirements at 42 C.F.R. § 484.18. Title 42 of the Code of Federal Regulations is hereby incorporated by reference.

8.520.1.V.[VU]. 8.520.1.R.[P] Pro Re Nata (PRN) means as needed.

~~[8.520.1.S. Protective Oversight means maintaining an awareness of the general whereabouts of a client. Also includes monitoring the clients activity so that a caregiver has the ability to intervene and supervise the safety, nutrition, medication, and other care needs of the client.]~~

8.520.1.W.[WV] Protective Oversight is the required supervision of the Member to prevent or mitigate disability, memory, or cognitive functioning-related behaviors or impairment, that may result in imminent harm to self, people, or property.

8.520.1.X.[XW.] Remote Patient Monitoring means the remote monitoring of clinical data transmitted through electronic information processing technologies, from the Member to the home health provider, which meet HIPAA compliance standards.

8.520.1.Y. Skilled Care Acuity Assessment means the assessment that will be used to assess Members for their skilled care needs. The Skilled Care Acuity Assessment will only be accepted



as valid documentation when completed by the authorized Nurse Assessor Vendor. The Assessment was finalized on September 25, 2024 and is available at <https://hcpf.colorado.gov/nurse-assessor>. []

~~8.520.1.Z.[YX.]~~ Skilled Nursing/Skilled Nursing Service means services provided under the licensure, scope, and standards of the Colorado Nurse and Nurse Aide Practice Act, (Title 12 Article ~~255~~ of the Colorado Revised Statutes), performed by a registered nurse (RN) under the direction of a Physician or Allowed Practitioner, or a licensed practical nurse (LPN) under the supervision of an RN and the direction of a Physician or Allowed Practitioner, for care that cannot be delegated by the judgment of the nurse.

~~8.520.1.AA.[ZY.]~~ Standard Nursing Visit means those Skilled Nursing Services that are provided to a Member by a registered nurse (RN) under applicable state and federal laws and professional standards or licensed practical nurse (LPN) under the direction of a RN to the extent allowed under applicable state and federal laws.

~~8.520.1.BB.[AAZ.]~~ ~~Utilization Review Contractor (URC)~~ Utilization Review Contractor (URC) means a third-party vendor contracted by the Department to perform utilization management functions for specific services.

## **8.520.2. Criteria for Services [Client Eligibility]**

8.520.2.A. Home Health Services are available to all ~~Medicaid [client]~~Members and to all Old Age Pension Program ~~[client]~~Members, as defined at Section 8.940, when all program and service requirements in this rule are met.

~~[8.520.2.B.~~

~~Medicaid clients aged 18 and over shall meet the Level of Care Screening Guidelines for Long-Term Care Services at Section 8.401, to be eligible for Long-Term Home Health Services, as set forth at Section 8.520.4.C.2.]~~

## **8.520.3. Provider Eligibility**

8.520.3.A. Services must be provided by a Medicare and Medicaid-certified Home Health Agency.

8.520.3.B. All Home Health ~~Agency~~[Services] providers shall comply with the rules and regulations set forth by the Colorado Department of Public Health and Environment, the Colorado Department of Health Care Policy and Financing, the Colorado Department of Regulatory Agencies, the Centers for Medicare and Medicaid Services, and the Colorado Department of Labor and Employment.

### **8.520.3.C. Provider Agency Requirements**

1. A Home Health Agency must:
  - a. Be certified for participation as a Medicare Home Health provider under Title XVIII of the Social Security Act;
  - b. Be a Colorado Medicaid enrolled provider;

- c. Maintain liability insurance for the minimum amount set annually -as outlined in 6 CCR 1011-1 Chapter 26~~[by the Department];~~ and
  - d. ~~[Be licensed by the ]~~Hold a State of Colorado ~~[as a]~~Class A Home Care Agency license in good standing.
  - e. ~~[All Home Health Agency providers shall e]~~Comply with applicable regulations promulgated by the Board of Health, Medical Services Board, Medical Board, Nursing Board, Department of Labor and Employment, and the Centers for Medicare and Medicaid Services.
- 2. Home Health Agencies which perform procedures in the ~~[client]~~Member's home that are considered waived clinical laboratory procedures under the Clinical Laboratory Improvement Act of 1988 shall possess a certificate of waiver from the Centers for Medicare and Medicaid Services (CMS) or its Designee. The Clinical Laboratory Improvement Act is hereby incorporated by reference.
  - 3. Home Health Agencies shall regularly review the Medicaid rules, 10 CCR 2505-10. The Home Health Agency shall make access to these rules available to all staff.
  - 4. A Home Health Agency cannot discontinue or refuse services to a ~~[client]~~Member unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal. The Home Health Agency must provide notice of at least ~~[thirty]~~30 calendar days to the ~~[client]~~Member, or the ~~[client]~~Member's designated representative. ~~[legal guardian.]~~
  - 5. In the event a Home Health Agency is ceasing operations, provider agencies must notify the Department within 30 calendar days. The notification must be submitted through the Provider Portal as a maintenance application for the disenrollment request. The provider must also email the Department the notice to~~[as]~~ the designated Home Health inbox.~~[or ceasing services to Medicaid clients, the agency will provide notice to the Department's Home Health Policy Specialist of at least thirty days prior to the end of operations.]~~

#### 6. Colorado Adult Protective Services (CAPS) and Criminal Background Checks

a. Home Health Agencies shall conduct criminal background checks and reference checks and compare the employee's/independent cContractor's name against the list of all currently excluded individuals maintained by the Office of Inspector General prior to employing staff or hiring independent cContractors to provide services and supports to Members. All costs related to obtaining a criminal background check shall be borne by the Provider Agency. Background checks shall be completed every five years for each employee and cContractor who provides direct care to Members.

b. Home Health Agencies shall comply with the CAPS check requirements set forth at § 26-3.1- 111(6)(a), C.R.S. and 12 C.C.R. 2518-1, § 30.960.G-J. The Home Health Agency shall maintain accurate records and make records available to the Department upon request.

i) HCPF or its Designee shall act as the oversight agency-Home Health Agency described at § 26--3.1-111(6)(a)(III), C.R.S. and shall receive CAPS check results for Home Health Agencies requiring Certification, the prospective Agency shall:

1) Submit to the CDPHE a copy of the CAPS check results as part of their initial application for Certification.

i) Substantiated findings as outlined in Section 8.7409 E.2.b may result in the denial of the Medicaid enrollment application.

ii) Direct Care Workers with any of the following are prohibited from providing direct care to any Member:

1) An allegation of Mistreatment, Abuse, Neglect and Exploitation (MANE) or harmful act, as defined in Section 26-3.1-101, C.R.S., substantiated by Adult Protection Services (APS) within the last 10 years, at a "Severity Level" of "Moderate" or "Severe" as defined in 12 C.C.R. 2518-1; Section 30.100;

2) Three or more allegations of MANE or harmful act, as defined in Section 26-3.1-101, C.R.S., substantiated by APS within the last five years, at the minor severity level as defined in 12 C.C.R. 2518; Section 30.100; or

3) A criminal conviction of MANE against an at-risk adult defined at § 26-3.1- 101, C.R.S.

4) Only substantiated allegations for which the state level appeal process as defined as 12 C.C.R. 2518-1; Section 30.920 has concluded shall be included in the above exclusions list.

#### **8.520.4. Covered Services**

**8.520.4.A.** Home Health Services are covered under Medicaid only when all of the following are met:

1. Services are Medically Necessary as defined in Section 8.520.1., Definitions;
2. Services are provided under a Plan of Care as defined at Section 8.520.1., Definitions;
3. Services are provided on an Intermittent basis, as defined at Section 8.520.1., Definitions;
4. The [client]Member meets one of the following:
  - a. The only alternative to Home Health Services is hospitalization or emergency room care or other institutionalization; or
  - b. [Client]Member medical records indicate that medically necessary services should be provided in the [client]Member's P[er] place of R[esidence] or community, instead of an outpatient setting, according to one or more of the following guidelines:
    - i) The [client]Member, due to illness, injury or disability, is unable to travel to an outpatient setting for the needed service;

- ii) Based on the [client]Member's illness, injury, or disability, travel to an outpatient setting for the needed service would create a medical hardship for the [client]Member;
  - iii) Travel to an outpatient setting for the needed service is contraindicated by a documented medical diagnosis;
  - iv) Travel to an outpatient setting for the needed service would interfere with the effectiveness of the service; or
  - v) The [client]Member's medical diagnosis requires teaching which is most effectively accomplished in the [client]Member's P[p]lace of R[f]esidence on a short-term basis.
- 5. The [client]Member is unable to perform the health care tasks for him or herself, and no [unpaid family/caregiver] Family/In-Home Caregiver is able and-or willing to voluntarily perform the tasks; and
  - a. Family/In-Home Caregiver responsibilities should be guided by age-appropriate expectations to distinguish when a Member's needs require care beyond typical caregiving duties due to the skilled nature of needs and/or intensity of need.
- 6. Covered service types are those listed in Service Types, Section 8.520.5.

#### **8.520.4.B. Place of Service**

- 1. Services shall be provided in the [client]Member's P[p]lace of R[f]esidence or one of the following places of service:
  - a. Assisted Living [Facilities (ALFs)]; Residence (ALR);
  - b. Alternative Care Facilities (ACFs);
  - c. Group Residential Services and Supports (GRSS) including licensed group homes servicing[e] four to eight Members [host homes, apartments or homes where three or fewer clients reside.] Services shall not duplicate those that are the contracted responsibility of the GRSS;
  - d. Individual Residential Services and Supports (IRSS) including host homes, apartments or homes where three or fewer [client]Members reside. Services shall not duplicate those that are the contracted responsibility of the IRSS; or
  - e. Hotels, or similar temporary accommodations while traveling, will be considered the temporary P[p]lace of R[f]esidence for purposes of this rule.
  - f. Nothing in this section should be read to prohibit a [client]Member from receiving Home Health Services in any setting in which normal life activities take place, other than a hospital, nursing facility; intermediate care facility for individuals with intellectual disabilities; or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.
  - g. Telemedicine may be provided in accordance with Section 8.095.

#### **8.520.4.C. Service Categories**

1. Acute Home Health Services

- a. Acute Home Health Services are covered for [client]Members who experience an acute health care need that requires Home Health Services.
- b. Acute Home Health Services are provided for 60 or fewer calendar days or until the A[a]cute M[m]edical C[e]ondition is resolved, whichever comes first.
- c. Acute Home Health Services are provided for the treatment of the following A[a]cute M[m]edical C[e]onditions/episodes that ~~could~~ include but are not limited to:
  - i) Infectious disease;
  - ii) Pneumonia;
  - iii) New diagnosis of a life-altering disease;
  - iv) Post-heart attack or stroke;
  - v) Care related to post-surgical recovery;
  - vi) Post-hospital care provided as follow-up care for medical conditions that required hospitalization, including neonatal disorders;
  - vii) Post-nursing home care, when the nursing home care was provided primarily for rehabilitation following hospitalization and the medical condition is likely to resolve or stabilize to the point where the [client]Member will no longer need Home Health Services within 60 days following initiation of Home Health Services;
  - viii) Complications of pregnancy or postpartum recovery; or
  - iv) Individuals who experience an acute incident related to a chronic disease may be treated under the acute home health benefit. Specific information on the acute incident shall be documented in the record.
- d. A [client]Member may receive additional periods of acute Home Health Services when at least 10 days have elapsed since the [client]Member's discharge from an acute home health episode and one of the following circumstances occurs:
  - i) The [client]Member has a change in medical condition that necessitates acute Home Health Services;
  - ii) New onset of a C[e]hronic M[m]edical C[e]ondition; or
  - iii) Treatment needed for a new A[a]cute M[m]edical C[e]ondition or episode.
- e. Nursing visits provided solely for the purpose of assessment or teaching are covered only during the acute period under the following guidelines:
  - i) An initial assessment visit ordered by a Physician or Allowed Practitioner [physician] is covered for determination of whether ongoing nursing or CNA care is needed. Nursing visits for the sole purpose of assessing a

[client]Member for recertification of Home Health Services shall not be reimbursed if the [client]Member receives only CNA services;

- ii) The visit instructs the [client]Member or [client]Member's [family member/caregiver] Family/In-Home Caregiver in providing safe and effective care that would normally be provided by a skilled home health provider; or
  - iii) The visit supervises the [client]Member or [client]Member's [family member/caregiver] Family/In-Home Caregiver to verify and document that they are competent in providing the needed task.
- f. Acute Home Health Services may be provided to [client]Members who receive Health Maintenance tasks through In-Home Supports and Services (IHSS) or Consumer Directed Attendant Supports and Services (CDASS).
- g. GRSS group home residents may receive acute Home Health Services.
- h. If the acute home health [client]Member is hospitalized for planned or unplanned services for 10 or more calendar days, the Home Health Agency may close the [client]Member's acute home health episode and start a new acute home health episode when the [client]Member is discharged.
- i. Acute Care Home Health Limitations:
- i) A new period of acute Home Health Services shall not be used for continuation of treatment from a prior Acute Home Health episode. New Acute Episodes must be utilized for a new or worsening condition.
  - ii) A [client]Member who is receiving either Long-Term Home Health Services or HCBS waiver services may receive acute Home Health Services only if the [client]Member experiences an event listed in subpart c. as an acute incident, which is separate from the standard needs of the [client]Member and makes acute Home Health Services necessary.
  - iii) If a [client]Member's A[a]cute M[m]edical C[e]ondition resolves prior to 60 calendar days from onset, the [client]Member shall be discharged from acute home health or transitioned to the [client]Member's normal Long-Term Home Health S[s]ervices.

## 2. Long-Term Home Health Services

- a. Long-T[t]erm Home Health Services are covered for [client]Members who have long-term chronic needs requiring [ongoing] Home Health Services.
  - b. Long-T[t]erm Home Health Services may be provided to [client]Members who receive health maintenance tasks through IHSS.
  - c. ~~Long-Term Home Health Services may not be provided to clientMembers who receive health maintenance tasks through CDASS.~~
- C[d]. Long-T[t]erm Home Health Services are provided:

- i) Following the 60th calendar day for acute home health ~~[client]~~Members who require additional services to meet treatment goals or to be safely discharged from Home Health Services;
- ii) On the first day of Home Health Services for ~~[client]~~Members with well documented chronic needs when the ~~[client]~~Member does not require an acute home health care transition period; or
- iii) Continuation of ~~[ongoing]~~long-term home health Plan of Care.

de. Long-Term Home Health Limitations:

- i) ~~[Client]~~Members aged 20 and younger may obtain long-term home health physical therapy, occupational therapy, and speech therapy services when Medically Necessary and when:
  - 1) Therapy services will be more effective if provided in the home setting; or
  - 2) Outpatient therapy would create a hardship for the ~~[client]~~Member.
- ii) ~~[Client]~~Members aged 21 and older who continue to require physical therapy, occupational therapy, and speech therapy services after the initial acute home health period may only obtain such long-term services in an outpatient setting.
- ~~iii) Clients admitted to Long-Term Home Health Services through the HCBS waiver program shall meet level of care criteria to qualify for long-term Home Health Services.~~
- iv) Long-T~~[t]~~erm Home Health Services may be provided in GRSS group home settings, when the GRSS provider agency reimburses the Home Health Agency directly for these Home Health Services. Long-term Home Health Service provision in GRSS group homes is not reimbursable through the State Plan.

v) Long-Term Home Health Services may be provided in IRSS settings when the IRSS provider agency reimburses the Home Health Agency directly for these Home Health Services. Long-term Home Health Service provision in IRSS is not a Medicaid reimbursable service, through the State Plan.

1) CNA services are not permitted within IRSS settings, and if such services are required, the IRSS provider agency must contract with the HHA for these services independently. CNA services can be provided under the per diem reimbursement structure.

2) Standard Nursing Visits are covered as long as they are not duplicative of what is already provided by the IRSS.

3. Long-Term with Acute Episode Home Health:

- a. An episode is considered acute only until it is resolved or until 60 calendar days after onset, whichever comes first.

- b. Long-term with acute episode home health is covered if the ~~[client]~~Member is receiving long-term ~~H[h]~~ome ~~H[h]~~ealth ~~S[s]~~ervices and requires treatment for an acute episode as defined in ~~S~~ection 8.520.4.C.1.

## **8.520.5. Service Types**

### **8.520.5.A. Nursing Services**

#### **1. Standard Nursing Visit**

- a. Those Skilled Nursing Services that are provided by a registered nurse under applicable state and federal laws, and professional standards;
- b. Those ~~S[s]~~killed ~~N[n]~~ursing ~~S[s]~~ervices provided by a licensed practical nurse under the direction of a registered nurse, to the extent allowed under applicable state and federal laws and professional standards;
- c. Standard Nursing Visits include but are not limited to:
  - i. 1st medication box fill (medication pre-pouring) of the week;
  - ii. 1st visit of the day; the remaining visits shall utilize brief nursing units as appropriate;
  - iii. Insertion or replacement of indwelling urinary catheters;
  - iv. Colostomy and ileostomy stoma care; excluding care performed by ~~[Client]~~Members;
  - v. Treatment of decubitus ulcers (stage 2 or greater);
  - vi. Treatment of widespread, infected or draining skin disorders;
  - vii. Wounds that require sterile dressing changes;
  - viii. Visits for foot care;
  - ix. Nasopharyngeal, tracheostomy aspiration or suctioning, ventilator care;
  - x. ~~[Bolus or continuous Levin tube and gastrostomy (G-tube) feedings,]~~  
~~Bolus or continuous nasogastric tube and/or gastrostomy (G-tube)~~  
feedings, when formula/feeding needs to be prepared or more than one  
(1) can of prepared formula is needed per bolus feeding per visit, ONLY when there is not an able or willing caregiver; and
  - xi. Complex Wound care requiring packing, irrigation, and application of an agent prescribed by the Physician or Allowed Practitioner ~~[physician]~~.

#### **2. Brief Nursing Visits**

- a. Brief ~~N[n]~~ursing ~~V[v]~~isits are for established long-term home health ~~[Client]~~Members who require multiple visits per day for uncomplicated skilled tasks that can be completed in a shorter or brief visit. Brief Nursing Vvisits cannot be ~~be~~ ~~[(excluding)]~~ the first ~~[regular]~~ nursing visit of the day.)



b. Brief Nursing Visits include, but are not limited to:

- i) Consecutive visits for two or more [Client]Members who reside in the same location and are seen by the same Home Health Agency nurse, ~~excluding the first visit of the day;~~
- ii) Intramuscular, intradermal and subcutaneous injections ~~-(including insulin)-~~ when required multiple times daily, ~~excluding the first visit of the day;~~
- iii) Insulin administration: if the sole reason for a daily visit or multiple visits per day, the first visit of the week is to be treated as a S[s]tandard N[n]ursing V[v]isit and all other visits of the week are to be treated as B[b]rief N[n]ursing V[v]isits.
- iv) Additional visits beyond the first visit of the day where simple wound care dressings are the sole reason for the visit;
- v) Additional visits beyond the first visit of the day where catheter irrigation is the sole reason for the visit;
- vi) Additional visits beyond the first visit of the day where external catheterization, or catheter care is the sole purpose for the visit;
- vii) ~~[Bolus Levin or G-tube feedings]-~~ Bolus or continuous nasogastric tube and/or gastrostomy (G-tube) feedings [of one can]- of prepared formula ~~[excluding the first visit of the day, ]~~ ONLY when there is no willing or able caregiver and it is the sole purpose of the visit;
- viii) Medication box refills or changes following the first medication pre-pouring of the week;
- ix) Other non-complex nursing tasks as deemed appropriate by the Department or its Designee when documented clinical findings support a brief visit as being appropriate; or
- x) A combination of uncomplicated tasks when deemed appropriate by the Department or its Designee when documented clinical findings support a brief visit as being appropriate.

c. Ongoing assessment shall be billed as B[b]rief N[n]ursing V[v]isits unless the [Client]Member experiences a change in status requiring a standard visit. If a S[s]tandard N[n]ursing V[v]isit is required for the assessment, the agency shall provide documentation supporting the need on the PAR form and on the Plan of Care for the Department or its Designee.

### 3. PRN Nursing Visits

- a. May be S[s]tandard N[n]ursing V[v]isits or B[b]rief N[n]ursing V[v]isits; and
- b. Shall include specific criteria and circumstances that warrant a PRN visit along with the specific number of PRN visits requested for the certification period.

### 4. Nursing Service Limitations

- a. Nursing assessment visits are not covered if provided solely to open or recertify the case for CNA services, physical, occupational, or speech therapy.
- b. Nursing visits solely for recertifying a ~~Client~~ Member for home health services are not covered.
- c. Nursing visits that are scheduled solely for CNA supervision are not covered.
- d. ~~Family member/caregivers~~ Family/In-Home Caregivers, who meet the requirements to provide nursing services and are nurses credentialed by, and in active status with the Department of Regulatory Agencies, may be employed by the Home Health Agency to provide nursing services to a ~~Client~~ Member, but may only be reimbursed for services that exceed the usual responsibilities of the ~~Family Member/Caregiver~~ Family/In-Home Caregiver.
- e. PRN nursing visits may be requested as ~~Standard~~ Nursing ~~V~~visits or ~~B~~brief ~~Nursing~~ Vvisits and shall include a ~~physician's~~ Physician or Allowed Practitioner's order with specific criteria and circumstances that warrant a PRN visit along with the specific number of PRN visits requested for the certification period.
- f. Nursing visits are not reimbursed by Medicaid if solely for the purpose of psychiatric counseling or Protective Oversight, because that is the responsibility of the Behavioral Health Organization. Nursing visits for ~~mentally ill~~ ~~Client~~ Members are reimbursed under Home Health Services for pre-pouring of medications, venipuncture, or other nursing tasks, provided that all other requirements in this section are met.
- g. Medicaid does not reimburse for two nurses during one visit except when two nurses are required to perform a procedure. For this exception, the provider may bill for two visits, or for all units for both nurses. Reimbursement for all visits or units will be counted toward the maximum reimbursement limit.
- h. Nursing visits provided solely for the purpose of assessing or teaching are reimbursed by the Department only in the following circumstances:
  - i) Nursing visits solely for the purpose of assessing the ~~Client~~ Member or teaching the ~~Client~~ Member or the ~~Client~~ Member's unpaid family member/caregiver Family/In-Home Caregiver are not reimbursed unless the care is acute home health or long-term home health with acute episode, per Section 8.520.3, or the care is for extreme instability of a ~~C~~ehronic ~~M~~medical ~~C~~ondition under long-term home health, per Section 8.520.3. Long-term home health nursing visits for the sole purpose of assessing or teaching are not covered.
  - ii) When an initial assessment visit is ordered by a ~~physician~~ Physician or Allowed Practitioner, and there is a reasonable expectation that ongoing nursing or CNA care may be needed. Initial nursing assessment visits cannot be reimbursed if provided solely to open the case for physical, occupational, or speech therapy.
  - iii) When a nursing visit involves the nurse performing a nursing task for the purpose of demonstrating to the ~~Client~~ Member or the ~~Client~~ Member's unpaid family member/caregiver Family/In-Home Caregiver how to perform the task, the visit is not considered as being solely for the

purpose of assessing and teaching. A nursing visit during which the nurse does not perform the task, but observes the ClientMember or unpaid family member/caregiver Family/In-Home Caregiver performing the task to verify that the task is being performed correctly is considered a visit that is solely for the purpose of assessing and teaching and is not covered.

- iv) Nursing visits provided solely for the purpose of assessment or teaching cannot exceed the frequency that is justified by the ClientMember's documented medical condition and symptoms. Assessment visits may continue only as long as there is documented clinical need for assessment, management, and reporting to physician-Physician or Allowed Practitioner of specific medical conditions or symptoms which are not stable or not resolved. Teaching visits may be as frequent as necessary, up to the maximum reimbursement limits, to teach the ClientMember or the ClientMember's unpaid family member/caregiver Family/In-Home Caregiver, and may continue only as long as needed to demonstrate understanding or to perform care, or until it is determined that the ClientMember or unpaid family member/caregiver Family/In-Home Caregiver is unable to learn or to perform the skill being taught. The visit in which the nurse determines that there is no longer a need for assessment or teaching shall be reimbursed if it is the last visit provided solely for assessment or teaching.
- v) Nursing visits provided solely for the purpose of assessment or teaching are not reimbursed if the ClientMember is capable of self-assessment and of contacting the physician-Physician or Allowed Practitioner as needed, and if the ClientMember's medical records do not justify a need for ClientMember teaching beyond that already provided by the hospital or attending physician Physician or Allowed Practitioner, as determined and documented on the initial Home Health assessment.
- vi) Nursing visits provided solely for the purpose of assessment or teaching cannot be reimbursed if there is an available and willing unpaid family member/caregiver Family/In-Home Caregiver who is capable of assessing the ClientMember's medical condition and needs and contacting the physician-Physician or Allowed Practitioner as needed; and if the ClientMember's medical records do not justify a need for teaching of the ClientMember's unpaid family member/caregiver Family/In-Home Caregiver beyond the teaching already provided by the hospital or attending physician Physician or Allowed Practitioner, as determined and documented on the initial Home Health assessment.
- i. Nursing visits provided solely for the purpose of providing foot care are reimbursed by Medicaid only if the ClientMember has a documented and supported diagnosis that supports the need for foot care to be provided by a nurse, and the ClientMember or unpaid family member/caregiver Family/In-Home Caregiver is not able or willing to provide the foot care.
- j. \_\_\_\_\_ Documentation in the medical record shall specifically, accurately, and clearly show the signs and symptoms of the disease process at each visit. The clinical record shall indicate and describe an assessment of the foot or feet, physical and clinical findings consistent with the diagnosis and the need for foot

care to be provided by a nurse. Severe peripheral involvement shall be supported by documentation of more than one of the following:

- i) Absent (not palpable) posterior tibial pulse;
- ii) Absent (not palpable) dorsalis pedis pulse;
- iii) Three of the advanced trophic changes:
  - 1) Hair growth (decrease or absence),
  - 2) Nail changes (thickening),
  - 3) Pigmentary changes (discoloration),
  - 4) Skin texture (thin, shiny), or
  - 5) Skin color (rubor or redness);
- iv) Claudication ~~(limping, lameness)~~;
- v) Temperature changes (cold feet);
- vi) Edema;
- vii) Paresthesia; or
- viii) Burning.

k. \_\_\_\_\_ Nursing visits provided solely for the purpose of pre-pouring medications into medication containers such as med-minders or electronic medication dispensers are reimbursed only if:

- i) The ~~Client~~Member is not living in a licensed Adult Foster Home or Alternative Care Facility, where the facility staff is trained and qualified to pre-pour medications under the medication administration law at Section 25-1.5-301 C.R.S.;
- ii) The ~~Client~~Member is not physically or mentally capable of pre-pouring medications or has a medical history of non-compliance with taking medications if they are not pre-poured;
- iii) The ~~Client~~Member has no ~~unpaid family member/caregiver~~ Family/In-Home Caregiver who is willing or able to pre-pour the medications for the ~~Client~~Member; and
- iv) There is documentation in the ~~Client~~Member's chart that the ~~Client~~Member's pharmacy was contacted upon admission to the Home Health Agency, and that the pharmacy will not provide this service; or that having the pharmacy provide this service would not be effective for this particular ~~Client~~Member.

l. \_\_\_\_\_ The unit of reimbursement for nursing services is one visit, which is defined as the length of time required to provide the needed care, up to a maximum of two and one-half hours spent in ~~Client~~Member care or treatment.

#### 8.520.5.B. Certified Nurse Aide Services

1. CNA services may be provided when a nurse or therapist determines that an eligible ~~client~~Member requires the skilled services of a qualified CNA, as such services are defined in this ~~S~~section 8.520.5.B.13
2. CNA tasks shall not duplicate waiver services or the ~~client~~Member's residential agreement (such as an ALRF, IRSS, GRSS, or other Medicaid reimbursed Residence, or adult day care setting).
3. Skilled care shall only be provided by a CNA when a ~~client~~Member is unable to independently complete one or more ADLs. Skilled CNA services shall not be reimbursed for tasks or services that are the contracted responsibilities of an ALRF, IRSS, GRSS or other Medicaid reimbursed Residence.
4. Before providing any services, all CNAs shall be trained and certified according to Federal Medicare regulations, and all CNA services shall be supervised according to Medicare Conditions of Participation for Home Health Agencies found at 42 C.F.R. § 484.36. Title 42 of the Code of Federal Regulations, ~~Part 484.36 as amended effective March 2025~~ Part 484.36 (2013) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. These regulations are available for public inspection at the Department of Health Care Policy and Financing, ~~303 E. 17th Avenue Denver, CO 80203-1570 Grant Street, Denver, CO 80203~~. The agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule.
5. If the ~~client~~Member receiving CNA services also requires and receives ~~S~~skilled ~~N~~nursing care or physical, occupational or speech therapy, the supervising registered nurse or therapist shall make on-site supervisory visits to the ~~client~~Member's home no less frequently than every ~~two weeks~~14 calendar days.
6. If the ~~client~~Member receiving CNA services does not require ~~S~~skilled ~~N~~nursing care or physical, occupational or speech therapy, the supervising registered nurse shall make on-site supervisory visits to the ~~client~~Member's home no less frequently than every 60 ~~calendar~~ days. Each supervisory visit shall occur while the CNA is providing care. Visits by the registered nurse to supervise and to reassess the care plan are considered costs of providing the CNA services and cannot be billed to Medicaid as nursing visits.
7. Registered nurses and physical, occupational and speech therapists supervising CNAs shall comply with applicable state laws governing their respective professions.
8. CNA services can include personal care and homemaking tasks if such tasks are completed during the skilled care visit and are defined below:
  - a. Personal care or homemaking services which are directly related to and secondary to skilled care are considered part of the skilled care task and are not further reimbursed. For ~~client~~ Members who are also eligible for HCBS personal care and homemaker services, the units spent on personal care and homemaker services may not be billed as CNA services.
  - b. Nurse aide tasks performed by a CNA pursuant to the nurse aide scope of practice defined by the State Board of Nursing but does not include those tasks

that are allowed as personal care, at Section 8.535, ~~PEDIATRIC PERSONAL CARE~~ Pediatric Personal Care.

- c. ~~Personal care means those tasks which are allowed as personal care at Section 8.7538, Home and Community Based Services, Personal Care. Personal care means those tasks which are allowed as personal care at Section 8.7527535, PEDIATRIC PERSONAL CARE, and Section 8.7583489, HOME AND COMMUNITY BASED SERVICES-EBD-EBD, PERSONAL CARE.~~
  - d. Homemaking means those tasks allowed as homemaking tasks at Section 8.7527490, ~~HOME AND COMMUNITY BASED SERVICES-EBD, HOMEMAKER SERVICES,~~ Home and Community Based Services-EBD, Homemaker Services.
9. CNA services solely for the purpose of behavior management or Protective Oversight are not a benefit under Medicaid Home Health, ~~because behavior management is outside the nurse aide scope of practice.~~
10. The usual frequency of all tasks is as ordered by the ~~Ordering Practitioner-Physician or Allowed Practitioner~~ on the Plan of Care unless otherwise noted.
11. The Home Health Agency shall document the decline in medical condition or the need for all medically necessary skilled tasks.
12. Skilled Certified Nurse Aide Tasks
- a. Ambulation
    - i) Task includes: Walking or moving from place to place with or without assistive device.
    - ii) Ambulation is a skilled task when:
      - 1) ~~Client~~Member is unable to assist or direct care;
      - 2) Hands on assistance is required for safe ambulation and ~~client~~Member is unable to maintain balance or to bear weight reliably; or
      - 3) ~~Client~~Member has not been deemed independent with assistive devices ordered by a qualified ~~physician~~ Physician or Allowed Practitioner.
    - iii) Special Considerations: Ambulation shall not be a sole reason for a CNA visit.
  - b. Bathing/Showering
    - i) Task includes either:
      - 1) Preparation for bath or shower, checking water temperature; assisting ~~client~~Member into bath or shower; applying soap and shampoo; rinsing off, towel drying; and all transfers and ambulation related to bathing; all hair care, pericare and skin care provided in conjunction with bathing; or

2) Bed bath or sponge bath.

~~ii) The usual frequency of this task shall be up to one time daily~~

~~iii)~~ Bathing/Showering is a skilled task when either:

- 1) Open wound(s), stoma(s), broken skin or active chronic skin disorder(s) are present; or
- 2) ClientMember is unable to maintain balance or to bear weight due to illness, injury, disability, a history of falls, temporary lack of mobility due to surgery or other exacerbation of illness, injury or disability.

~~iiiiv)~~ Special Considerations:

- 1) Additional baths may be warranted for treatment and shall be documented by physician-Physician or Allowed Practitioner order and Plan of Care.
- 2) A second person may be staffed when required to safely bathe the clientMember.
- 3) Hand over hand assistance may be utilized for short term (up to 90 days) training of the clientMember in Activities of Daily Living when there has been a change in the clientMember's medical condition that has increased the clientMember's ability to perform this task.

c. Bladder Care

i) Task includes:

- 1) Assistance with toilet, commode, bedpan, urinal, or diaper;
- 2) Transfers, skin care, ambulation and positioning related to bladder care; and
- 3) Emptying and rinsing commode or bedpan after each use.

ii) Bladder Care concludes when the clientMember is returned to a pre-urination state.

iii) Bladder Care is a skilled task when either:

- 1) ClientMember is unable to assist or direct care, broken skin or recently healed skin breakdown (less than 60 days); or
- 2) ClientMember requires skilled skin care associated with bladder care or clientMember has been assessed as having a high and ongoing risk for skin breakdown.

d. Bowel Care

i) Task includes:

- 1) Changing and cleaning incontinent ~~client~~Member, or hands on assistance with toileting; and
  - 2) Returning ~~client~~Member to pre-bowel movement status, which includes transfers, skin care, ambulation and positioning related to bowel care.
- ii) Bowel care is a skilled task when either:
- 1) ~~Client~~Member is unable to assist or direct care, broken skin or recently healed skin breakdown (less than 60 days) is present; or
  - 2) ~~Client~~Member requires skilled skin care associated with bowel care or ~~client~~Member has been assessed as having a high and ongoing risk for skin breakdown.

e. Bowel Program

- i) Skilled Task includes:
- 1) Administering bowel program as ordered by the ~~client~~Member's qualified ~~physician~~Physician or Allowed Practitioner, including digital stimulation, administering enemas, suppositories, and returning ~~client~~Member to pre-bowel program status; or
  - 2) Care of a colostomy or ileostomy, which includes emptying the ostomy bag, changing the ostomy bag and skin care at the site of the ostomy and returning the ~~client~~Member to pre-procedure status.
- ii) Special Considerations
- 1) To perform the task, the ~~client~~Member must have a relatively stable or predictable bowel program/condition and a qualified ~~physician~~Physician or Allowed Practitioner deems that the CNA is competent to provide the ~~client~~Member-specific program.
  - 2) Use of digital stimulation and over-the-counter suppositories or over-the-counter enema (not to exceed 120ml) only when the CNA demonstrates competence in the Home Health Agency's Policies & Procedures for the task. (Agencies may choose to delegate this task to the CNA.)

f. Catheter Care

- i) Task includes:
- 1) Care of external, Foley and Suprapubic catheters;
  - 2) Changing from a leg to a bed bag and cleaning of tubing and bags as well as perineal care;
  - 3) Emptying catheter bags; and



- 4) Transfers, skin care, ambulation and positioning related to the catheter care.

~~ii) The usual frequency of this task shall not exceed two times daily.~~

~~iii)~~ Catheter care is a skilled task when either:

- 1) Emptying catheter collection bags (indwelling or external) includes a need to record and report the clientMember's urinary output to the clientMember's nurse; or
- 2) The indwelling catheter tubing needs to be opened for any reason and the clientMember is unable to do so independently.

~~iiiiv)~~ Special Considerations: Catheter care shall not be the sole purpose of the CNA visit.

g. Dressing

i) Task includes:

- 1) Dressing and undressing with ordinary clothing, including pantyhose or socks and shoes;
- 2) Placement and removal of braces and splints; and
- 3) All transfers and positioning related to dressing and undressing.

~~ii) The usual frequency of this task shall not exceed twice daily.~~

~~iii)~~ Dressing is a skilled task when:

- 1) ClientMember requires assistance with the application of anti-embolic or pressure stockings and placement of braces or splints that can be obtained only with a prescription from a qualified physician Physician or Allowed Practitioner; or
- 2) ClientMember is unable to assist or direct care; or
- 3) ClientMember experiences a temporary lack of mobility due to surgery or other exacerbation of illness, injury or disability.

~~iiiiv)~~ Special Considerations: Hand-over-hand assistance may be utilized for short term (up to 90 days) training of the clientMember in Activities of Daily Living when there has been a change in the clientMember's medical condition that has increased the clientMember's ability to perform this task.

h. Exercise/Range of Motion (ROM)

i) Task includes: ROM and other exercise programs prescribed by a therapist or qualified physician Physician or Allowed Practitioner, and only when the clientMember is not receiving exercise/ROM from a therapist or a doctor on the same day.

- ii) Exercise/Range of Motion (ROM) is a skilled task when: The exercise/ROM, including passive ROM, is prescribed by a qualified ~~physician~~ Physician or Allowed Practitioner and the CNA has demonstrated competency.
- iii) Special Considerations: The Home Health Agency shall ensure the CNA is trained in the exercise program. The Home Health Agency shall maintain the exercise program documentation in the ~~client~~ Member record and it shall be evaluated/renewed by the qualified ~~physician~~ Physician or Allowed Practitioner or therapist with each Plan of Care.

i. Feeding

i) Task includes:

- 1) Ensuring food is the proper temperature, cutting food into bite-size pieces, and ensuring the food is proper consistency;
- 2) Placing food in ~~client~~ Member's mouth; and
- 3) A Home Health Agency may allow a Certified Nursing Assistant (CNA) to administer feedings via tube, gravity, syringe and/or pump including gastrostomy-tube and jejunostomy-tube feeding for members with stable health conditions and are not considered high risk if the CNA is deemed competent.

~~3) Gastric tube (g-tube) formula preparation, verifying placement and patency of tube, administering tube feeding and flushing tube following feeding if the Home Health Agency and supervising nurse deem the CNA competent.~~

- ii) The usual frequency of this task shall not exceed ~~three times daily~~ what is ordered by the Physician or Allowed Practitioner.

iii) Feeding is a skilled task when:

- 1) ~~Client~~ Member is unable to communicate verbally, non-verbally or through other means;
- 2) ~~Client~~ Member is unable to be positioned upright;
- 3) ~~Client~~ Member is on a modified texture diet;
- 4) ~~Client~~ Member has a physiological or neurogenic chewing or swallowing problem;
- 5) ~~Client~~ Member is on mechanical ventilation;
- 6) ~~Client~~ Member requires oral suctioning;
- 7) A structural issue (such as cleft palate) or other documented swallowing issues are present; or
- 8) ~~Client~~ Member has a history of choking or aspirating on food. has a history of aspirating food.

iv) Special Considerations:

- 1) There shall be a documented decline in medical condition or an ongoing need documented in the ~~client~~Member's record.
- 2) Consistent with Section 12-255-206, C.R.S., a Home Health Agency may allow a competent CNA to perform a syringe feeding, ~~and tube feeding if the gastrostomy-tube, and jejunostomy-tube feeding for members with stable health conditions and are not considered high risk, if the CNA is deemed competent by the Home Health Agency.~~

j. Hygiene – Hair Care/Grooming

i) Task includes: Shampooing, conditioning, drying, and combing.

~~ii) Task does not include perming, hair coloring, or other extensive styling including, but not limited to, updos, placement of box braids or other elaborate braiding or placing hair extensions.~~

iii) Task may be completed during skilled bath/shower.

~~iv) The usual frequency of this task shall not exceed twice daily.~~

iii) Hygiene – Hair Care/Grooming is a skilled task when:

- 1) ~~Client~~Member is unable to complete task independently;
- 2) ~~Client~~Member requires shampoo/conditioner that is prescribed by a qualified ~~physician-Physician or Allowed Practitioner~~ and dispensed by a pharmacy; or
- 3) ~~Client~~Member has open wound(s) or stoma(s) on the head.

~~iv)~~iv) Special Considerations:

- 1) Hand over hand assistance may be utilized for short term (up to 90 days) training of the ~~client~~Member in Activities of Daily Living when there has been a change in the ~~client~~Member's medical condition that has increased the ~~client~~Member's ability to perform this task.
- 2) Styling of hair is never considered a skilled task.

k. Hygiene – Mouth Care

i) Task includes:

- 1) Brushing teeth;
- 2) Flossing;
- 3) Use of mouthwash;
- 4) Denture care;

- 5) Swabbing (toothette); or
- 6) Oral suctioning.

~~ii) The usual frequency of this task is up to three times daily.~~

~~iii)~~ Hygiene – Mouth Care is a skilled task when:

- 1) ~~Client~~Member is unconscious;
- 2) ~~Client~~Member has difficulty swallowing;
- 3) ~~Client~~Member is at risk for choking and aspiration;
- 4) ~~Client~~Member requires oral suctioning;
- 5) ~~Client~~Member has decreased oral sensitivity or hypersensitivity;  
or
- 6) ~~Client~~Member is on medications that increase the risk of bleeding of the mouth.

~~iiiiv)~~ Special Considerations: Hand over hand assistance may be utilized for short term (up to 90 days) training of the ~~client~~Member in Activities of Daily Living when there has been a change in the ~~client~~Member's medical condition that has increased the ~~client~~Member's ability to perform this task.

I. Hygiene – Nail Care

i) Task includes: Soaking, filing, and nail trimming.

~~ii) The usual frequency of this task shall not exceed one time weekly.~~

~~iii)~~ Hygiene – Nail Care is a skilled task when:

- 1) The ~~client~~Member has a medical condition that involves peripheral circulatory problems or loss of sensation;
- 2) The ~~client~~Member is at risk for bleeding; or
- 3) The ~~client~~Member is at high risk for injury secondary to the nail care.

~~iiiiv)~~ Nail Care shall only be completed by a CNA who has been deemed competent in nail care by the Home Health Agency for this population.

~~ivv)~~ Special Considerations: Hand over hand assistance may be utilized for short term (up to 90 days) training of the ~~client~~Member in Activities of Daily Living when there has been a change in the ~~client~~Member's medical condition that has increased the ~~client~~Member's ability to perform this task.

m. Hygiene – Shaving

- i) Task includes: shaving of face, legs and underarms with manual or electric razor.
- ii) ~~The usual frequency of this task shall not exceed once daily;~~ Task may be completed with bathing/showering.
- iii) Hygiene – Shaving is a skilled task when:
  - 1) The clientMember has a medical condition involving peripheral circulatory problems;
  - 2) The clientMember has a medical condition involving loss of sensation;
  - 3) The clientMember has an illness or takes medications that are associated with a high risk for bleeding; or
  - 4) The clientMember has broken skin at/near shaving site or a chronic active skin condition.
- iv) Special Considerations: Hand over hand assistance may be utilized for short term (up to 90 days) training of the clientMember in Activities of Daily Living when there has been a change in the clientMember's medical condition that has increased the clientMember's ability to perform this task.

n. Meal Preparation

- i) Task includes:
  - 1) Preparation of food, ensuring food is proper consistency based on the clientMember's ability to swallow food safely; or
  - 2) Formula preparation.
- ii) ~~The usual frequency of this task shall not exceed three times daily.~~
- iii) Meal Preparation is a skilled task when: ClientMember's diet requires either nurse oversight to administer correctly, or meals requiring a modified consistency.

o. Medication Reminders

- i) Task includes:
  - 1) Providing clientMember reminders that it is time to take medications;
  - 2) Handing of pre-filled medication box to clientMember;
  - 3) Handing of labeled medication bottle to clientMember; or
  - 4) Opening of prefilled box or labeled medication bottle for clientMember.

- ii) This task may be completed by a CNA during the course of a visit but cannot be the sole purpose of the visit.
- ~~iii) A CNA may not perform this task, unless the CNA meets the DORA-approved CNA-MED certification, at 3 C.C.R. § 716-1 Chapter 19 Section 6. If the CNA does not meet the DORA certifications, the CNA may still ask if the client has taken medications and may replace oxygen tubing and may set oxygen to ordered flow rate.~~
- ~~iiiiv)~~ Special Considerations: CNAs shall not administer medications without obtaining the CNA-MED certification from the DORA approved course. 3 C.C.R. 716-1 Chapter 19 Section 6. If the CNA has obtained this certification, the CNA may perform pre-pouring and medication administration within the scope of CNA-MED certification at 3 C.C.R. 716-1 Chapter 19 Section 3.

p. Positioning

- i) Task includes:
  - 1) Moving the ~~client~~Member from the starting position to a new position while maintaining proper body alignment and support to a ~~client~~Member's extremities, and avoiding skin breakdown; and
  - 2) Placing any padding required to maintain proper alignment.
  - 3) Positioning as a stand-alone task excludes positioning that is completed in conjunction with other Activities of Daily Living.
  - ~~4) Positioning the Member requires adjusting the Member's alignment or posture in a bed, wheelchair, other furniture, assistive devices, or Durable Medical Equipment that has been ordered by a qualified Physician or Allowed Practitioner.~~
- ii) Positioning is a skilled task when:
  - 1) ~~Client~~Member is unable to communicate verbally, non-verbally or through other means;
  - 2) ~~Client~~Member is not able to perform this task independently due to illness, injury or disability; or
  - 3) ~~Client~~Member has temporary lack of mobility due to surgery or other exacerbation of illness, injury or disability.
  - ~~4) Positioning the client requires adjusting the client's alignment or posture in a bed, wheelchair, other furniture, assistive devices, or Durable Medical Equipment that has been ordered by a qualified physician.~~
- iii) Special Considerations:

- 1) The Home Health Agency shall coordinate visits to ensure that effective scheduling is utilized for skilled Intermittent visits.
- 2) Positioning cannot be the sole reason for a visit.

q. Skin Care

i) Task includes:

- 1) Applying lotion or other skin care product, when it is not performed in conjunction with bathing or toileting tasks.

ii) Skin care is a skilled task when:

- 1) ~~Client~~Member requires additional skin care that is prescribed by a qualified ~~physician~~Physician or Allowed Practitioner or dispensed by a pharmacy;
- 2) ~~Client~~Member has broken skin; or
- 3) ~~Client~~Member has a wound(s) or active skin disorder and is unable to apply product independently due to illness, injury or disability.

iii) Special Considerations:

- 1) Hand over hand assistance may be utilized for short term (up to 90 days) training of the ~~client~~Member in Activities of Daily Living when there has been a change in the ~~client~~Member's medical condition that has increased the ~~client~~Member's ability to perform this task.
- 2) This task may be included with positioning.

r. Transfers

i) Task includes:

- 1) Moving the ~~client~~Member from one location to another in a safe manner.

ii) It is not considered a separate task when a transfer is performed in conjunction with bathing, bladder care, bowel care or other CNA task.

iii) Transfers is a skilled task when:

- 1) ~~Client~~Member is unable to communicate verbally, non-verbally or through other means;
- 2) ~~Client~~Member is not able to perform this task independently due to fragility of illness, injury or disability;
- 3) ~~Client~~Member has a temporary lack of mobility due to surgery or other exacerbation of illness, injury or disability;

- 4) ~~Client~~Member lacks the strength and stability to stand or bear weight reliably;
- 5) ~~Client~~Member is not deemed independent in the use of assistive devices or Durable Medical Equipment that has been ordered by a qualified ~~physician~~ Physician or Allowed Practitioner; or
- 6) ~~Client~~Member requires a mechanical lift for safe transfers. In order to transfer ~~client~~Members via a mechanical lift, the CNA shall be deemed competent in the particular mechanical lift used by the ~~client~~Member.

iv) Special Considerations:

- 1) A second person may be used when required to safely transfer the ~~client~~Member.
- 2) Transfers may be completed with or without mechanical assistance.
- 3) Any unskilled task which requires a skilled transfer shall be considered a skilled task.

s. Vital Signs Monitoring

i) Task includes:

- 1) Taking and reporting the temperature, pulse, blood pressure and respiratory rate of the ~~client~~Member.
- 2) Blood glucose testing and pulse oximetry readings only when the CNA has been deemed competent in these measures.

ii) Vital sign monitoring is always a skilled task.

iii) Special Considerations:

- 1) ~~Shall only be performed when delegated by the client's nurse.~~ Vital signs monitoring cannot be the sole purpose of the CNA visit.
- 2) Vital signs shall be taken only as ordered by the ~~client~~Member's nurse or the Plan of Care and shall be reported to the nurse in a timely manner.
- 3) The CNA shall not provide any intervention without the nurse's direction, and may only perform interventions that are within the CNA practice act and for which the CNA has demonstrated competency.

13. Certified Nurse Aide Limitations

- a. In accordance with the Colorado Nurse Aide Practice Act, a CNA shall only provide services that have been ordered on the Home Health Plan of Care as written by the ~~Ordering~~Physician or Allowed Practitioner.



- b. CNAs assist with Activities of Daily Living and cannot perform a visit for the purpose of behavior modification. When a ~~client~~Member's disabilities involve behavioral manifestations, the CNA shall follow all applicable behavioral plans and refrain from actions that will escalate or upset the ~~client~~Member. In such cases the guardian, case manager, behavioral professional or mental health professional shall provide clear direction to the agency for the provision of care. The CNA shall not perform Behavioral Interventions, beyond those listed in c. of this section.
- c. If the ~~client~~Member has a behavior plan created by a behavior or mental health professional, the CNA shall follow this plan within their scope and training to the same extent that a family ~~client~~Member or paraprofessional in a school would be expected to follow the plan.
- d. When an agency allows a CNA to perform skilled tasks that require competency or delegation, the agency shall have policies and procedures regarding its process for determining the competency of the CNA. All competency testing and documentation related to the CNA shall be retained in the CNA's personnel file.
- e. CNA services can only be ordered when the task is outside of the usual responsibilities of the ~~client~~Member's ~~family member/caregiver~~ Family/In-Home Caregiver.
- f. Cuing or hand over hand assistance to complete Activities of Daily Living is not considered a skilled task, however, the agency may provide up to 90 days of care to teach a ~~client~~Member Activities of Daily Living when the ~~client~~Member is able to learn to perform the tasks independently. Cuing or hand over hand care that exceeds 90 days or is provided when the ~~client~~Member has not had a change in ability to complete self-care techniques, is not covered. If continued cuing or hand over hand assistance is required after 90 days, this task shall be transferred to a Personal Care Worker or other competent individual who can continue the task.
- g. Personal care needs or skilled CNA services that are the contracted responsibility of an ALRF, GRSS or IRSS are not reimbursable as a separate Medicaid Home Health Service.
- h. ~~Family members/caregivers~~ Family/In-Home Caregiver who meet all relevant requirements may be employed as a ~~client~~Member's CNA but may only provide services that are identified in this benefit coverage standard as skilled CNA services and that exceed the usual responsibilities of the ~~family member/caregiver~~ Family/In-Home Caregiver. ~~Family member/caregiver~~ Family/In-Home Caregiver CNAs must meet all CNA requirements.
- i. All CNAs who provide Home Health Services shall be subject to all requirements set forth by the policies of the Home Health Agency, and all applicable State and Federal laws.
- j. When a CNA holds other licensure(s) or certification(s), but is employed as or functions as a CNA, the services are reimbursed at the CNA rate for services.
- k. CNA visits cannot be approved for, nor can extended units be billed for the sole purpose of completing personal care, homemaking tasks or instrumental Activities of Daily Living.

- l. Personal care needs for ~~client~~Members ages ~~twenty~~ 20 years and under, not directly related to a skilled care task, shall be addressed through Section 8.535, Pediatric Personal Care~~PEDIATRIC PERSONAL CARE~~.
- m. Homemaker Services provided as directly related tasks secondary to skilled care during a skilled CNA visit shall be limited to the permanent living space of the ~~client~~Member. Such services are limited to tasks that benefit the ~~client~~Member and are not for the primary benefit of other persons living in the home.
- n. Nursing or CNA visits, or requests for extended visits, for the sole purpose of Protective Oversight are not reimbursable by Medicaid.
- o. CNA services for the sole purpose of providing personal care or homemaking services are not covered.
- p. The Department does not reimburse for services provided by two CNAs to the same ~~client~~Member at the same time, except when two CNAs are required for transfers, there are no other persons available to assist, and the reason why adaptive equipment cannot be used instead is documented in the Plan of Care. For this exception, the provider may bill for two visits, or for all units for both aides. Reimbursement for all visits or units will be counted toward the maximum reimbursement limit.
- q. The basic unit of reimbursement for CNA services is up to ~~60 minutes~~one hour. A unit of time that is less than ~~fifteen~~ 15 minutes cannot be reimbursed as a basic unit.
- r. For CNA visits that last longer than one-hour, extended units may be billed in addition to the basic unit. Extended units shall be increments of ~~fifteen~~ 15 minutes up to ~~30 minutes~~one-half hour. Any unit of time that is less than ~~fifteen~~ 15 minutes cannot be reimbursed as an extended unit.

#### 14. Certified Nurse Aide (CNA) Supervision

- a. CNA services shall be supervised by a registered nurse, by the physical therapist, or when appropriate, the speech therapist or occupational therapist depending on the specific Home Health Services the ~~client~~Member is receiving.
- b. If the ~~client~~Member receiving CNA services is also receiving ~~S~~skilled ~~N~~nursing care or physical therapy or occupational therapy, the supervising registered nurse or therapist shall make supervisory visits to the ~~client~~Member's home no less frequently than every 14 days. The CNA does not have to be present for every supervisory visit. However, the registered nurse, or the therapist shall make on-site supervisory visits to observe the CNA in the ~~client~~Member's home at least every 60 days.
- c. If the ~~client~~Member is only receiving CNA services, the supervising registered nurse or the physical therapist shall make on-site supervisory visits to observe the CNA in the ~~client~~Member's home at least every 60 days.
- d. The Department does not reimburse for any visit made solely for the purpose of supervising the CNA.
- e. For all ~~client~~Members expected to require CNA services for at least a year, during supervisory visits the supervising nurse shall:

- i) Obtain input from the clientMember, or the clientMember's designated representative into the Certified Nurse Aide Assignment Form, including all CNA tasks to be performed during each scheduled time period.
- ii) Document details, duties, and obligations on the Certified Nurse Aide Assignment Form.
- iii) Assure the Certified Nurse Aide Assignment Form contains information regarding special functional limitations and needs, safety considerations, special diets, special equipment, and any other information pertinent to the care to be provided by the CNA.
- iv) Obtain the clientMember's, or the clientMember's authorized representative's ~~, per section 8.520.7.E.1,~~ signature on the Certified Nurse Aide Assignment Form form, and provide a copy to the clientMember at the beginning of services, and at least once per year thereafter. A new copy of the Written Notice of Home Care Consumer Rights form, per Section 8.520.7.E.1, shall also be provided at these times.
- v) Explain the rights listed in the patient's rights form whenever the Certified Nurse Aide Assignment Form is renegotiated and rewritten.
- vi) For purposes of complying with this requirement, once per year means a date within one year of the prior certification.

15. ~~If a Member does not meet the factors that make a task skilled, as outlined in Section 8.520.5.B.12., the Member may be eligible to receive those services as unskilled personal care through Section 8.7538, Home and Community Based Services, Personal Care. If a client does not meet the factors that make a task skilled, as outlined in Section 8.520.5.B.125., the client may be eligible to receive those services as unskilled personal care through Section 8.535, PEDIATRIC PERSONAL CARE, or Section 583008.489, HOME AND COMMUNITY BASED SERVICES-EBD, PERSONAL CARE-EBD.~~

#### **8.520.5.C. Therapy Services**

- 1. Therapies are only covered:
  - a. In acute home health care; or
  - b. ClientMembers 20 years of age or younger may receive long-term home health therapy when services are medically necessary.
  - c. When the clientMember's Ordering Practitioner Physician or Allowed Practitioner prescribes therapy services, and the therapist is responsible for evaluating the clientMember and creating a treatment plan with exercises in accordance with practice guidelines.
- 2. The therapist shall teach the clientMember, the clientMember's family member/caregiver Family/In-Home Caregiver and other clientMembers of the Home Health care team to perform the exercises as necessary for an optimal outcome.
- 3. When the therapy Plan of Care includes devices and equipment, the therapist shall assist the clientMember in initiating or writing the request for equipment and train the clientMember on the use of the equipment.

4. Home Health Agencies shall only provide physical, occupational, or speech therapy services when:
  - a. Improvement of functioning is expected or continuing;
  - b. The therapy assists in overcoming developmental problems;
  - c. Therapy visits are necessary to prevent deterioration;
  - d. Therapy visits are indicated to evaluate and change ongoing treatment plans for the purpose of preventing deterioration, and to teach CNAs or others to carry out such plans, when the ongoing treatment does not require the skill level of a therapist; or
  - e. Therapy visits are indicated to assess the safety or optimal functioning of the ~~client~~Member in the home, or to train in the use of equipment used in implementation of the therapy Plan of Care.
5. Physical Therapy
  - a. Physical therapy includes any evaluations and treatments allowed under state law at C.R.S. § 12-41-101 through 130, which are applicable to the home setting.
  - b. When devices and equipment are indicated by the therapy Plan of Care, the therapist shall assist in initiating or writing the request in accordance with ~~Sections 8.590 through 8.590.7.P. Sections 8.590 through 8.594.03~~, Durable Medical Equipment, and shall assist in training on the use of the equipment.
  - c. Treatment must be provided by or under the supervision of a licensed physical therapist who meets the qualifications prescribed by federal regulation for participation in Medicare, ~~at 42 CFR 484.4~~, and who meets all requirements under state law. ~~Title 42 of the Code of Federal Regulations, Part 484.4 (2013) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. These regulations are available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. The agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule.~~
  - i) Physical therapy assistants (PTA) can render Home Health therapy but shall practice under the supervision of a registered physical therapist.
  - d. For ~~client~~Members who do not require ~~Skilled~~ Nursing care, the physical therapist may open the case and establish the Plan of Care.
  - e. Physical therapists are responsible for completing ~~client~~Member assessments related to various physical skills and functional abilities.

- f. Physical therapy includes evaluations and treatments allowed under state law and is available to all acute home health ~~client~~Members and pediatric long-term Home Health ~~client~~Members. Therapy plans and assessments shall contain the therapy services requested; the specific procedures and modalities to be used, including amount, duration, and frequency; and specific goals of therapy service provision.
- g. Limitations
  - i) Physical therapy for ~~client~~Members ages 21 or older is not covered for acute care needs when treatment becomes focused on maintenance, and no further functional progress is apparent or expected to occur.
  - ii) Physical therapy is not a benefit for adult long-term home health ~~client~~Members. ~~Client~~Members 20 years of age or younger may receive Long-Term Home Health therapy services when services are medically necessary.
  - iii) ~~Client~~Members ages 21 and older who continue to require therapy after the acute home health period may obtain long-term therapy services in an outpatient setting. ~~Client~~Members shall not be moved to acute home health for the sole purpose of continuing therapy services from a previous acute home health care episode.
  - iv) ~~Client~~Members 20 years of age or younger may obtain therapy services for maintenance care through acute home health and through long-term home health.
  - v) Physical therapy visits for the sole purpose of providing massage or ultrasound are not covered.
  - vi) Medicaid does not reimburse for two physical therapists during one visit.
  - vii) The unit of reimbursement for physical therapy is one visit, which is defined as the length of time required to provide the needed care, up to a maximum of two and one-half hours spent in ~~client~~Member care or treatment.

## 6. Occupational Therapy

- a. Occupational therapy includes evaluations and treatments allowed under the standards of practice authorized by the American Occupational Therapy Association, which are applicable to the home setting.
- b. When devices and equipment are indicated by the therapy Plan of Care, the therapist shall assist in initiating or writing the request and shall assist in training the ~~client~~Member on the use of the equipment.
- c. Treatment shall be provided by or under the supervision of a registered occupational therapist who meets the qualifications prescribed by federal regulations for participation under applicable federal and state laws, including Medicare requirements at 42 C.F.R. § 484.4. Title 42 of the Code of Federal Regulations is hereby incorporated by reference.

- i) Occupational therapy assistants (OTA) can render Home Health therapy but shall practice under the supervision of a registered occupational therapist.
- d. For ~~client~~Members who do not require ~~Skilled N~~nursing care, the occupational therapist may open the case and establish the Plan of Care.
- e. Occupational therapy includes only evaluations and treatments that are allowed under state law for occupational therapists.
- f. Occupational therapists shall create a plan and perform assessments which state the specific therapy services requested, the specific procedures and modalities to be used, the amount, duration, frequency, and the goals of the therapy service provision.
- g. Limitations
  - i) Occupational therapy for ~~client~~Members ages 21 or older is not a benefit under acute Home Health Services when treatment becomes maintenance, and no further functional progress is apparent or expected to occur.
  - ii) Occupational therapy is not a benefit for adult long-term home health ~~client~~Members.
  - iii) ~~Client~~Members ages 21 and older who continue to require therapy after the acute home health period may only obtain long-term therapy services in an outpatient setting.
  - iv) ~~Client~~Members shall not be moved to acute home health for the sole purpose of continuing therapy services from a previous acute home health care episode.
  - v) ~~Client~~Members 20 years of age or younger may continue to obtain therapy services for maintenance care in acute home health and in long-term home health.
  - vi) Medicaid does not reimburse for two occupational therapists during one visit.
  - vii) The unit of reimbursement for occupational therapy is one visit, which is defined as the length of time required to provide the needed care, up to a maximum of two and one-half hours spent in ~~client~~Member care or treatment.

## 7. Speech Therapy

- a. Speech therapy services include any evaluations and treatments allowed under the American Speech-Language-Hearing Association (ASHA) authorized scope of practice statement, which are applicable to the home setting.
- b. When devices and equipment are indicated by the therapy ~~P~~plan of ~~C~~care, the therapist shall assist in initiating or writing the request in accordance with ~~Sections 8.590 through 8.590.7.P.Sections 8.590 through 8.594.03~~, Durable Medical Equipment, and shall assist in training on the use of the equipment.

- c. Treatment must be provided by a speech/language pathologist who meets the qualifications prescribed by federal regulations for participation under Medicare at 42 C.F.R. § 484.4. Title 42 of the Code of Federal Regulations is hereby incorporated by reference.
- d. For ~~client~~Members who do not require ~~Skilled~~ ~~N~~nursing care, the speech therapist may open the case and establish the Medicaid ~~P~~plan of ~~C~~care.
- e. The speech/language pathologist shall state the specific therapy services requested, the specific procedures and modalities to be used, as well as the amount, duration, frequency and specific goals of therapy services on the Plan of Care.
- f. Limitations
  - i) Speech therapy for ~~client~~Members ages 21 or older is not a benefit under acute Home Health Services when treatment becomes maintenance, and no further functional progress is apparent or expected to occur.
  - ii) ~~Client~~Members cannot be moved to acute home health for the sole purpose of continuing therapy services from a previous acute home health care episode.
  - iii) Speech therapy is not a benefit for adult long-term home health ~~client~~Members.
  - iv) Treatment of speech and language delays is only covered when associated with a ~~C~~hronic ~~M~~medical ~~C~~ondition, neurological disorder, acute illness, injury, or congenital issue.
  - v) ~~Client~~Members 20 years of age or younger may continue to obtain therapy services for maintenance care in acute home health and in long-term home health.
  - vi) Medicaid does not reimburse for two speech therapists during one visit.
  - vii) The unit of reimbursement for speech therapy is one visit, which is defined as the length of time required to provide the needed care, up to a maximum of two and one-half hours spent in ~~client~~Member care or treatment.

**8.520.5.D. ~~Home Health-Telehealth Services~~Remote Patient Monitoring**

- 1. The Home Health Agency shall create policies and procedures for the use and maintenance of the monitoring equipment and the process of ~~telehealth monitoring~~ Remote Patient Monitoring. This service shall be used to monitor the ~~client~~Member and manage the ~~client~~Member's care, and shall include all of the following elements:
  - a. The ~~client~~Member's designated registered nurse or licensed practical nurse, consistent with state law, shall review all data collected within 24 hours of receipt of the ordered transmission, or in cases where the data is received after business hours, on the first business day following receipt of the data;
  - b. The ~~client~~Member's designated nurse shall oversee all planned interventions;

- c. ~~ClientMember~~-specific parameters and protocols defined by the agency staff and the ~~clientMember's~~ Physician or Allowed Practitioner ~~authorizing physician or podiatrist~~; and
  - d. Documentation of the clinical data in the ~~clientMember's~~ chart and a summary of response activities, if needed.
    - i) The nurse assessing the clinical data shall sign and date all documentation; and
    - ii) Documentation shall include the health care data that was transmitted and the services or activities that are recommended based on the data.
2. The Home Health Agency shall provide monitoring equipment that possesses the capability to measure any changes in the monitored diagnoses, and meets all of the following requirements:
- a. Food and Drug Administration (FDA) certified or ~~UL~~ Underwriters Laboratory (UL) listed, and used according to the manufacturer's instructions;
  - b. Maintained in good repair and free from safety hazards; and
  - c. Sanitized before installation in a ~~clientMember's~~ home.
3. ~~Home Health Telehealth Remote Patient Monitoring~~ services are covered for ~~clientMembers~~ receiving Home Health Services, when all of the following requirements are met:
- a. ~~ClientMember~~ receives services from a home health provider for at least one of the following diagnoses:
    - i) Congestive Heart Failure;
    - ii) Chronic Obstructive Pulmonary Disease;
    - iii) Asthma;
    - iv) Diabetes;
    - v) Pneumonia; or
    - vi) Other diagnosis or medical condition deemed eligible by the Department or its Designee.
  - b. ~~ClientMember~~ requires ongoing and frequent monitoring, minimum of five times weekly, to manage their qualifying diagnosis as defined and ordered by a ~~physician~~ Physician or Allowed Practitioner or podiatrist;
  - c. ~~ClientMember~~ has demonstrated a need for ongoing monitoring as evidenced by:
    - i) Having been hospitalized or admitted to an emergency room two or more times in the last ~~twelve~~ 12 months for medical conditions related to the qualifying diagnosis;



- ii) If the clientMember has received Home Health Services for less than six months, the clientMember was hospitalized at least once in the last three months;
    - iii) An acute exacerbation of a qualifying diagnosis that requires Remote Patient Monitoring; or
    - iv) New onset of a qualifying disease that requires ongoing monitoring to manage the clientMember in their residence.
  - d. ClientMember or caregiver misses no more than five transmissions of the provider and agency prescribed monitoring events in a ~~thirty~~ 30-day period; and
  - e. ClientMember's home environment has the necessary connections to transmit the ~~telehealth-Remote Patient Monitoring~~ data to the agency and has space to set up and use the equipment as prescribed.
4. The Home Health Agency shall make at least one home health nursing visit every 14 days to a clientMember using ~~Home Health Telehealth Remote Patient Monitoring services~~.
5. The Home Health Agency shall develop agency-specific criteria for assessment of the need for ~~Home Health Telehealth Remote Patient Monitoring services~~, to include patient selection criteria, home environment compatibility, and patient competency. The agency shall complete these assessment forms prior to the submission of the enrollment application and they shall be kept on file at the agency.
6. The clientMember and/or caregiver shall comply with the ~~telehealth monitoring~~ Remote Patient Monitoring as ordered by the qualifying ~~physician~~ Physician or Allowed Practitioner.
7. Limitations:
- a. ClientMembers who are unable to comply with the ordered ~~telehealth monitoring~~ Remote Patient Monitoring shall be disenrolled from the services.
  - b. Services billed prior to obtaining approval to enroll a clientMember into ~~Home Health Telehealth Remote Patient Monitoring services~~ by the Department or its Designee are not a covered benefit.
  - c. The unit of reimbursement for ~~Home Health Telehealth Remote Patient Monitoring~~ is one calendar day.
    - i) The Home Health Agency may bill one initial installation unit per clientMember lifetime when the monitoring equipment is installed in the home.
    - ii) The Home Health Agency may bill the daily rate for each day the ~~telehealth monitoring-Remote Patient Monitoring~~ equipment is used to monitor and manage the clientMember's care.
  - d. Once per lifetime per clientMember, a Home Health Agency may bill for the installation of the ~~Home Health Telehealth Remote Patient Monitoring~~ equipment.

8.520.6.A. Reimbursement for routine supplies is included in the reimbursement for nursing, CNA, physical therapy, occupational therapy, and speech therapy services. Routine supplies are supplies that are customarily used during the course of home care visits. These are standard supplies utilized by the Home Health Agency staff and not designated for a specific ~~client~~Member.

8.520.6.B. Non-routine supplies may be a covered benefit when approved by the Department or its Designee.

8.520.6.C. Limitations

1. A Home Health Agency cannot require a ~~client~~Member to purchase or provide supplies that are necessary to carry out the ~~client~~Member's Plan of Care.
2. A ~~client~~Member may opt to provide his or her own supplies.

#### **8.520.7. Documentation**

8.520.7.A. Home Health Agencies shall have written policies regarding delegation of tasks by nurses ~~delegation~~.

8.520.7.B. Home Health Agencies shall have written policies regarding maintenance of ~~client~~Members' durable medical equipment and make full disclosure of these policies to all ~~client~~Members with durable medical equipment in the home. The Home Health Agency shall provide such disclosure to the ~~client~~Member at the time of intake.

8.520.7.C. Home Health Agencies shall have written policies regarding procedures for communicating with case managers of ~~client~~Members who are also enrolled in HCBS programs. Such policies shall include, at a minimum:

1. How agencies will inform case managers that services are being provided or are being changed; and
2. Procedures for sending copies of Plans of Care if requested by case managers. These policies shall be developed with input from case managers.

8.520.7.D. **Plan of Care Requirements**

1. The ~~client~~Member's ~~Ordering Practitioner-Physician or Allowed Practitioner~~ shall order Home Health Services in writing, as part of a written Plan of Care. The written Plan of Care shall be reviewed and updated every 60 calendar days but need not be provided to the Department or its Designee unless the ~~client~~Member's status has changed significantly, a new PAR is needed, or if requested by the Department or its Designee.
2. The initial assessment or continuation of care assessments shall be completed by a registered nurse, or by a physical therapist, occupational therapist or speech therapist when no ~~S~~skilled ~~N~~nursing needs are required. The assessment shall be utilized to develop the Plan of Care with provider input and oversight. The written Plan of Care and associated documentation shall be used to complete the CMS-485 ~~(or a document that is identical in content)-Plan of Care, or a form that is of similar format to the CMS-485~~ and shall include:
  - a. Identification of the ~~Ordering Practitioner-Physician or Allowed Practitioner~~;
  - b. ~~Ordering Practitioner-Physician or Allowed Practitioner~~ orders;

- c. Identification of the specific diagnoses, including the primary diagnosis, for which Medicaid Home Health Services are requested.
- d. The specific circumstances, clientMember medical condition(s) or situation(s) that require services to be provided in the clientMember's residence rather than in a Ordering-Physician or Allowed Practitioner's office, clinic or other outpatient setting including the availability of natural supports and the clientMember's living situation;
- e. A complete list of supplements, and medications, both prescription and over the counter, along with the dose, the frequency, and the means by which the medication is taken;
- f. A complete list of the clientMember's allergies;
- g. A list of all non-routine durable medical equipment used by the clientMember;
- h. A list of precautions or safety measures in place for the clientMember, as well as functional limitations or activities permitted by the clientMember's -Physician or Allowed Practitioner qualified physician;
- i. A behavioral plan when applicable. Physical Behavioral Interventions, such as restraints, shall not be included in the home health Plan of Care;
- j. A notation regarding the clientMember's Ordering-Physician or Allowed Practitioner-ordered dietary (nutritional) requirements and restrictions, any special considerations, other restrictions or nutritional supplements;
- k. The Home Health Agency shall indicate a comprehensive list of the amount, frequency, and expected duration of provider visits for each discipline ordered by the clientMember's Ordering-Physician or Allowed Practitioner, including:
  - i) The specific duties, treatments and tasks to be performed during each visit;
  - ii) All services and treatments to be provided on the Plan of Care;
    - 1) Treatment plans for physical therapy, occupational therapy and speech therapy may be completed on a form designed specifically for therapy Plans of Care; and
  - iii) Specific situations and circumstances that require a PRN visit, if applicable.
- l. Current clinical summary of the clientMember's health status, including mental status, and a brief statement regarding homebound status of the clientMember;
- m. The clientMember's prognosis, goals, rehabilitation potential and where applicable, the clientMember's specific discharge plan;
  - i) If the clientMember's illness, injury or disability is not expected to improve, or discharge is not anticipated, the agency is not required to document a discharge plan;

- ii) The clientMember's medical record shall include the reason that no discharge plan is present;
- n. The Ordering-Practitioner-Physician or Allowed Practitioner shall approve the Plan of Care with a dated signature. If an electronic signature is used, the agency shall document that an electronic signature was used and shall keep a copy of the Ordering-Physician or Allowed Practitioner's physical signature on file;
- o. Brief statement regarding the clientMember's support network including the availability of the clientMember's family member/caregiver Family/In-Home Caregiver and if applicable, information on why the clientMember's family member/caregiver Family/In-Home Caregiver is unable or unwilling to provide the care the clientMember requires; and
- p. Other relevant information related to the clientMember's need for Home Health care.
- 3. A new Plan of Care shall be completed every 60 calendar days while the clientMember is receiving Home Health Services. The Plan of Care shall include a statement of review by the Ordering-Practitioner-Physician or Allowed Practitioner every 60 days.
- 4. Home Health Agencies shall send new Plans of Care and other documentation as requested by the Department or its Designee.

#### **8.520.7.E. Additional Required ClientMember Chart Documentation**

- 1. A signed copy of the Written Notice of Home Care Consumer Rights as required by the Department and at 42 C.F.R. § 484.10. Title 42 of the Code of Federal Regulations is hereby incorporated by reference. Title 42 of the Code of Federal Regulations, Part 484.10 (2013) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. These regulations are available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. The agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule;
- 2. Evidence of a face-to-face visit with the clientMember's referring provider, or other appropriate provider, as required at 42 C.F.R. § 440.70. Title 42 of the Code of Federal Regulations is hereby incorporated by reference. Title 42 of the Code of Federal Regulations, Part 440.70 (2016) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. These regulations are available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. The agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule;
- 3. A signed and dated copy of the Agency Disclosure Form as required by the Department, with requirements at 42 C.F.R. § 484.12. Title 42 of the Code of Federal Regulations is hereby incorporated by reference. Title 42 of the Code of Federal Regulations, Part 484.12 (2013) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. These

~~regulations are available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. The agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule;~~

4. Dates of the most recent hospitalization or nursing facility stay. If the most recent stay was within the last 90 days, reason for the stay (diagnoses), length of stay, summary of treatment, date and place discharged to shall be included in the clinical summary or update;
5. The expected health outcomes, which may include functional outcomes;
6. An emergency plan including the safety measures that will be implemented to protect against injury;
7. A specific order from the clientMember's Physician or Allowed Practitioner ~~qualified physician~~ for all PRN visits utilized;
8. Clear documentation of skilled and non-skilled services to be provided to the clientMember with documentation that the clientMember or clientMember's family member/caregiver ~~Family/In-Home Caregiver~~ agrees with the Plan of Care;
9. Accurate and clear clinical notes or visit summaries from each discipline for each visit that include the clientMember's response to treatments and services completed during the visit. Summaries shall be signed and dated by the person who provided the service. If an electronic signature is used, the agency shall document that an electronic signature was used and keep a copy of the physical signature on file;
10. Documented evidence of Care Coordination with the clientMember's other providers;
11. When the clientMember is receiving additional services (skilled or unskilled) evidence of Care Coordination between the other services shall be documented and include an explanation of how the requested Home Health Services do not overlap with these additional services;
12. A plan for how the agency will cover clientMember services (via family member/caregiver ~~Family/In-Home Caregiver~~ or other agency staff) if inclement weather or other unforeseen incident prevents agency staff from delivering the Home Health care ordered by the Physician or Allowed Practitioner; ~~and~~ ~~qualified physician~~; and
13. If foot or wound care is ordered for the clientMember, the Home Health Agency shall ensure the signs and symptoms of the disease process/medical condition that requires foot or wound care by a nurse are clearly and specifically documented in the clinical record. The Home Health Agency shall ensure the clinical record includes an assessment of the foot or feet, or wound, and physical and clinical findings consistent with the diagnosis, and the need for foot or wound care to be provided by a nurse.

## **8.520.8 Prior Authorization**

### **8.520.8.A. General Requirements**

1. Approval of the PAR does not guarantee payment by Medicaid.

2. The ~~client~~Member and the HHA shall meet all applicable eligibility requirements at the time services are rendered and services shall be delivered in accordance with all applicable service limitations.
3. Medicaid is always the payer of last resort and the presence of an approved or partially approved PAR does not release the agency from the requirement to only bill for Medicaid approved services to Medicare or other third-party insurance prior to billing Medicaid.
  - a. Exceptions to this include Early Intervention Services documented on a child's Individualized Family Service Plan (IFSP) and the following services that are not a skilled Medicare benefit (CNA services only, OT services only, Med-box pre-pouring and routine lab draws).
4. \_\_\_\_\_ In the event a Member changes provider agencies, the receiving HHA shall submit a Change of Provider Form and POC to the URC within 10 business days of starting LTHH services.

#### **8.520.8.B. Acute Home Health**

1. Acute Home Health Services do not require prior authorization. This includes episodes of acute home health for ~~L~~ong-~~T~~erm ~~H~~ome ~~H~~health ~~client~~Members. A condition is considered acute only until it is resolved or until 60 calendar days after onset, whichever comes first.
2. If a ~~client~~Member receiving ~~L~~ong-~~T~~erm Home Health Services experiences an acute care event that necessitates moving the ~~client~~Member to an acute home health episode, the agency shall notify the Department or its Designee that the ~~client~~Member is moving from long-term home health to acute Home Health Services.
3. If the ~~client~~Member's acute home health needs resolve prior to 60 calendar days, the Home Health Agency shall discharge the ~~client~~Member, or submit a PAR for ~~L~~ong-~~T~~erm Home Health Services if the ~~Member~~ is eligible.
  - a. If an acute home health ~~client~~Member experiences a change in status (e.g. an inpatient admission), that totals ~~9~~nine calendar days or less, the Home Health Agency shall resume the ~~client~~Member's care under the current acute home health Plan of Care.
  - b. If an acute home health ~~client~~Member experiences a change in status (e.g. an inpatient admission), that totals 10 calendar days or more, the Home Health Agency may start a new Acute Home Health episode when the ~~client~~Member returns to the Home Health Agency.
  - c. The Home Health Agency shall inform the SEP case manager or the Medicaid fiscal agent within 10 working days of the beginning and within 10 working days of the end of the acute care episode.

#### **8.520.8.C. Long-Term Home Health**

1. Long-~~T~~erm Home Health Services ~~do not~~ require prior authorization, ~~under Section 8.017.E.~~
2. When an agency accepts an HCBS waiver ~~client~~Member to ~~L~~ong-~~T~~erm Home Health Services, the Home Health Agency shall contact the ~~client~~Member's case management

agency to inform the case manager of the ~~client~~Member's need for Home Health Services.

3. Long-Term Home Health Services for all Members require prior authorization by the Department or its Designee. Require the completion of the Skilled Care Acuity Assessment Acuity Tool to reliably provide consistent information, and that is to be completed by the designated Nurse Assessor Vendor. The assessment results are a part of a body of evidence used to determine Medical Necessity but does not independently determine the outcomes of service eligibility.

43. The complete formal written PAR shall include:

- a. A completed Department-prescribed Prior Authorization Request Form, see Section 8.058;
- b. A home health Plan of Care, which includes all clinical assessments and current clinical summaries or updates of the ~~client~~Member. The Plan of Care shall be on the CMS-485 form, or a form that is of similar format identical in content to the CMS-485, and all sections of the form shall be completed. For ~~client~~Members 20 years of age or younger, all therapy services requested shall be included in the Plan of Care or addendum, which lists the specific procedures and modalities to be used and the amount, duration, frequency and goals. If extended aide units, as described in Section 8.520.5.B.13.r. Section 8.520.9.B. are requested, there shall be sufficient information about services on each visit to justify the extended units. Documentation to support any PRN visits shall also be provided. If there are no nursing needs, the Plan of Care and assessments may be completed by a therapist if the ~~client~~Member is 20 years of age or younger and is receiving home health therapy services;
- c. For Members under 21 years of age, written documentation of the results of the EPSDT medical screening, or other equivalent examination results provided by the ~~client~~Member's third-party insurance;
- d. Any other medical information which will document the ~~M~~medical ~~N~~ecessity for the Home Health Services. Support for Medical Necessity must be documented in the PAR submission to be considered in the PAR review and any subsequent appeal;
- e. If applicable, written instructions from the therapist or other medical professional to support a current need when range of motion or other therapeutic exercise is the only skilled service performed on a CNA visit;
- f. When the PAR includes a request for nursing visits solely for the purpose of pre-pouring medications, evidence that the ~~client~~Member's pharmacy was contacted, and advised the Home Health Agency that the pharmacy will not provide medication set-ups, shall be documented; and
- g. When a PAR includes a request for reimbursement for two aides at the same time to perform two-person transfers, documentation supporting the current need for two-person transfers, and the reason adaptive equipment cannot be used instead, shall be provided.
- h. Long-Term Home Health Services for ~~client~~Members 20 years of age or younger require prior authorization by the Department or its Designee using the approved utilization management tool.



54. Authorization time frames:

- a. PARs shall be submitted for and may be approved for up to a one-year period.
- b. The Department or its Designee may initiate PAR revisions if the Plans of Care indicate significantly decreased services.
- c. PAR revisions for increases initiated by Home Health Agencies shall be submitted and processed according to the same requirements as for new PARs, except that current written assessment information pertaining to the increase in care may be submitted in lieu of the ~~CMS-485~~ CMS-485 Plan of Care, or a form that is of similar format to the CMS-485.

65. The PAR shall not be backdated to a date prior to the 'from' date of the ~~CMS-485~~ CMS-485 Plan of Care, or a form that is of similar format to the CMS-485.

76. The Department or its Designee shall approve or deny according to the following guidelines for safeguarding ~~client~~ Members:

- a. PAR Approval: If services requested are in compliance with Medicaid rules and are medically necessary and appropriate for the diagnosis and treatment plan, the services are approved retroactively to the start date on the PAR form. Services may be approved retroactively for no more than 10 days prior to the PAR submission date.
- b. PAR Denial:
  - i) The Department or its Designee shall notify Home Health Agencies in writing of denials that result from non-compliance with Medicaid rules or failure to establish ~~M~~medical ~~N~~necessity (e.g., the PAR is not consistent with the ~~client~~ Member's documented medical needs and functional capacity). Denials based on ~~M~~medical ~~N~~necessity shall be determined by a registered nurse, ~~or physician~~ Physician or Allowed Practitioner.
  - ii) When denied or reduced, services shall be approved in accordance with Section 8.057.5 for 60 additional days after the date on which the notice of denial is mailed to the client, through August 31, 2022. If the denial is appealed by the member in accordance with Section 8.057, services will be maintained for the duration of the appeal until the final agency action is rendered. After August 31, 2022, services shall be approved for an additional 15 days after the date on which the notice of denial is mailed to the client. Services may be approved retroactively for no more than 10 days prior to the PAR submission date.
- c. Interim Services: Services provided during the period between the provider's submission of the PAR form to the Department or its Designee, to the final approval or denial by the Department may be approved for payment. Payment may be made retroactive to the start date on the PAR form, or up to 30 working days, whichever is shorter.
  - i) If the PAR is denied and the Member appeals that denial, the Department will not be the proponent of an order regarding that denial solely by virtue of having provided interim services. The Member will maintain the burden of proof to establish eligibility for services requested in the PAR.



#### 8.520.8.D. EPSDT Services

1. Home Health Services beyond those allowed in Section 8.520.5, for ~~clientMembers~~ ages 0 through 20 under the age of 21, shall be reviewed for ~~M~~medical ~~N~~ecessity under the EPSDT requirement, as defined at Section 8.280.1.
2. Home Health Services beyond those in Section 8.520.5, which are provided under the Home Health benefit due to ~~M~~medical ~~N~~ecessity, cannot include services that are available under other Colorado Medicaid benefits for which the ~~clientMember~~ is eligible, including, but not limited to, Private Duty Nursing, Section 8.540; Home and Community-Based Services (HCBS)~~HCBS Personal Care~~, Section ~~8.7000~~8.489; Pediatric Personal Care, Section 8.535; School Health and Related Services, Section 8.290, or Outpatient Therapies, Section 8.200.3.A.6, Section 8.200.5.B., and Section 8.200.3.D.2. ~~Section 8.200.3.A.6, Section 8.200.5 and Section 8.200.3.D~~ Exceptions may be made if EPSDT Home Health Services will be more cost-effective, provided that ~~clientMember~~ safety is assured. Such exceptions shall, in no way, be construed as mandating the delegation of nursing tasks.
3. PARs for EPSDT home health shall be submitted and reviewed as outlined in Section 8.520.8, including all documentation outlined in Section 8.520.8, and any other medical information which will document the ~~M~~medical ~~N~~ecessity for the EPSDT Home Health Services. The Plan of Care shall include the place of service for each home health visit.

#### 8.520.8.E. ~~Home Health Telehealth Services~~Remote Patient Monitoring

1. ~~Home Health Telehealth services~~Remote Patient Monitoring requires s prior authorization.
2. The ~~Home Health Telehealth~~ Remote Patient Monitoring PARs shall include all of the following:
  - a. A completed enrollment form;
  - b. An order for ~~telehealth monitoring~~ Remote Patient Monitoring signed and dated by the ~~Ordering Practitioner~~Physician or Allowed Practitioner or podiatrist;
  - c. A Plan of Care, which includes nursing and therapy assessments for ~~clientMembers~~. ~~Telehealth monitoring~~Remote Patient Monitoring shall be included on the CMS-485form, or a form that contains identical information to the CMS-485, Plan of Care, or a form that is of similar format to the CMS-485 and all applicable forms shall be complete; and
  - d. For ongoing~~telehealth~~ Remote Patient Monitoring, the agency shall include documentation on how ~~telehealth~~ Remote Patient ~~-data~~Monitoring data has been used to manage the ~~clientMember~~'s care, if the ~~clientMember~~ has been using ~~Home Health Telehealth services~~Remote Patient Monitoring.

#### 8.520.9 Reimbursement

##### 8.520.9.A. ~~Rates of Reimbursement:~~ Payment for Home Health Services is the lower of the billed charges or the maximum unit rate of reimbursement.

1. The maximum reimbursement for any ~~24-~~hour period, as measured from midnight to midnight, shall not exceed the daily maximum as designated by the Department and in alignment with the Legislative Budget.

2. The maximum daily reimbursement includes reimbursement for nursing visits, home health CNA visits, physical therapy visits, occupational therapy visits, speech/language pathology visits, and any combinations thereof.

3. No individual Nurse (RN/LPN), Physical Therapist (PT), Occupational Therapist (OT), Speech Therapist (ST), or Certified Nursing Assistant (CNA) may be reimbursed for more than 16 hours of care per day for one or more members collectively.

#### **8.520.9.B. Special Reimbursement Conditions**

1. Total reimbursement by the Department combined with third party liability and Medicare crossover claims shall not exceed Medicaid rates.
2. When Home Health Agencies provide Home Health Services in accordance with these regulations to ClientMembers who receive Home and Community-based Services for the Developmentally Disabled (HCBS-DD), the Home Health Agency is reimbursed:
  - a. Under normal procedures for home health reimbursement if the ClientMember resides in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), ~~or in IRSS host homes and settings~~; or
  - b. By the group home provider, if the ClientMember resides in a GRSS, because the provider has already received Medicaid funding for the Home Health Services and is responsible for payment to the Home Health Agency.
3. Acute Home Health Services for Medicaid HMO ClientMembers are the responsibility of the Medicaid HMO, including ClientMembers who are also HCBS recipients.
4. Services for a dual eligible ClientMember shall be submitted first to Medicare for reimbursement. All Medicare requirements shall be met and administrative processes exhausted prior to any dual eligible ClientMember's claims being billed to Medicaid, as demonstrated by a Medicare denial of benefits, except for the specific services listed in Section 8.520.0.E.4.a below for ClientMembers which meet the criteria listed in Section 8.520.9.E.4.b below.
  - a. A Home Health Agency may bill only Medicaid without first billing Medicare if both of the following are true:
    - i) The services below are the only services on the claim:
      - 1) Pre-pouring of medications;
      - 2) CNA services;
      - 3) Occupational therapy services when provided as the sole skilled service; or
      - 4) Routine laboratory draw services.
    - ii) The following conditions apply:
      - 1) The ClientMember is stable;
      - 2) The ClientMember is not experiencing an acute episode; and

- 3) The ClientMember routinely leaves the home without taxing effort and unassisted for social, recreational, educational, or employment purposes.
- b. The Home Health Agency shall maintain clear documentation in the ClientMember's record of the conditions and services that are billed to Medicaid without first billing Medicare.
  - c. A Home Health Change of Care Notice or Advance Beneficiary Notice of Non-Coverage shall be filled out as prescribed by Medicare.
5. Services for a dually eligible long-term home health ClientMember who has an acute episode shall be submitted first to Medicare for reimbursement. Medicaid may be billed if payment is denied by Medicare as a non-covered benefit and the service is a Medicaid benefit, or when the service meets the criteria listed in Section 8.520.9.E.4 above.
6. If both Medicare and Medicaid reimburse for the same visit or service provided to a ClientMember in the same episode, the reimbursement is considered a duplication of payment and the Medicaid reimbursement shall be returned to the Department.
  - a. Home Health Agencies shall return any payment made by Medicaid for such visit or service to the Department within ~~sixty~~ 60 calendar days of receipt of the duplicate payment.

#### **8.520.9.C. Reimbursement for Supplies**

1. A Home Health Agency shall not ask a ClientMember to provide any supplies. A request for supplies from a ClientMember may constitute a violation of Section 8.012, providers prohibited from collecting payment from recipients. PROVIDERS PROHIBITED FROM COLLECTING PAYMENT FROM RECIPIENTS.
2. Supplies other than those required for practice of universal precautions which are used by the Home Health Agency staff to provide Home Health Services are not the financial responsibility of the Home Health Agency. Such supplies may be requested by the ~~physician~~ Physician or Allowed Practitioner as a benefit to the ClientMember under Section 8.590, ~~DURABLE MEDICAL EQUIPMENT AND DISPOSABLE MEDICAL SUPPLIES~~ Durable Medical Equipment and disposable medical supplies.
3. Supplies used for the practice of universal precautions by the ~~ClientMember's family or other informal caregivers~~ Family/In-Home Caregiver are not the financial responsibility of the Home Health Agency. Such supplies may be requested by the ~~physician~~ Physician or Allowed Practitioner as a benefit to the ClientMember under Section 8.590, ~~DURABLE MEDICAL EQUIPMENT AND DISPOSABLE MEDICAL SUPPLIES~~ Durable Medical Equipment and disposable medical supplies.

#### **8.520.9.D. Restrictions**

1. When the ClientMember has Medicare or other third-party insurance, Home Health claims to Medicaid will be reimbursed only if the ClientMember's care does not meet the Home Health coverage guidelines for Medicare or other insurance.
2. When an agency provides more than one employee to render a service, in which one employee is supervising or instructing another in that service, the Home Health Agency shall only bill and be reimbursed for one employee's visit or units.

3. Any visit made by a nurse or therapist to simultaneously serve two or more ClientMembers residing in the same household shall be billed by the Home Health Agency as one visit only, unless services to each ClientMember are separate and distinct. If two or more ClientMembers residing in the same household receive Medicaid CNA services, the services for each ClientMember shall be documented and billed separately for each ClientMember.
- ~~4. No more than one Home Health Agency may be reimbursed for providing Home Health Services during a specific plan period to the same Client, unless the second agency is providing a Home Health Service that is not available from the first agency. The first agency shall take responsibility for the coordination of all Home Health Services. Home and Community-based Services, including personal care, are not Home Health Services.~~
4. In the event of limited resources for a Home Health Agency, two agencies may coordinate care and provide services to the same Member as long as there is no duplication of services on the same date(s) of service and the Home Health Agencies comply with the following:
  - a. The Home Health Agencies shall document the need and reason for two Home Health Agencies to render services to a Member.
  - b. The Home Health Agencies shall coordinate the Member's Plan of Care and maintain the Plan of Care and documentation on all services rendered by each provider in the member's records.
  - c. Each Home Health Agency shall obtain prior authorization, identify to the URC the coordinated Plan of Care and revise the PAR as needed to ensure coverage.
5. Improper Billing Practices: Examples of improper billing include, but are not limited to:
  - a. Billing for visits without documentation to support the claims billed. Documentation for each visit billed shall include the nature and extent of services, the care provider's signature, the month, day, year, and the exact time in and time out of the ClientMember's home. Providers shall submit or produce requested documentation in accordance with rules at Section 8.076.2;
  - b. Billing for unnecessary visits, or visits that are unreasonable in number, frequency or duration;
  - c. Billing for CNA visits in which no skilled tasks were performed and documented;
  - d. Billing for skilled tasks that were not medically necessary;
  - e. Billing for Home Health Services provided at locations other than an eligible place of service, except EPSDT services provided with prior authorization; and
  - f. Billing of personal care or homemaker services as Home Health Services.
6. A Home Health Agency that ~~isare~~ also certified as a personal care/homemaker provider shall ensure that neither duplicate billing nor unbundling of services occurs in billing for Home Health Services and HCBS personal care services. Examples of duplicate billing and unbundling of services include:
  - a. One employee makes one visit, and the agency bills Medicaid for a CNA visit, and also bills all of the hours as HCBS personal care or homemaker.

- b. One employee makes one visit, and the agency bills for one CNA visit, and bills some of the hours as HCBS personal care or homemaker, when the total time spent on the visit does not equal at least 1 hour plus the number of hours billed for HCBS personal care and homemaker.
  - c. Any other practices that circumvent these rules and result in excess Medicaid payment through unbundling of CNA and personal care or homemaker services.
- 7. The Department may take action against the offending Home Health Agency, including termination from participation in Colorado Medicaid in accordance with [10 C.C.R. 2505-10](#), Section 8.076.

## **8.520.10 Compliance Monitoring Reviews**

### **8.520.10.A. General Requirements**

- 1. Compliance monitoring of Home Health Services may be conducted by state and federal agencies, their contractors and law enforcement agencies in accordance with [10 C.C.R. 2505-10](#), Section 8.076.
- 2. Home Health Agencies shall submit or produce all requested documentation in accordance with [10 C.C.R. 2505-10](#), Section 8.076.
- 3. ~~Physician~~ **Physician or Allowed Practitioner** -signed Plans of Care shall include nursing or therapy assessments, current clinical summaries and updates for the **ClientMember**. The Plan of Care shall be on the CMS-485 ~~form, or a form that is identical in content to the CMS-485. Plan of Care, or a form that is of similar format to the CMS-485.~~ All sections of the form shall be completed. All therapy services provided shall be included in the Plan of Care, which shall list the specific procedures and modalities to be used and the amount, duration and frequency.
- 4. Provider records shall document the nature and extent of the care actually provided.
- 5. Unannounced site visits may be conducted in accordance with Section 25.5-4-301(14)(b) C.R.S.
- 6. Home Health Services which are duplicative of any other services that the **ClientMember** has received funded by another source or that the **ClientMember** received funds to purchase shall not be reimbursed.
- 7. Services which total more than ~~twenty-four~~ **24** hours per day of care, regardless of funding source shall not be reimbursed.
- 8. Billing for visits or contiguous units which are longer than the length of time required to perform all the tasks prescribed on the care plan shall not be reimbursed.
- 9. Home Health Agencies shall not bill **ClientMembers** or families of **ClientMember** for any services for which Medicaid reimbursement is recovered due to administrative, civil or criminal actions by the state or federal government.

## **8.520.11 Denial, Termination, or Reduction in Services [by the Home Health Agency](#)**

- 8.520.11.A. When services are denied, terminated, or reduced by action of the Home Health Agency, the Home Health Agency shall notify the **ClientMember**.

8.520.11.B. Termination of services to ClientMembers still medically eligible for Coverage of Medicaid Home Health Services:

1. When a Home Health Agency decides to terminate services to a clientMember who needs and wants continued Home Health Services, and who remains eligible for coverage of services under the Medicaid Home Health rules, the Home Health Agency shall give the clientMember, or the clientMember's designated representative/legal guardian, written advance notice of at least 30 business days. The Ordering Practitioner Physician or Allowed Practitioner and the Department's Home Health Policy Specialist shall also be notified.
2. Written notice to the ClientMember, or ClientMember's designated representative/legal guardian shall be provided in person or by certified mail and shall be considered given when it is documented that the recipient has received the notice. The notice shall provide the reason for the change in services
3. The agency shall make a good faith effort to assist the ClientMember in securing the services of another agency.
4. If there is indication that ongoing services from another source cannot be arranged by the end of the advance notice period, the terminating agency shall ensure ClientMember safety by making referrals to appropriate case management agencies or County Departments of Social Services; and the attending physician-Physician or Allowed Practitioner shall be informed.
5. Exceptions will be made to the requirement for 30 days advance notice when the provider has documented that there is immediate danger to the ClientMember, Home Health Agency, staff, or when the ClientMember has begun to receive Home Health Services through a Medicaid HMO.

## **DO NOT PUBLISH THIS PAGE**

Title of Rule: Revision to the Special Financing Division Rules concerning Changes  
per HB 24-1399, Sections 8.900 & 8.3000  
Rule Number: MSB 25-01-09-B  
Division / Contact / Phone: Special Financing / Taryn Graf / 5634

## **SECRETARY OF STATE**

### **RULES ACTION SUMMARY AND FILING INSTRUCTIONS**

#### **SUMMARY OF ACTION ON RULE(S)**

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 25-01-09-B, Revision to the Special Financing Division Rules concerning Changes per HB 24-1399, Sections 8.900 & 8.3000
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):  
Sections(s) 8.900, 8.920, 8.950, 8.3000, 8.3001, 8.3003.A., 8.3003.B, and 8.3004.D, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No  
If yes, state effective date:  
Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

#### **PUBLICATION INSTRUCTIONS\***

Delete the text beginning at 8.900 through the end of 8.900 Appendix A. Replace the current text at 8.921 with the proposed text beginning at 8.921.C through the end of 8.950.5.B. Replace the current text at 8.3000 with the proposed text beginning at 8.3000 through the end of 8.3004.D.3.a. This rule is effective June 30, 2025.

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### STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

During the 2024 session, the Colorado General Assembly passed House Bill 24-1399 which made changes to the Colorado Indigent Care Program, Hospital Discounted Care, the Primary Care Fund, and the Disproportionate Share Hospital payments under the Colorado Healthcare Affordability and Sustainability Enterprise. House Bill 24-1399 sunsets the Colorado Indigent Care Program, adds a Hospital Discounted Care advisory committee, updates the Primary Care Fund to allow patients who are at or below 200% of the federal poverty guidelines instead of those below 200%, and replaces participation in the Colorado Indigent Care Program as a qualifier for the Disproportionate Share Hospital payments with new qualifying requirements.

This rule change is being brought as one update instead of four separate rule updates as there is a constant between all four sections: to remove all references to the Colorado Indigent Care Program that are currently contained in the four different rule sections.

2. An emergency rule-making is imperatively necessary

☐ to comply with state or federal law or federal regulation and/or  
☐ for the preservation of public health, safety and welfare.

Explain: N/A

3. Federal authority for the Rule, if any:

42 CFR 433.68 and 42 U.S.C. § 1396b(w)

4. State Authority for the Rule:

Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2024);  
Sections 25.5-3-101 through 25.5-3-111, C.R.S. (2024);  
Sections 25.5-3-301 through 25.5-3-304, C.R.S. (2024);  
Sections 25.5-3-501 through 25.5-3-507, C.R.S. (2024);  
Sections 25.5-4-402.4(4)(b),(g), C.R.S.(2024).

Initial Review  
Proposed Effective Date

**04/11/25**  
**06/30/25**

Final Adoption  
Emergency Adoption

**05/09/25**

**DOCUMENT #**



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per HB 24-1399, Sections 8.900 & 8.3000

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### **REGULATORY ANALYSIS**

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

Patients and hospital providers will benefit from the sunset of the Colorado Indigent Care Program in that there will be less confusion for patients and less administrative burden for hospitals with only Hospital Discounted Care remaining. Having the Colorado Indigent Care Program available at only participating hospitals added confusion for patients, whereas the Hospital Discounted Care law must be followed by all general acute and critical access hospitals. Patients may bear some costs from the sunset of the Colorado Indigent Care Program, as it is unknown how many hospitals will replace the program with a similar sliding fee scale or apply a more generous discount than required under Hospital Discounted Care.

Hospitals, clinics, consumer advocates, and patients will benefit from the creation of the Hospital Discounted Care Advisory Committee, as it will continue the ability for stakeholders to have a direct advisory role in the operation, policy, and rule changes for Hospital Discounted Care as the Colorado Indigent Care Program Advisory Council ends with the program.

The Primary Care Fund is a grant program that awards clinics for comprehensive primary care services provided to the uninsured population. Changing the federal poverty guideline from up to 200% to at or below 200% means providers will be able to count services provided to a larger population for the Primary Care Fund.

The Colorado Indigent Care Program is being repealed from rules. No classes of persons will be affected by removing the language from the Primary Care Fund rules.

Hospitals who have participated in the Colorado Indigent Care Program have qualified for Disproportionate Share Hospital (DSH) payments. Hospitals will benefit by being able to continue to receive DSH funds if their charity care programs mirror or continue to be at least as favorable as the Colorado Indigent Care Program. Lower income, uninsured Coloradans will benefit from being able to access discounted care at hospitals similar to how they have under the Colorado Indigent Care Program historically. These patients will also benefit from the prohibition of

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hospital collection actions for care provided under the hospitals' charity care programs.

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

Hospital providers who currently participate in the Colorado Indigent Care Program will have reduced administrative burden by not having to abide by the rules of both the program and Hospital Discounted Care, which includes varying policies on patient eligibility and billing. Patients will have reduced confusion on when and where the Colorado Indigent Care Program applies or when services fall only under Hospital Discounted Care. Patients may have slightly higher costs at hospitals who do not replace the Colorado Indigent Care Program with a similar or more generous sliding scale or write off policy but will continue to benefit from the protections provided by Hospital Discounted Care related to maximum billed amounts, payment plan limits, and collection action restrictions.

Hospitals, clinics, consumer advocates, and patients will continue to have the ability to have a direct advisory role in the operation, policy, and rule changes for Hospital Discounted Care as they did through the Colorado Indigent Care Program Advisory Council, which will end with the program.

Changing the Primary Care Fund rule to allow clinics to count patients who are at or below 200% of the federal poverty guidelines will allow providers to include the additional patients on their application thus increasing their patient count and ultimately their grant award.

The Colorado Indigent Care Program is being repealed from rules. Removing the language from the Primary Care Fund rules has no economic impact.

Hospitals will benefit by being able to continue to receive DSH funds if their charity care programs mirror or continue to be at least as favorable as the Colorado Indigent Care Program. Lower income, uninsured Coloradans will benefit from being able to access discounted care at hospitals similar to how they have under the Colorado Indigent Care Program historically. These patients will also benefit from the prohibition of hospital collection actions for care provided under the hospitals' charity care programs.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

There is no fiscal impact to the Department of Health Care Policy and Financing with this rule change. Funds for administering these requirements were appropriated by

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the General Assembly to the Department and funding for hospitals will continue in accordance with rule 8.3000.

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

The Department must implement these rules in accordance with the adoption of House Bill 24-1399 and there are no increased costs for the Department, hospitals, or Coloradans due to these rules. There are no benefits to inaction. These rules will sunset the Colorado Indigent Care Program, which will benefit participating hospitals in that they will no longer have to abide by the differing policies in patient eligibility and billing between the program and Hospital Discounted Care. Patients will benefit from the end of the program in that it will reduce the confusion between when the Colorado Indigent Care Program or Hospital Discounted Care applies to their hospital services, but may not benefit in terms of how much their services may cost if the hospital does not replace the Colorado Indigent Care Program with a similar or more generous sliding fee scale or write off policy.

Hospitals, clinics, consumer advocates, and patients will benefit from the creation of the Hospital Discounted Care Advisory Committee, as it will continue the ability for stakeholders to have a direct advisory role in the operation, policy, and rule changes for Hospital Discounted Care. These groups of stakeholders had similar advisory ability through the Colorado Indigent Care Program Advisory Council, which will end with the program.

HB 05-1262 declares the Primary Care Fund to be funded by nineteen percent of tobacco tax revenue and awarded based on the number of uninsured or medically indigent patients served by the provider in proportion to the total number of uninsured or medically indigent patients served by all eligible qualified providers in the previous calendar year. Therefore, the allocation of money will remain the same even with the revision of the rule at no extra cost or burden on state revenues.

Hospitals will benefit by being able to continue to receive DSH funds if their charity care programs mirror or continue to be at least as favorable as the Colorado Indigent Care Program. Lower income, uninsured Coloradans will benefit from being able to access discounted care at hospitals like they have under the Colorado Indigent Care Program historically. These patients will also benefit from the prohibition of hospital collection actions for care provided under the hospitals' charity care programs.

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

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There are no less costly methods to achieve the purpose of the proposed rule. The Department of Health Care Policy and Financing must comply with the provisions of House Bill 24-1399 and has been appropriated funds to do so.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

No other alternative methods were considered as these changes are required by House Bill 24-1399.

## **8.900 ~~[Repealed effective 7/1/2025]COLORADO INDIGENT CARE PROGRAM (CICP)~~**

### **~~PROGRAM OVERVIEW AND LEGAL BASIS~~**

~~The Colorado Indigent Care Program (CICP) is a program that distributes federal and State funds to partially compensate Qualified Health Care Providers for uncompensated costs associated with services rendered to uninsured or underinsured patients. Qualified Health Care Providers who receive this funding render discounted health care services to Colorado residents and migrant workers with limited financial resources who are uninsured or underinsured and not eligible for benefits under the Medicaid Program or the Children's Basic Health Plan.~~

~~The Colorado Department of Health Care Policy and Financing (Department) administers the CICP by distributing funding to Qualified Health Care Providers who serve eligible persons. The CICP issues procedures to ensure the funding is used to serve the uninsured and underinsured population in a uniform method. Any significant departure from these procedures will result in termination of the approval of, and the funding to, a health care provider. The CICP is authorized by state law at Title 25.5, Article 3, Part 1.~~

~~The CICP does not offer a specified discounted medical benefit package or an entitlement to medical benefits or funding to individuals or medical providers. The CICP does not offer a health coverage plan as defined in section 10-16-102(34), C.R.S. Eligible persons receiving discounted health care services from Qualified Health Care Providers are subject to the limitations and requirements imposed by Title 25.5, Article 3, Part 1, C.R.S.~~

### **~~8.901 DEFINITIONS~~**

- ~~A. Applicant means an individual who has applied at a Qualified Health Care Provider to receive discounted health care services.~~
- ~~B. Children's Basic Health Plan or the Child Health Plan Plus (CHP+) means the Children's Basic Health Plan as defined in Title 25.5, Article 8, C.R.S.~~
- ~~C. Client means an individual whose application to receive discounted health care services has been approved by a Qualified Health Care Provider.~~
- ~~D. Clinic Provider means any Qualified Health Care Provider that is a community health clinic licensed or certified by the Department of Public Health and Environment pursuant to C.R.S. §25-1.5-103, a federally qualified health center as defined in 42 U.S.C. sec. 1395x (aa)(4), or a rural health clinic, as defined in 42 U.S.C. sec. 1395x (aa)(2).~~
- ~~E. Colorado Indigent Care Program or CICP or Program means the Colorado Indigent Care Program as authorized by state law at Title 25.5, Article 3, Part 1, C.R.S.~~
- ~~F. Denver Metropolitan Area means the Denver-Aurora-Lakewood, CO metropolitan area as defined by the Bureau of Labor Statistics.~~
- ~~G. Department means the Department of Health Care Policy and Financing established pursuant to section 25.5-1-104, C.R.S.~~
- ~~H. Doubled-up means a person who has no permanent housing of their own and who is temporarily living with a person who has no legal obligation to financially support them.~~

- ~~I. Emergency Care means treatment for conditions of an acute, severe nature which are life, limb, or disability threats requiring immediate attention, where any delay in treatment would, in the judgment of the responsible physician, threaten life or loss of function of a patient or viable fetus.~~
- ~~J. General Provider means a general hospital, birth center, or community health clinic licensed or certified by the Department of Public Health and Environment pursuant to Section 25-1.5-103(1)(a)(I) or (1)(a)(II), C.R.S., a federally qualified health center, as defined in 42 U.S.C. sec. 1395x(aa)(4), a rural health clinic, as defined in 42 U.S.C. sec. 1395x(aa)(2), a health maintenance organization issued a certificate authority pursuant to Section 10-16-402, C.R.S., and the University of Colorado Health Sciences Center when acting pursuant to Section 25.5-3-108(5)(a)(I) or (5)(a)(II)(A), C.R.S. For the purposes of the Program, General Provider includes associated physicians.~~
- ~~K. Homeless means a person who lacks a fixed, regular, and adequate night-time residence, or is in a doubled-up situation, or is in imminent danger of losing their primary night-time residence, and who lacks resources or support networks to remain in housing, or has a primary night-time residency that is: (A) a supervised publicly or privately operated shelter designed to provide temporary living accommodations, (B) an institution that provides a temporary residence for individuals intended to be institutionalized, or (C) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings. This does not include an individual imprisoned or otherwise detained pursuant to federal or state law.~~
- ~~L. Hospital Discounted Care means Health Care Billing for Indigent Patients as defined in Title 25.5, Article 3, Part 5, C.R.S.~~
- ~~M. Hospital Provider means any Qualified Health Care Provider that is a general hospital licensed or certified by the Department of Public Health and Environment pursuant to section 25-1.5-103, C.R.S. and which operates inpatient facilities.~~
- ~~N. Medicaid means the Colorado medical assistance program as defined in Title 25.5, Article 4, C.R.S.~~
- ~~O. Qualified Health Care Provider means any General Provider who is approved by the Department to provide, and receive funding for, discounted health care services under the CIGP.~~
- ~~P. Transitional housing means housing designed to provide homeless individuals and families with the interim stability and support to successfully move to and maintain permanent housing.~~
- ~~Q. Uniform Application means the application for discounted care created pursuant to Section 8.922.~~
- ~~R. Urgent Care means treatment needed because of an injury or serious illness that requires treatment within 48 hours.~~

#### ~~8.902 PROVISIONS APPLICABLE TO QUALIFIED HEALTH CARE PROVIDERS~~

##### ~~A. Requirements for Qualified Health Care Providers~~

- ~~1. Agreements will be made annually between the Department and Qualified Health Care Providers through an application process.~~

2. ~~Agreements may be executed with Hospital Providers throughout Colorado that meet the following requirements:~~
  - a. ~~Licensed or certified as a general hospital or birth center by the Department of Public Health and Environment.~~
  - b. ~~Hospital Providers shall provide Emergency Care to all Clients throughout the Program year at discounted rates.~~
  - c. ~~Hospital Providers shall have at least two obstetricians with staff privileges at the Hospital Provider who agree to provide obstetric services to individuals under Medicaid. In the case where a Hospital Provider is located in a rural area (that is, an area outside of a metropolitan statistical area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the Hospital Provider to perform non-emergency obstetric procedures.~~

~~This requirement does not apply to a Hospital Provider in which the inpatients are predominantly under 18 years of age or which does not offer non-emergency obstetric services as of December 21, 1987.~~

- d. ~~Using the information submitted by an Applicant and the Uniform Application developed and distributed by the Department, the Qualified Health Care Provider shall determine whether the Applicant meets all requirements to receive discounted health care services under the Program. Eligibility shall be determined at the time of application, unless required documentation is not available, in which case the Applicant will be notified of the missing documentation within three business days. An eligibility determination shall be made within 14 calendar days of receipt of the missing documents. Hospital Providers shall determine Client financial eligibility using the following information:~~
  - I. ~~Income from each Applicant age 18 and older;~~
  - II. ~~Household size, where all non-spouse or civil union partner, non-student adults ages 18 to 64 included on the application must have financial support demonstrated or attested to.~~
    - i. ~~An applicant must include their spouse or civil union partner in their household for purposes of the application.~~
    - ii. ~~Any additional person living at the same address as the applicant may also be included in the household.~~
    - iii. ~~An applicant may include household members who live in other states or countries if the applicant attests that they provide at least 50% of the household member's support.~~
- e. ~~Hospital Providers shall use the Sliding Fee Scale developed by the Department or submit for Department approval with their annual application a Sliding Fee Scale that shows copayments for different service categories divided into at least three income tiers covering 0 to 250% of the federal poverty guideline. Copayments shall be expressed in dollar amounts and shall not exceed the copayments in the Standard Client Copayment Table found in Appendix A. Hospital Providers shall inform Applicants and Clients of their copayment responsibilities at the time their application is approved.~~
- f. ~~Hospital Providers shall submit Program utilization and charge data in a format and timeline determined by the Department.~~

- ~~3. Agreements may be executed with Clinic Providers throughout Colorado that meet the following minimum criteria:~~
  - ~~a. Licensed or certified as a community health clinic by the Department of Public Health and Environment or certified by the U.S. Department of Health and Human Services as a federally-qualified health center or rural health clinic.~~
  - ~~b. Using the information submitted by an Applicant, the provider shall use the application developed and distributed by the Department to determine whether the Applicant meets all requirements to receive discounted health care services under the Program. Clinic Providers may develop their own application and submit it to the Department for approval. Eligibility shall be determined at the time of application, unless required documentation is not available, in which case the Applicant will be notified of the missing documentation within three business days. An eligibility determination shall be made within 14 calendar days of receipt of the missing documents. Clinic Providers who are federally-qualified health centers shall determine Client financial eligibility as required under federal regulations and guidelines. Clinic Providers who are not federally-qualified health centers shall determine Client financial eligibility using the following information:~~
    - ~~I. Income from each Applicant age 18 and older, and~~
    - ~~II. Household size.~~
  - ~~c. Clinic Providers shall submit a Sliding Fee Scale for Department approval with their annual application that shows copayments for different service categories. Copayments for Clients between 0 and 100% of the federal poverty guideline shall be nominal or \$0. Sliding Fee Scales shall have at least three tiers between 101 and 250% of the federal poverty guideline.~~
    - ~~I. Sliding fee scales used by federally-qualified health centers approved by the federal government meet all requirements of the Program.~~
    - ~~II. Copayments for Clients between 101 and 250% of the federal poverty guideline may not be less than the copayments for Clients between 0 and 100% of the federal poverty guideline.~~
    - ~~III. The same sliding fee scale shall be used for all Clients eligible for the Program.~~
    - ~~IV. Sliding fee scales shall be reviewed by the Qualified Health Care Provider on a regular basis to ensure there are no barriers to care.~~
  - ~~d. Clinic Providers shall inform Applicants and Clients of their copayment responsibilities at the time their application is approved.~~
- ~~4. Qualified Health Care Providers shall provide the Applicant and/or representative a written notice in the Applicant's preferred language of the provider's determination as to the Applicant's eligibility to receive discounted services under the Program. If eligibility to receive discounted health care services is granted by the Qualified Health Care Provider, the notice shall include the dates of eligibility and the Applicant's copay responsibilities. If eligibility to receive discounted health care services is denied, the notice shall include a brief, plain language explanation of the reason(s) for the denial. Every notice of the Qualified Health Care Provider's decision, whether an approval or a denial, shall include an explanation of the Applicant's appeal rights found at Section 8.902.B in these regulations.~~
- ~~5. Qualified Health Care Providers shall screen all Applicants for eligibility for Medicaid and the Children's Basic Health Plan and refer Applicants to those programs if they appear~~



~~eligible. The Qualified Health Care Provider shall refer Applicants to Colorado's health insurance marketplace for information about private health insurance.~~

- ~~6. Qualified Health Care Providers shall not discriminate against Applicants or Clients based on race, color, ethnic or national origin, ancestry, age, sex, gender, sexual orientation, gender identity and expression, religion, creed, political beliefs, or disability.~~

~~B. Client Appeals~~

- ~~1. If an Applicant or Client feels that a financial determination or denial is in error, he or she shall only challenge the financial determination or denial by filing an appeal with the Qualified Health Care Provider who determined eligibility to receive discounted health care services under the CIGP pursuant to this Section 8.902. There is no appeal process available through the Office of Administrative Courts.~~

~~2. Instructions for Filing an Appeal~~

~~The Qualified Health Care Provider shall inform the Applicant or Client that he or she has the right to appeal the financial determination or denial if he or she is not satisfied with the Qualified Health Care Provider's decision.~~

~~An Applicant or Client who wishes to appeal a denial must:~~

- ~~a. Submit a letter requesting appeal within 30 calendar days of the date of the denial notice. Appeals submitted after the deadline may be denied for being submitted untimely;~~

- ~~b. Enclose any supporting documentation;~~

~~If no denial notice is received earlier, an appeal letter may be submitted within 45 calendar days of the date the application was completed. The deadline for an appeal letter may be extended for good cause.~~

~~3. Appeals~~

- ~~a. An Applicant or Client may file an appeal if he or she wishes to challenge the accuracy of his or her initial financial determination.~~

- ~~b. Each Qualified Health Care Provider must designate a manager to review appeals and supporting documentation.~~

- ~~c. If the initial financial determination is found to be inaccurate, the financial determination will be corrected, with eligibility effective retroactive to the initial effective date of application.~~

- ~~d. A decision shall be issued to the Applicant or Client and the Department in writing within 15 calendar days following receipt of the appeal request.~~

~~4. Provider Management Exception~~

- ~~a. An Applicant or Client may request a provider management exception simultaneously with an appeal, or within 15 calendar days of the date of the Qualified Health Care Provider's decision regarding an appeal.~~

- ~~b. A provider management exception may be granted at the Qualified Health Care Provider's discretion if the Applicant or Client can demonstrate that there are circumstances that should be taken into consideration when establishing the household financial status.~~
- ~~c. Each Qualified Health Care Provider must designate a manager to review provider management exceptions and supporting documents.~~
- ~~i. The facility shall notify the Client in writing of the Qualified Health Care Provider's findings within 15 calendar days of receipt of the Client's written request.~~
- ~~ii. The Qualified Health Care Provider must note provider management exceptions on the application.~~
- ~~d. A financial determination from a provider management exception is effective as of the initial effective date of application.~~
- ~~e. Qualified Health Care Providers are not required to honor provider management exceptions granted by other Qualified Health Care Providers.~~

### ~~C. Financial Eligibility~~

~~General Rule: An Applicant shall be financially eligible for discounted health care services under the CICP if their household income is no more than 250% of the current federal poverty guidelines for a household of that size.~~

- ~~1. Qualified Health Care Providers determine eligibility for the CICP and shall maintain auditable files of applications for discounted health care services under the CICP until June 30 of the seventh state fiscal year following the eligibility determination.~~
- ~~2. The determination of financial eligibility process looks at the financial circumstances of a household as of the date that an application is started.~~
- ~~3. All Qualified Health Care Providers must accept each other's CICP financial determinations unless the Qualified Health Care Provider believes that the financial determination was determined incorrectly, the Qualified Health Care Provider's financial determination process is materially different from the process used by the issuing Qualified Health Care Provider, or that the financial determination was a result of a provider management exception.~~
- ~~4. CICP eligibility is retroactive for services received from a Qualified Health Care Provider up to 181 days prior to application.~~
- ~~5. Documentation concerning the Applicant's financial status shall be maintained by the provider until June 30 of the seventh state fiscal year following the eligibility determination.~~
- ~~6. Beyond the distribution of available funds made by the CICP, allowable Client copayments, and other third-party sources, a provider shall not seek payment from a Client for the provider's CICP discounted health care services to the Client.~~
- ~~7. Emergency Application for Providers~~
  - ~~a. In emergency circumstances, an Applicant may be unable to provide all of the information or documentation required by the usual application process. For emergency situations, the Qualified Health Care Provider shall follow these steps in processing the application:~~

~~I. Use the regular application to receive discounted health care services under the CICP but indicate emergency application on the application.~~

~~II. Ask the Applicant to give spoken answers to all questions and apply the federal poverty guideline based on the spoken information provided. If the Applicant appears eligible for Medicaid or CHP+, the Applicant will need to apply for the applicable program prior to being placed on CICP.~~

~~III. Ask the Applicant to sign the application indicating their understanding of their eligibility determination in relationship to the federal poverty guideline made using their spoken information.~~

~~b. An emergency application is good for only one episode of service in an emergency room and any subsequent service related to the emergency room episode. If the Client receives any care other than the emergency room visit, the Hospital Provider must request the Client to submit documentation to support all figures on the emergency application or complete a new application. If the documentation submitted by the Client does not support the earlier, spoken information, the Hospital Provider must obtain a new application from the Client. If the Client does not submit any supporting documentation or complete a new application upon the request of the provider, the provider shall use the information contained in the emergency application.~~

#### ~~D. Audit Requirements~~

~~The Department will conduct audits of Qualified Health Care Providers. Qualified Health Care Providers shall comply with requests for data and other information from the Department. Qualified Health Care Providers shall complete corrective actions when required by the Department. The Department's intention is to audit one third of the participating Qualified Health Care Providers each year. After any Qualified Health Care Provider discontinues participation in the program, the provider must maintain compliance with audit requirements for the records created during the period during which the Qualified Health Care Provider was participating.~~

#### ~~E. HIPAA~~

~~The CICP does not meet the definition of a covered entity or business associate under the Health Insurance Portability and Accountability Act of 1996 at 45 C.F.R. sec. 160.103. The CICP is not a part of the Colorado Medical Assistance Program, nor of Health First Colorado, Colorado's Medicaid program. CICP's principal activity is the making of grants to providers who serve eligible persons who are uninsured or underinsured. The state personnel administering the CICP will provide oversight in the form of procedures and conditions to ensure funds provided are being used to serve the target population, but they will not be significantly involved in any health care decisions or disputes involving a Qualified Health Care Provider or Client.~~

### ~~8.903 DISCOUNTED HEALTH CARE SERVICES~~

~~A. Funding provided under the CICP shall be used to provide Clients with discounted health care services determined to be medically necessary by the Qualified Health Care Provider.~~

~~B. All health care services normally provided at the Qualified Health Care Provider should be available at a discount to Clients. If health care services normally provided at the Qualified Health Care Provider are not available to Clients at a discount, Clients must be informed that the services can be offered without a discount prior to the rendering of such services. Service availability is to be applied uniformly for all Clients.~~

~~C. Qualified Health Care Providers receiving funding under the CICP shall prioritize the use of funding such that discounted health care services are available in the following order:~~

- ~~1. Emergency Care;~~
- ~~2. Urgent Care; and~~
- ~~3. Any other medical care.~~

~~D. Additional discounted health care services may include:~~

- ~~1. Emergency mental health services if the Qualified Health Care Provider renders these services to a Client at the same time that the Client receives other medically necessary services.~~
- ~~2. Qualified Health Care Providers may provide discounted pharmaceutical services. The Qualified Health Care Provider should only provide discounted prescriptions that are written by doctors on its staff, or by a doctor that is under contract with the Qualified Health Care Provider. Qualified Health Care Providers shall exclude prescription drugs included in the definition of Medicare Part-D from eligible Clients who are also eligible for Medicare.~~
- ~~3. Qualified Health Care Providers may provide packages of services to patients with modified copayment requirements.~~
  - ~~a. Packages of services benefit Clients who need to utilize services more often than average Clients. Things that would be beneficial to the client include but are not limited to charging a lower copay, charging the copay on an alternative schedule (i.e. once a week, or ever other time), or setting a cap on the amount or number of copayments made towards the packaged services. Examples of packages may include but are not limited to oncology treatments, physical therapy, and dialysis.~~
  - ~~b. Qualified Health Care Providers may provide a prenatal benefit with a predetermined copayment designed to encourage access to prenatal care for uninsured or underinsured women. This prenatal benefit shall not cover the delivery or the hospital stay, or visits that are not related to the pregnancy. The Qualified Health Care Provider is responsible for providing a description of the services included in the prenatal benefit to the Client prior to services rendered. Services and copayments may vary among sites.~~

~~E. Excluded Discounted Health Care Services~~

~~Funding provided under the CICP shall not be used for providing discounted health care services for the following:~~

- ~~1. Non-urgent dental services.~~
- ~~2. Nursing home care.~~
- ~~3. Chiropractic services.~~
- ~~4. Cosmetic surgery.~~
- ~~5. Experimental and non-United States Federal Drug Administration approved treatments.~~
- ~~6. Elective surgeries that are not medically necessary.~~

- ~~7. Court ordered procedures, such as drug testing.~~
- ~~8. Abortions Except as specified in section 25.5-3-106, C.R.S.~~
- ~~9. Mental health services in clinic settings pursuant to section 25.5-3-110, C.R.S., Title 27, Article 66, Part 1, any provisions of Title 23, Article 22, C.R.S., or any other provisions of law relating to the University of Colorado Psychiatric Hospital.~~

#### ~~8.904 PROVISIONS APPLICABLE TO CLIENTS~~

##### ~~A. Overview of Requirements~~

~~In order to qualify to receive discounted health care services under available CICP funds, an Applicant shall satisfy the following requirements:~~

- ~~1. Be a resident of Colorado; and~~
- ~~2. Meet all CICP eligibility requirements as defined in Section 8.902.C, 25.5-3-104, C.R.S., and this Section 8.904.~~

##### ~~B. Applicants~~

- ~~1. Any adult age 18 and older may apply to receive discounted health care services on behalf of themselves and members of the Applicant's family household.~~
- ~~2. If an Applicant is deceased, the personal representative of the estate or a family member may complete the application on behalf of the Applicant. The family member completing the application will not be responsible for any copayments incurred on behalf of the deceased member.~~
- ~~3. The application to receive discounted health care services under available CICP funding shall include the names of all members of the Applicant's family household. All non-spouse or civil union partner, non-student adults ages 18-64 must have financial support demonstrated or attested to in order to be included in household size. All minors and those 65 or older do not need documentation of financial support to be counted in household size. Income from spouses or civil union partners and all non-student adults must be included in the application.~~
- ~~4. A minor shall not be rated separately from his or her parents or guardians unless he or she is emancipated or there exists a special circumstance. A minor is an individual under the age of 18.~~

##### ~~C. Signing the Application~~

~~The Applicant or an authorized representative of the Applicant must sign the application to receive discounted health care services submitted to the Qualified Health Care Provider within 181 calendar days of the date of health care services. If an Applicant is unable to sign the application or has died, a spouse, civil union partner, relative, or guardian may sign the application. Until it is signed, the application is not complete, the Applicant cannot receive discounted health care services under the CICP, and the Applicant has no appeal rights. All information needed by the provider to process the application must be submitted before the application is signed.~~

##### ~~D. Residence in Colorado~~

~~An Applicant must be a resident of Colorado. A Colorado resident is a person who currently lives in Colorado and intends to remain in the state.~~

~~Migrant workers and all dependent family members must meet all of the following criteria to comply with residency requirements:~~

- ~~1. Maintains a temporary home in Colorado for employment reasons; and~~
- ~~2. Employed in Colorado.~~

~~E. Applicants Not Eligible~~

- ~~1. The following individuals are not eligible to receive discounted services under the CACP:~~
  - ~~a. Individuals who are being held or confined involuntarily under governmental control in State or federal prisons, jails, detention facilities or other penal facilities. This includes those individuals residing in detention centers awaiting trial, at a wilderness camp, residing in half-way houses who do not have freedom of movement and association, and those persons in the custody of a law enforcement agency temporarily released for the sole purpose of receiving health care.~~
  - ~~b. College students whose residence is from outside Colorado or the United States that are in Colorado for the purpose of higher education. These students are not Colorado residents and cannot receive services under the CACP.~~
  - ~~c. Visitors from other states or countries temporarily visiting Colorado and have primary residences outside of Colorado.~~
  - ~~d. Persons who qualify for Medicaid. However, Applicants whose only Medicaid benefits are the following shall not be excluded from consideration for CACP eligibility:~~
    - ~~I. QMB benefits described at Section 8.100.6.L of these regulations;~~
    - ~~II. SLMB benefits described at Section 8.100.6.M, or~~
    - ~~III. The Q11 benefits described at Section 8.100.6.N.~~
  - ~~e. Individuals who are eligible for the Children's Basic Health Plan.~~
- ~~F. Health Insurance Information~~

~~The Applicant shall submit all necessary information related to health insurance, including a copy of the insurance policy or insurance card, the address where the medical claim forms must be submitted, policy number, and any other information determined necessary.~~

~~G. Subsequent Insurance Payments~~

~~If a Client receives discounted health care services under the CACP, and their insurance subsequently pays for services, or if the Client is awarded a settlement, the insurance company or patient shall reimburse the Qualified Health Care Provider for discounted health care services rendered to the Client.~~

~~8.905 DEPARTMENT RESPONSIBILITIES~~

~~A. Provider Application~~

- ~~1. The Department shall produce and publish a provider application annually using updated Program information and incorporating any necessary changes.~~
- ~~2. The Department shall determine Qualified Health Care Providers annually through the application process.~~
- ~~3. An agreement will be executed between the Department and Denver Health for the purpose of providing discounted health care services to the residents of the City and County of Denver, as required by Section 25.5-3-108(5)(a)(I), C.R.S.~~
- ~~4. An agreement will be executed between the Department and University Hospital for the purpose of providing discounted health care services in the Denver Metropolitan Area and complex care that is not contracted for in the remaining areas of the state, as required by Section 25.5-3-108(5)(a)(II), C.R.S.~~
- ~~5. The Department shall produce and publish a provider directory annually.~~

~~B. Payments to Providers~~

- ~~1. Funding for hospitals shall be distributed in accordance with Sections 8.300 and 8.905.B.2.~~
- ~~2. Pediatric Major Teaching Hospital Payment. Hospital Providers shall qualify for additional payment when they meet the criteria for being a major teaching hospital provider and when their Medicaid-eligible inpatient days combined with CICP care days (days of care provided under the CICP) equal or exceed 30 percent of their total inpatient days for the most recent year for which data are available. A major teaching hospital provider is defined as a Colorado hospital, which meets the following criteria:~~
  - ~~a. Maintains a minimum of 110 total Intern and Resident (I/R) F.T.E.s;~~
  - ~~b. Maintains a minimum ratio of .30 Intern and Resident (I/R) F.T.E.s per licensed bed;~~
  - ~~c. Qualifies as a Pediatric Specialty Hospital under the Medicaid Program, such that the hospital provides care exclusively to pediatric populations;~~
  - ~~d. Has a percentage of Medicaid-eligible inpatient days relative to total inpatient days that equal or exceeds one standard deviation above the mean; and~~
  - ~~e. Participates in the CICP.~~

~~The Major Teaching Hospital Rate is set by the Department such that the payment will not exceed the appropriation set by the General Assembly.~~

~~C. Provider Appeals~~

- ~~1. Any provider who submits an application to become a Qualified Health Care Provider whose application is denied may appeal the denial to the Department.~~
- ~~2. The provider's first level appeal must be filed within five business days of the receipt of the denial letter. The Department's Special Financing Division Director will respond to any first level appeals within ten business days of receipt of the appeal.~~
- ~~3. If a provider disagrees with the Department's Special Financing Division Director's first level appeal determination, they may file a second level appeal within five business days of the receipt of the first level appeal determination. The Department's Executive Director~~

~~will respond to the second level appeal within ten business days of the receipt of the second level appeal.~~

~~D. Advisory Council~~

~~The Department shall create a CICP Stakeholder Advisory Council, effective July 1, 2017. The Executive Director of the Department shall appoint 11 members to the CICP Stakeholder Advisory Council. Members shall include:~~

- ~~1. A member representing the Department;~~
- ~~2. Three consumers who are eligible for the Program or three representatives from a consumer advocate organization or a combination of each;~~
- ~~3. A representative from a federally qualified health center as defined at 42 U.S.C. sec. 1395x (aa)(4);~~
- ~~4. A representative from a rural health clinic as defined at 42 U.S.C. sec. 1395x (aa)(2), or a representative from a clinic licensed or certified as a community health clinic by the Department of Public Health and Environment, or a representative from an organization that represents clinics who are not federally qualified health centers;~~
- ~~5. A representative from either Denver Health or University Hospital;~~
- ~~6. A representative from an urban hospital;~~
- ~~7. A representative from a rural or critical access hospital;~~
- ~~8. A representative of an organization of Colorado community health centers, as defined in the federal "Public Health Service Act", 42 U.S.C. sec. 254b;~~
- ~~9. A representative from an organization of Colorado hospitals.~~

~~Members shall serve without compensation or reimbursement of expenses. The Executive Director shall select a chair for the council and the appointment will be valid until the seat is vacated, the Chair steps down, or a new chair is selected by the Executive Director. The Department shall staff the council. The council shall convene at least twice every fiscal year according to a schedule set by the chair. Members of the council shall serve three-year terms. In the event of a vacancy on the advisory council, the executive director shall appoint a successor to fill the unexpired portion of the term of such member.~~

~~The council shall~~

- ~~1. Advise the Department of operation and policies for the Program~~
- ~~2. Make recommendations to the Medical Services Board regarding rules for the Program~~

~~E. Annual Report~~

- ~~1. The Department shall prepare an annual report concerning the status of the Program to be submitted to the Health and Human Services committees of the Senate and House of Representatives, or any successor committees, no later than February 1 of each year.~~
- ~~2. The report shall at minimum include charges for each Hospital Provider, numbers of Clients served, and total payments made to each Hospital Provider..~~



# ~~10 CCR 2505-10 § 8.900 APPENDIX A: STANDARD CACP CLIENT COPAYMENT~~

## ~~A. Client Copayments—General Policies~~

~~A Client is responsible for paying a portion of his or her medical bills. The Client's portion is called the Client Copayment. Qualified Health Care Providers are responsible for charging the Client a copayment. Qualified Health Care Providers may require Clients to pay their copayment prior to receiving care (except for Emergency Care). Qualified Health Care Providers may charge copayments in accordance with the Standard Client Copayment Table or an alternate sliding fee scale that is submitted by the provider with the annual application for the CACP and approved by the Department.~~

Percent of FPL	0—40% and Homeless	0— 40%	41— 62%	63— 81%	82— 100%	101— 117%	118— 133%	134— 159%	160— 185%	186— 200%	201— 250%
Ambulatory Surgery	\$0	\$15	\$65	\$105	\$155	\$220	\$300	\$390	\$535	\$600	\$630
Inpatient Facility	\$0	\$15	\$65	\$105	\$155	\$220	\$300	\$390	\$535	\$600	\$630
Hospital Physician	\$0	\$7	\$35	\$55	\$80	\$110	\$150	\$195	\$270	\$300	\$315
Emergency Room	\$0	\$15	\$25	\$25	\$30	\$30	\$35	\$35	\$45	\$45	\$50
Emergency Transportation	\$0	\$15	\$25	\$25	\$30	\$30	\$35	\$35	\$45	\$45	\$50
Outpatient Hospital Services	\$0	\$7	\$15	\$15	\$20	\$20	\$25	\$25	\$35	\$35	\$40
Clinic Services	\$0	\$7	\$15	\$15	\$20	\$20	\$25	\$25	\$35	\$35	\$40
Specialty Outpatient	\$0	\$15	\$25	\$25	\$30	\$30	\$35	\$35	\$45	\$45	\$50
Prescription	\$0	\$5	\$10	\$10	\$15	\$15	\$20	\$20	\$30	\$30	\$35
Laboratory	\$0	\$5	\$10	\$10	\$15	\$15	\$20	\$20	\$30	\$30	\$35
Basic Radiology & Imaging	\$0	\$5	\$10	\$10	\$15	\$15	\$20	\$20	\$30	\$30	\$35
High-Level Radiology & Imaging	\$0	\$30	\$90	\$130	\$185	\$250	\$335	\$425	\$580	\$645	\$680

~~There are different copayments for different service charges. The following information explains the different types of medical care charges and the related Client Copayments under the Standard Client Copayment Table.~~

- ~~1. Inpatient facility charges are for all non-physician (facility) services received by a Client while receiving care in the hospital setting for a continuous stay of 24 hours or longer.~~
- ~~2. Ambulatory Surgery charges are for all non-physician (facility) Ambulatory Surgery operative procedures received by a Client who is admitted to and discharged from the hospital setting on the same day. The Client is also responsible for the corresponding Hospital Physician charges.~~
- ~~3. Hospital Physician charges are for services provided directly by a physician in the hospital setting, including inpatient, ambulatory surgery, and emergency room care.~~
- ~~4. Clinic Services charges are for all non-physician (facility) and physician services received by a Client while receiving care in the outpatient clinic setting. Outpatient charges include primary and preventive medical care. This charge does not include radiology or laboratory services performed at the clinic.~~
- ~~5. Emergency Room charges are for all non-physician (facility) services received by a Client while receiving Emergency Care or Urgent Care in the hospital setting for a continuous stay less than 24 hours (i.e., emergency room care).~~
- ~~6. Specialty Outpatient charges are for all non-physician (facility) and physician services received by a Client while receiving care in the specialty outpatient setting. These services can be provided in standalone clinics and outpatient hospital settings. Specialty Outpatient charges include distinctive medical care (i.e., oncology, orthopedics, hematology, pulmonary) that is not normally available as primary and preventive medical care. Specialty Outpatient charges do not include radiology, laboratory, emergency room, or ambulatory surgery services provided in a hospital setting.~~
- ~~7. Emergency Transportation charges are for transportation provided by an ambulance.~~
- ~~8. Laboratory Service charges are for all laboratory tests received by a Client while receiving care in the outpatient hospital or clinic setting. Laboratory Service charges may not be charged in addition to charges for emergency room or inpatient services provided in the hospital setting.~~
- ~~9. Basic Radiology and Imaging Service charges are for all radiology and imaging services received by a Client while receiving care in the outpatient hospital or clinic setting. Basic Radiology and Imaging Service charges may not be charged in addition to charges for emergency room or inpatient services provided in the hospital setting.~~
- ~~10. Prescription charges are for prescription drugs received by a Client at a Qualified Health Care Provider's pharmacy as an outpatient service. To encourage the availability of discounted prescription drugs, providers are allowed to modify (increase or decrease) the Prescription Copayment with the written approval of the Department.~~
- ~~11. High-Level Radiology and Imaging Service charges are for Clients receiving a Magnetic Resonance Imaging, Computed Tomography, Positron Emission Tomography or other Nuclear Medicine services, Sleep Studies, or Catheterization Laboratory in the outpatient hospital, emergency room, or clinic setting.~~

- ~~12. Outpatient Hospital Service charges are for all non-physician (facility) and physician services received by a Client while receiving non-Emergency Care or non-Urgent Care in the outpatient clinic setting. Outpatient Hospital Services charges include primary and preventive medical care. This charge does not include radiology, laboratory, emergency room, or ambulatory surgery services provided in a hospital setting.~~
- ~~13. Clients who are seen in the hospital setting in an observation bed should be charged the emergency room copay if their stay is less than 24 hours and the inpatient facility copay if their stay is 24 hours or longer.~~

~~B. Homeless Clients, Clients living in transitional housing, “doubled-up” Clients, or recipients of Colorado’s Aid to the Needy Disabled financial assistance program, who are at or below 40% of the federal poverty guideline are exempt from Client Copayments.~~

- ~~1. Homeless Clients are exempt from Client Copayments, the income verification requirement, and providing proof of residency when completing the CACP application.~~
- ~~2. Transitional housing is designed to assist individuals in becoming self-supporting. Clients living in transitional housing must provide a written statement from their counselor or program director asserting that they are participating in a transitional housing program. Transitional housing Clients are exempt from the income verification requirement when completing the CACP application.~~
- ~~3. Clients who have no permanent housing of their own and who are temporarily living with a person who has no legal obligation to financially support the Client are considered doubled-up. The individual allowing the Client to reside with him or her may be asked to provide a written statement confirming that the Client is not providing financial assistance to the household and that the living arrangement is not intended to be permanent.~~
- ~~4. Recipients of Colorado’s Aid to the Needy Disabled financial assistance program are exempt from Client Copayments, and the income verification requirement when completing the CACP application.~~

~~C. Client Annual Copayment Cap~~

- ~~1. Homeless Clients whose financial determination is between 0 and 40% of the federal poverty guideline are exempt from copayments, so their copayment cap is \$0. Clients whose financial determination is between 0 and 40% of the federal poverty guideline who are not homeless have a copayment cap that is the lesser of 10% of the family’s net income or \$120. Clients who are also Old Age Pension Health and Medical Care Program clients have a copayment cap of \$300 as mandated by Section 8.941.10. For all other CACP Clients, annual copayments shall not exceed 10% of the family’s financial determination.~~
- ~~2. Clients who are also Old Age Pension Health and Medical Care Program clients have annual copayment caps based on a calendar year. All other Client annual copayment caps (annual caps) are based on the Client’s date of eligibility.~~
- ~~3. Clients are responsible for any charges incurred prior to the determination of the Client’s financial eligibility.~~
- ~~4. Clients are responsible for tracking their CACP copayments and informing the provider in writing, including documentation, within 90 days after meeting or exceeding their annual cap. If a Client overpays the annual cap and informs the Qualified Health Care Provider of that fact in writing, the Qualified Health Care Provider shall reimburse the Client for the overpayment.~~

- ~~5. A CICIP Client is eligible to receive a new determination if his or her financial or family situation has changed since the initial financial determination. CICIP copayments made under the prior financial determination will not count toward a new CICIP copayment cap and the Client's annual copayment cap resets when the Client completes a new application.~~
- ~~6. An annual cap applies only to charges incurred after a Client is eligible to receive discounted health care services and applies only to discounted services incurred at a CICIP Qualified Health Care Provider, including services discounted under Hospital Discounted Care.~~
- ~~D. The Client must pay the lower of the copayment listed, the patient responsibility portion if the Client is insured, or actual charges. Payment plans must be offered to Clients and must follow the requirements set forth in Section 8.923 of the Hospital Discounted Care rule.~~
- ~~E. Clients shall be notified at or before time of services rendered of their copayment responsibility and available payment plan option.~~
- ~~F. Grants from foundations to Clients from non-profit, tax exempt, charitable foundations specifically for Client copayments are not considered other medical insurance or income. The provider shall honor these grants and may not count the grant as a resource or income.~~

## **8.920 Hospital Discounted Care**

The Health Care Billing for Indigent Patients Act of 2021, C.R.S. § 25.5-3-501, et. seq., referred to as Hospital Discounted Care, establishes the maximum rate a Health Care Facility and Licensed Health Care Professional may bill low-income patients for Discounted Care provided in the hospital, requires written description of patient's rights, establishes patient appeals and complaint processes, and imposes requirements on hospitals before assigning or selling patient debt to a medical creditor or before pursuing collection action. Senate Bill 24-116 added an increase in payment plan amounts for Health Care Facilities who bill for their own professionals, requires professionals who bill separately from the Health Care Facility to report their own data to the Department, and excludes primary care provided at rural or frontier clinics who have an approved sliding fee scale.

## **8.921 DEFINITIONS**

- A. Billing Statement means any patient-facing communication, whether electronic or in writing, that specifies an amount due for services and instructions for making payment.
- B. Children's Basic Health Plan or the Child Health Plan Plus (CHP+) means the Children's Basic Health Plan as defined in Title 25.5, Article 8, C.R.S.
- ~~C. Colorado Indigent Care Program or CICIP means the safety net program established in Title 25.5, Article 3, Part 1, C.R.S.~~
- ~~D. Department means the Department of Health Care Policy and Financing established pursuant to section 25.5-1-104, C.R.S.~~
- ED. Discounted Care means the amount a Provider may charge a Qualified Patient for Medically Necessary Health Care Services rendered.

- ~~FE~~. Emergency Medicaid means short-term Medicaid coverage for eligible people who do not meet immigration or citizenship requirements for Medicaid and need treatment for life- and/or limb-threatening emergencies.
- ~~GE~~. Emergency Hospital Services means treatment for conditions of an acute, severe nature which are life, limb, or disability threats requiring immediate attention, where any delay in treatment would, in the judgment of the responsible physician, threaten life or loss of function of a patient or viable fetus.
- ~~HG~~. Federal Poverty Guidelines or FPG means a measure of income level issued annually by the United States Department of Health and Human Services. For Hospital Discounted Care, the FPG is updated annually every April 1.
- ~~IH~~. Health Care Facility means a hospital licensed as a general hospital pursuant to Title 25, Article 3, Part 1, C.R.S., a hospital established pursuant to section 23-21-503, C.R.S. or section 25-29-103, C.R.S., any freestanding emergency department licensed pursuant to section 25-1.5-114, C.R.S., or any outpatient health care facility that is licensed as an on-campus department or service of a hospital or that is listed as an off-campus location under a hospital's license. Health Care Facility does not include a federally qualified health center as defined in the federal "Social Security Act", 42 U.S.C. sec. 1395x(aa)(4), or a student-learning medical or dental clinic that is established for the purpose of student learning, offering Discounted Care as part of a program of student learning that is physically situated within a health sciences school, Health Care Facility does not apply to primary care services provided in a clinic located in a designated rural or frontier county that offers a sliding-fee scale equal to the Medicare rural health clinic all inclusive rate payment established in accordance with 42 U.S.C. 1395l (f)(3)(B) or payment rate that is lower than usual and customary charges and considers a patient's household size and income size as approved by the Department.
- ~~IJ~~. Health Care Services has the same meaning as set forth in section 10-16-102(33), C.R.S.
- ~~KJ~~. Impermissible Extraordinary Collection Action means initiating foreclosure on an individual's primary residence or homestead, including a mobile home, as defined in section 38-12-201.5(5), C.R.S.
- ~~LK~~. Inpatient Hospital Service has the same meaning as set forth in 42 C.F.R. § 440.10. 42 C.F.R. § 440.10 (2024) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. This regulation is available for public inspection at the Department of Health Care Policy and Financing, 303 E. 17th Ave, Denver, CO 80203. Pursuant to C.R.S § 24-4-410(12.5)(V)(b), the Department shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule.
- ~~ML~~. Licensed Health Care Professional or Professional means any health care professional who is registered, certified, or licensed pursuant to Title 12, C.R.S. or who provides services under the supervision of a health care professional who is registered, certified, or licensed pursuant to Title 12, C.R.S. and who provides Health Care Services in a Health Care Facility.
- ~~NM~~. Medicaid means the Colorado Medical Assistance Act set forth in Title 25.5, Articles 4, 5, and 6, C.R.S.
- ~~ON~~. Medical Creditor means any entity that attempts to collect on a medical debt, including a Provider or Provider's billing office, a collection agency as defined in section 5-16-103(3), a debt buyer as

defined in section 5-16-103(8.5), C.R.S. and a debt collector as defined in 15 U.S.C. sec. 1692a(6).

**PO.** Outpatient Hospital Service has the same meaning as set forth in 42 C.F.R. § 440.20. 42 C.F.R. § 440.20 (2024) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. This regulation is available for public inspection at the Department of Health Care Policy and Financing, 303 E. 17th Ave., Denver, CO 80203. Pursuant to C.R.S § 24-4-410(12.5)(V)(b), the Department shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule.

**QP.** Patient Contact Best Efforts means the process of communication efforts completed by the Provider to contact a patient. This includes phone calls, SMS messages, emails, and portal messages.

**RQ.** Permissible Extraordinary Collection Action means an action other than an Impermissible Extraordinary Collection Action that requires a legal or judicial process, including but not limited to placing a lien on an individual's real property, attaching or seizing an individual's bank account or any other personal property, or garnishing an individual's wages. A Permissible Extraordinary Collection Action does not include the attachment of a hospital lien pursuant to section 38-27-101, C.R.S.

**SR.** Provider means any Health Care Facility or Licensed Health Care Professional subject to Title 25.5, Article 3, Part 5, C.R.S.

**TS.** Qualified Patient means an individual who attests to residing in Colorado, whose household income is not more than two hundred fifty percent of the Federal Poverty Guidelines and who received an Inpatient Hospital Service or Outpatient Hospital Service at a Health Care Facility.

**UT.** Screen or Screening means a process identified in rule by the Department whereby Health Care Facilities assess a patient's circumstances related to eligibility criteria and determine whether the patient is likely to qualify for public health care coverage or Discounted Care, inform the patient of the Health Care Facility's determination, and provide information to the patient about how the patient can enroll in public health care coverage.

**VU.** SMS means short messaging service messages, commonly referred to as text messages.

**WV.** Uninsured means an uninsured individual, as defined in section 10-22-113(5)(d), C.R.S.

## **8.922 SCREENING AND APPLICATION**

### **A. Screening, Application, and Determination Notice**

1. Beginning September 1, 2022, using the single uniform application developed and distributed by the Department, a Health Care Facility shall screen each uninsured patient and any insured patients who request to be screened for:
  - a. Public health insurance programs including but not limited to Medicare, Medicaid, Emergency Medicaid, and the Children's Basic Health Plan.
  - b. ~~Eligibility for the CIGP, if the patient receives or is scheduled to receive a service eligible for reimbursement through the CIGP.~~

~~e.~~ Discounted Care, as described in section 25.5-3-503, C.R.S.

## 2. Uninsured Patients

- a. Health Care Facilities must complete the screening process using the uniform application within 45 days from the uninsured patient's date of service or date of discharge, whichever is later.
- b. The screening process consists of completing the first page of the uniform application using self-attested information provided by the patient or their guardian.
- c. If the self-attested screening process results in a determination that the patient may be eligible for Discounted Care, then, at the time of the screening, the Health Care Facility must provide the patient or their guardian with a list of information and documents required to complete the application process. The patient is permitted 45 days to provide the documentation required to complete the application. When all necessary documentation has been received from the patient, the Health Care Facility must determine the patient's eligibility for Discounted Care and send written notice of the determination to the patient or guardian within 21 days.
- d. If the self-attested screening process results in a determination that a patient likely is ineligible for Discounted Care, the patient must be informed that the screening results are not an official determination and that they have the right to complete the application and receive an official determination of eligibility for Discounted Care if they choose. If the patient requests to complete the application process for Discounted Care, the Health Care Facility must complete the application process and provide an official determination of eligibility for Discounted Care.
- e. If the self-attested screening process results in a determination that the patient may be eligible for one or more public health coverage options, the Health Care Facility must inform the patient of those options and provide information on how the patient may apply for them, including any application deadlines the patient should be aware of.

## 3. Insured Patients

- a. If the insured patient or their guardian requests to be screened for public health insurance programs, ~~CICP~~, and Discounted Care, Health Care Facilities must screen insured patients within 45 days of their date of service or date of discharge, or within 45 days of the date of their first bill after their insurance adjustment, whichever is later.
- b. The request to be screened may be made in person, by telephone, email, or by using the portal, if available. Health Care Facilities must contact the insured patient or their guardian to schedule the screening within three business days after receiving the insured patient's request.
- c. Patients believed to have health insurance coverage when services were rendered and who are subsequently determined to be uninsured on their date of service are considered Uninsured. Within 45 days from the date of the notification that the patient was not insured on the date of service, the Health Care Facility must complete the screening.



4. Health Care Facility Determination Notice

- a. The Health Care Facility must provide the patient written notice of the determination within 21 days of receiving all required documentation to complete the patient's application for Discounted Care. A copy of the determination must be sent to any and all applicable Licensed Health Care Professionals.
- b. The determination shall be written in plain language and in the patient or their guardian's preferred language.
- c. If a Health Care Facility fails to issue written notice of the determination to the patient within 21 days of receiving all required documentation to complete the patient's application, the patient may file an appeal. If the appeal is filed within 60 calendar days of the patient submitting all required documentation, the Health Care Facility must review the appeal and respond to the patient or their guardian and the Department within 15 calendar days of the date of the appeal.
- d. For patients determined to be eligible for Discounted Care, the determination notice must include but is not limited to:
  1. The programs and discounts for which the patient was determined likely eligible for, including but not limited to Medicaid, Emergency Medicaid, CHP+, Medicare, and Hospital Discounted Care, ~~and CICP~~, and the availability of subsidies through Connect for Health Colorado. This must also include where to find additional information and how to apply for each program the patient was determined potentially eligible for.
    - i. If the patient appears likely eligible for a program, and there is a deadline by which the patient must apply ~~for~~ that program for their services to be covered, that date must be included in the determination notice.
  2. The dates for which the Discounted Care determination is valid.
  3. The household size and income used to determine eligibility and the household calculated FPG.
  4. The patient's monthly installment amounts calculated on their gross household income pursuant to Section 8.923.A.2.
  5. ~~If the patient was applying and approved for CICP, the patient's CICP rating.~~
  6. ~~If the patient was applying and approved for CICP, the patient's CICP copay cap.~~
  7. ~~If the Health Care Facility is not a CICP Provider, information on where the patient may obtain CICP services.~~
  8. ~~Information on how to file a complaint and how to file an appeal with the Health Care Facility and the Department.~~
- e. The determination notice for patients determined not eligible for Discounted Care must include but is not limited to:



1. The basis for denial of Discounted Care.
  2. The programs and discounts for which the patient was determined likely eligible for, including but not limited to Medicaid, Emergency Medicaid, CHP+, Medicare, and the availability of subsidies through Connect for Health Colorado. This must also include where to find additional information and how to apply for each program the patient was determined potentially eligible for.
    - i. If the patient appears likely eligible for a program, and there is a deadline by which the patient must apply to that program for their services to be covered, that date must be included in the determination notice.
  3. The service date the Discounted Care denial covers and an explanation that the household may qualify for coverage of future services if there is a change in household size or income.
  4. The household size and income used to determine eligibility and the household calculated FPG.
  5. Information on how to file a complaint and how to file an appeal with the Health Care Facility and the Department.
5. A Health Care Facility is no longer obligated to screen an uninsured patient for past dates of service if the patient or their guardian signs the decline screening form developed by the Department that notes those specific dates of service or a past date range that includes those specific dates of service except when a patient or guardian who opted out of screening subsequently requests to complete the screening, if the subsequent request is made prior to starting Permissible Extraordinary Collections Actions.
- a. The Health Care Facility must keep on file a decline screening form signed by the patient, or their guardian until June 30 of the seventh state fiscal year after the patient's date of service or date of discharge, whichever is later.
6. For patients who are discharged without being screened or signing the decline screening form, the Health Care Facility must attempt to contact the patient by at least one method of contact that the patient indicates is their preferred method, which can include phone call, SMS message, email, and portal message at least once a month for six months after the patient's date of discharge with the first contact sent prior to the expiration of 45 days after screening. The Health Care Facility may commence billing 46 days after the patient's date of service or date of discharge, whichever is later. If the patient requests that the Health Care Facility cease contacting them by phone, SMS message, or email, the provider may consider those requirements as fulfilled. The Health Care Facility must document the patient's request and maintain the request as part of the patient record.
7. If a Health Care Facility has attempted to contact the patient in accordance with Patient Contact Best Efforts, and the patient does not respond within 182 days of their date of service or date of discharge, whichever is later, the Facility may conclude that the patient has made an informed decision to decline screening. Patient Contact Best Efforts, at a minimum, must include:
- a. Notice that the failure to respond may result in the loss of their right to be screened for cost saving options.

- b. Calling any phone numbers provided by the patient and leaving voice messages with allowable information under the Health Insurance Portability and Accountability Act as defined at 45 C.F.R. sec. 164.502 and the Telephone Consumer Protection Act as defined at 47 U.S.C. sec. 227 if the calls are unanswered,

1. 45 C.F.R. § 164.502 (2024) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. This regulation is available for public inspection at the Department of Health Care Policy and Financing, 303 E. 17th Ave, Denver, CO 80203. Pursuant to C.R.S § 24-4-410(12.5)(V)(b), the Department shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule.

- c. SMS messages to any of the patient's phone numbers identified by the patient as a mobile number if the Health Care Facility has the ability to send SMS messages,
  - d. Sending emails to any email address provided by the patient, and
  - e. Sending messages through any appropriate patient portal.
- 8. If a patient does not indicate their preferred method of contact, the Provider shall contact patients in accordance with their internal patient communication policies. Documentation of the communication attempts for patients must be kept in their patient records and the communication policy must be kept on file until the June 30 of the seventh state fiscal year past the patient's date of service.
  - 9. Documentation of the attempts to contact the patient or guardian to complete the screening must be maintained as part of the patient record. This may include call logs, message logs, copies of sent emails, portal messages sent, and copies of bills.
  - 10. Providers shall maintain all Discounted Care-related records, including but not limited to, documentation to support screenings and determinations, service data including dates of service for Qualified Patients and services provided to them on those dates, and expenditures until June 30 of the seventh state fiscal year following the creation of the documentation.

## B. Patients

- 1. Any patient or patient's guardian aged 18 and older may apply to receive Discounted Care.
- 2. The decision regarding eligibility for Discounted Care applies to both the patient and the members of the patient's household.
- 3. If a patient is deceased, the personal representative of the estate or a family member may complete the screening and application on behalf of the patient.

4. The application to receive Discounted Care shall include the names, birth dates, and relationship to the patient of all members of the patient's household who are included on the application.
  - a. A patient must include their spouse or civil union partner in their household for the application.
  - b. Any additional person living at the same address as the patient may also be included in the household.
  - c. A patient may include household members who live in other states or countries if the patient attests to the fact that they provide at least 50% of the household member's support.
5. A minor shall not be screened separately from his or her parents or guardians unless they are emancipated or there exists a special circumstance. A minor is an individual under the age of 18.

C. Household Income

1. Using the information submitted by a patient or patient's guardian, the Health Care Facility shall determine whether the patient meets all requirements to receive Discounted Care. Health Care Facilities must follow the income counting methodology determined by the Department. Health Care Facilities shall determine Qualified Patient financial eligibility based on income from each household member 18 and older and household size. The Health Care Facility may not consider assets in determining eligibility.
2. Eligibility shall be determined at the time of application, unless required documentation is not available, in which case the patient or patient's guardian will be notified of the missing documentation within three business days after receipt of the application. An eligibility determination shall be made within 21 calendar days after the application is complete.
3. Patients may establish household income by providing documents that satisfy documentation guidelines established by the Department. Acceptable forms of documentation may include but is not limited to pay stubs, employer letter, tax returns, and business financial statements. The Health Care Facility may not require more than the minimum amount of documentation to substantiate declared income.
  - a. Patients who are experiencing homelessness are exempt from the documentation requirements related to establishing income and may self-attest to their household income.

**8.923 HEALTH CARE SERVICE DISCOUNTS**

- A. Beginning September 1, 2022, if a patient screened pursuant to Ssection 8.922 is determined to be a Qualified Patient, a Health Care Facility and a Licensed Health Care Professional shall for Emergency Hospital and other Health Care Services:
1. Limit the amounts billed for Health Care Services to no more than the rate established in Department rule pursuant to Ssection 8.929.
  2. Enter into a payment plan with the Qualified Patient in which the Qualified Patient pays for care in monthly installments. For services provided by a Health Care Facility, monthly installments shall not exceed four percent of the patient's gross monthly household income on a bill from a Health Care Facility that contains only facility charges and shall

not exceed six percent of the patient's gross monthly household income on a bill from a Health Care Facility containing both facility and Licensed Health Care Professional charges. For services provided by each Licensed Health Care Professional who bills separately from the Health Care Facility, monthly installments shall not exceed two percent of the patient's gross monthly household income; and

3. After a cumulative thirty-six months of payments, the Health Care Facility shall treat the Qualified Patient's bill as paid in full and must permanently cease collection activities on any balance that remains unpaid.
4. Providers shall not suggest or require that patients obtain loans that include fees, interest, or payment plans that exceed 36 payments to pay for services in lieu of setting up a payment plan directly with the Health Care Facility or Licensed Health Care Professional.
  - a. If a patient defaults on a loan from the Provider, the same rules apply related to any collection actions taken by the Provider as apply for payment plans under this section. If a patient defaults on a loan from the Provider, the same rules apply related to any collection actions taken by the Provider as apply for payment plans under this section..

B. A Health Care Facility shall not:

1. Deny Discounted Care on the basis that the patient has not applied for any public benefits program; or
2. Adopt or maintain any policies that result in the denial of admission or treatment of a patient because the patient may qualify for Discounted Care.

#### **8.924 PATIENT RIGHTS**

A. Beginning September 1, 2022, a Health Care Facility shall make available to the public and to each patient information developed by the Department about patient's rights pursuant to Part 5 of Article 3 of Title 25.5 C.R.S. (2021) and the uniform application developed by the Department pursuant to section 25.5-3-505 (2)(i), C.R.S.

B. At a minimum, the Health Care Facility shall:

1. Post the information in all languages spoken by ten percent or more of the population in any Colorado county conspicuously on the Health Care Facility's website, including a link to the information on the Health Care Facility's main landing page;
2. Make the information available in patient waiting areas;
3. Make the information available to each patient, or the patient's legal guardian, before the patient is discharged from the Health Care Facility, verbally or in writing in the patient's or legal guardian's preferred language, which may include using professional interpretation and/or translation services; and
4. Inform each patient on the patient's Billing Statement of the patient's rights pursuant to Part 5 of Article 3 of Title 25.5, C.R.S. (2021) including the right to apply for Discounted Care, and provide the website, email address, and telephone number where the information may be obtained in the patient's preferred language.

- C. Providers shall not present the patient's rights in a format that differs from the format in which the material is distributed by the Department without Department approval.
  - 1. Providers may not make any part of the patient's rights information part of a footnote or use any other format that may minimize its importance.

#### **8.925 REPORTING REQUIREMENTS**

- A. Beginning September 1, 2023 for Health Care Facilities and beginning September 1, 2025 for Licensed Health Care Professionals, and each September 1 thereafter, each Health Care Facility and Licensed Health Care Professional shall report to the Department data that the Department determines is necessary to evaluate compliance across race, ethnicity, age, and primary-language-spoken patient groups with the screening, Discounted Care, payment plan, and collections practices required by Title 25.5, Article 3, Part 5, C.R.S. . The Department shall distribute a compliance data reporting template to each Health Care Facility.
  - 1. If a Health Care Facility or Licensed Health Care Professional is not capable of disaggregating the required data by race, ethnicity, age, and primary language spoken, the Health Care Facility or Licensed Health Care Professional shall report to the Department the steps the Health Care Facility or Licensed Health Care Professional is taking to improve race, ethnicity, age, and primary language spoken data collection and the date by which the facility or Licensed Health Care Professional will be able to disaggregate the reported data.
- B. Beginning September 1, 2023 for Health Care Facilities and beginning September 1, 2025 for Licensed Health Care Professionals, and each September 1 thereafter, each Health Care Facility and Licensed Health Care Professional shall submit Discounted Care utilization and charge data in a format and timeline determined by the Department.

#### **8.926 COLLECTIONS**

- A. Beginning September 1, 2022, before assigning or selling patient debt to a collection agency or a debt buyer, or before pursuing, either directly or indirectly, any Permissible Extraordinary Collection Action:
  - 1. A Health Care Facility shall meet the screening requirements in Section 8.922;
  - 2. A Provider shall provide Discounted Care to a Qualified Patient pursuant to Section 8.920;
  - 3. A Provider shall provide a plain language explanation of the health care services and fees and notify the patient or their guardian of potential collection actions in their preferred language on the timeline developed by the Department; and
  - 4. A Provider shall bill any third-party payer that is responsible for providing health care coverage to the patient. If a Licensed Health Care Professional is an out-of-network provider under a Qualified Patient's health insurance plan, the Licensed Health Care Professional and health insurance carrier shall comply with the out-of-network billing requirements described in sections 10-16-704 (3) and 12-30-113, C.R.S.
- B. A Health Care Facility must complete the Patient Contact Best Efforts in their attempts to contact a patient who has not signed a Decline Screening Form or who has not been screened as described in Section 8.922 prior to starting Permissible Extraordinary Collections Actions.

- C. Documentation of Patient Contact Best Efforts communication attempts with the patient as outlined in Section 8.922 satisfies the screening requirements for Health Care Facilities.
- D. For a Qualified Patient with an established payment plan, Permissible Extraordinary Collections Actions may not be started until the patient has failed to remit three consecutive payments and has not communicated with the Provider asking for a deferment or to be redetermined prior to or during those three months of missed payments. Providers must notify Qualified Patients with established payment plans at least 30 days prior to the commencement of Permissible Extraordinary Collections Actions.
- E. Providers shall not commence collection proceedings against a patient for any amount in excess of the rates established at Section 8.923.A.2, and must reduce the amount owed by the amount of any payments received from the patient or a third-party payer.

#### **8.927 APPEALS AND COMPLAINTS**

- A. If a patient is determined ineligible for Discounted Care after the uniform application has been completed, the patient may appeal the decision as follows:
  - 1. No later than 30 calendar days from the date on the Health Care Facility's eligibility determination letter, the patient or their guardian may submit an appeal in writing via U.S. Mail, email, or patient portal message if available to the Health Care Facility that made the determination.
  - 2. Within 15 calendar days from the date of the appeal, the Health Care Facility shall complete a redetermination of eligibility and respond to the patient or guardian and the Department.
  - 3. If the Health Care Facility upholds its initial eligibility determination, the patient or guardian may proceed to the next step of the appeals process as described in Section 8.927.A.4.
  - 4. No later than 15 calendar days from the date of the Health Care Facility's initial appeal decision, the patient shall submit a written appeal to the Department. Email submissions must be addressed to [hcpf\\_HospDiscountCare@state.co.us](mailto:hcpf_HospDiscountCare@state.co.us). Letters must be mailed to:

Department of Health Care Policy and Financing

Attention: State Programs Unit, Special Financing Division  
% Hospital Discounted Care  
303 E. 17th Avenue Suite 1100  
Denver, CO 80203
  - 5. Within 15 calendar days from date of receipt of the appeal, the Department shall issue a final determination letter to both the patient and the Health Care Facility. If the Department deems that the redetermination was inaccurate, the Health Care Facility must resend a determination letter to the patient and the Department stating the patient is/was eligible for Discounted Care on the date of service.
- B. A patient or guardian who believes a Health Care Facility has improperly calculated a payment plan based on inaccurate income information may appeal the payment plan offered by the Facility to the Department using the process described in Section 8.927.A.1.

- C. The Department shall maintain records of all appeals and its final determinations for each Health Care Facility. If the Department determines a Health Care Facility has a repeated pattern of errors in patient eligibility determinations, the Department will require the Health Care Facility to attend training with the Department. The Health Care Facility may be subject to random application checks for 12 months following the training to ensure that the errors have been corrected.
- D. Patients and their guardians may file complaints against Providers directly with the Department. Patients are not required to file a complaint with the Provider prior to filing a complaint with the Department.

- 1. Patients may submit complaints via U.S. Mail, email, or phone as follows:

**Phone:** 303-866-2580  
**Email:** hcpf\_HospDiscountCare@state.co.us  
**U.S. Mail:** Department of Health Care Policy and Financing  
Attention: State Programs Unit, Special Financing Division  
% Hospital Discounted Care  
303 E. 17th Avenue Suite 1100  
Denver, CO 80203

- 2. The Department shall review complaints within 30 calendar days of receipt.
- 3. The Department shall maintain records of all complaints for each Provider. If the Department determines there is a repeated pattern in the complaints filed against the Provider, the Provider may be subject to a corrective action plan.
  - a. Providers will have 90 days to submit a corrective action plan. Extensions may be made at the Department's discretion up to no more than 120 days.

## **8.928 DEPARTMENT RESPONSIBILITIES HOSPITAL DISCOUNTED CARE PROGRAM STRUCTURE**

### **8.928.1 REVIEW OF PROVIDERS FOR NONCOMPLIANCE**

- A. The Department ~~shall~~will periodically review Providers to ensure compliance with Part 5 of Article 3 of Title 25.5, C.R.S. (2024) and these rules. If the Department finds that a Provider is not in compliance with these rules, the Department ~~shall~~will notify the Provider.
- B. The Provider will have 90 days to file a corrective action plan with the Department that must include measures to inform impacted patients about the noncompliance and provide financial corrections consistent with these rules.
  - 1. At the Department's discretion, a Provider may be permitted up to 120 days to submit a corrective action plan upon request.
  - 2. The Department may require a Provider that is not in compliance with Title 25.5, Article 3, Part 5, C.R.S. or these rules to develop and operate under a corrective action plan until the Department determines the Provider is in compliance.
- C. If a Provider's noncompliance with these rules is determined by the Department to be knowing or willful or there is a repeated pattern of noncompliance, the Department may fine the Provider no more than \$5,000. If the Provider fails to take corrective action or fails to file a corrective action

plan with the Department pursuant to this section, the Department may fine the Provider no more than \$5,000 per week until the Provider takes corrective action. The Department ~~shall~~will consider the size of the Health Care Facility and the seriousness of the violation in setting the fine amount.

- D. The Department ~~shall~~will make the information reported pursuant to this section and any corrective action plans for which fines were imposed pursuant to this section available to the public and shall annually report the information as part of its presentation to its committees of reference at a hearing held pursuant to section 2-7-203 (2)(a), C.R.S. of the “State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act.”
- E. For audit purposes, Providers shall maintain all Discounted Care related records, including but not limited to, documentation to support screenings and determinations, service data including dates of service for Qualified Patients and services provided to them on those dates, and expenditures until June 30 of the seventh state fiscal year following the screening or determination.

## **8.9298.928.2 RATES**

The Department ~~shall~~will annually establish rates for Discounted Care. The rates will approximate and not be less than one hundred percent of the Medicare rate or one hundred percent of the Medicaid rate, whichever is greater. The Department ~~shall~~will publicly post the established rates on the Department’s website pursuant to section 25.5-3-505, C.R.S.

## **8.928.3 ADVISORY COMMITTEE**

A. Committee Makeup. The Department ~~shall~~will create a Hospital Discounted Care Advisory Committee, effective July 1, 2025. The Executive Director of the Department ~~shall~~will appoint 11 members to the Hospital Discounted Care Advisory Committee. ~~Committee M~~members ~~shall~~will include:

1. A member representing the Department;
2. Three members who are health care consumers, of whom no more than two members may be employed by a health care consumer advocacy organization;
3. A member who is a representative of a safety net hospital for which the percent of Medicaid-eligible inpatient days relative to the hospital’s total inpatient days is equal to or greater than one standard deviation above the mean;
4. A member who is a representative of a hospital in a rural area;
5. A member who is a representative of a hospital in an urban area;
6. A member who is a representative of a statewide organization of hospitals;
7. A member who is a representative of licensed health care professionals who provide services to patients in a hospital setting;
8. A member who is a representative of an organization of Colorado community health centers or a representative of a Colorado community health center, as defined in 42 U.S.C. ~~§~~see 254b;
9. A member who is a representative of an organization of safety net health providers or a safety net health provider that is not a community health center.



Members shall serve without compensation or reimbursement of expenses. The ~~E~~xecutive ~~D~~irector of the Department ~~shall~~will designate a member to serve as chair of the committee and the appointment will be valid until the seat is vacated, the ~~C~~hair steps down, or a new chair is selected by the ~~E~~xecutive ~~D~~irector. ~~The Department will~~shall staff the council. The council shall convene at least twice every state fiscal year according to a schedule set by the chair. Members of the council shall serve three-year terms. Of the members initially appointed to the advisory committee, the ~~e~~Executive ~~d~~irector ~~shall~~will appoint six members for two-year terms and five members for three-year terms. In the event of a vacancy on the advisory committee, the ~~e~~Executive ~~d~~irector ~~shall~~will appoint a successor to fill the unexpired portion of the term for the member.

B. ~~Committee Duties.~~ The advisory committee shall:

1. ~~Advise the Department on the operations and policies for Hospital Discounted Care, and~~
2. ~~Make recommendations to the Medical Services Board regarding rules for Hospital Discounted Care.~~

## **8.950 PRIMARY CARE FUND**

### **8.950.1 GENERAL DESCRIPTION**

8.950.1.A. In accordance with Section 21 of Article X (Tobacco Taxes for Health Related Purposes) of the State Constitution, an increase in Colorado's tax on cigarettes and tobacco products became effective January 1, 2005, and created a cash fund that was designated for health related purposes. House Bill 05-1262 divided the tobacco tax cash fund into separate funds, assigning 19% of the moneys to establish the Primary Care Fund, set forth how the funds will be allocated and designated the Department of Health Care Policy and Financing (the Department) as the administrator of the Primary Care Fund.

8.950.1.B. The Primary Care Fund provides an allocation of moneys to health care providers that make basic health care services available in an outpatient setting to residents of Colorado who are considered ~~medically indigent~~low-income and uninsured. Moneys shall be allocated based on the number of ~~medically indigent~~eligible patients in an amount proportionate to the total number of ~~medically indigent~~eligible patients served by all health care providers who qualify for moneys from this fund.

### **8.950.2 DEFINITIONS**

8.950.2.A. Arranges For - Demonstrating Established Referral Relationships with health care providers for any of the Comprehensive Primary Care services not directly provided by the provider.

8.950.2.B. Children's Basic Health Plan also known as Child Health Plan Plus (CHP+) - As specified in Article ~~49-8~~ of Title ~~26~~25.5, C.R.S.

~~8.950.2.C. Colorado Indigent Care Program (CICP) - As specified in Article 15 of Title 26, C.R.S.~~

8.950.2.~~DC~~. Comprehensive Primary Care - Basic, entry-level health care provided by health care practitioners or non-physician health care practitioners that is generally provided in an outpatient setting. At a minimum, this includes providing or arranging for the provision of the following services on a Year-Round Basis: primary health care; maternity care, including prenatal care; preventive, developmental, and diagnostic services for infants and children; adult preventive services, diagnostic laboratory and radiology services; emergency care for minor trauma;

Pharmaceutical Services; and coordination and follow-up for hospital care. It may also include optional services based on a patient's needs such as dental, behavioral health and eyeglasses.

8.950.2.~~ED~~. Cost-Effective Care - Provides or Arranges for Comprehensive Primary Care that is appropriate and at a reasonable average cost per patient Visit and/or Encounter.

8.950.2.~~FE~~. Eligible Patient is ~~–A~~ a patient receiving medical services from a Qualified Provider:

1. Whose yearly family income is at or below two hundred percent (200%) of the Federal Poverty ~~Level~~Guideline (FPLG):
2. Who is not eligible for the Medical Assistance Program, the Children's Basic Health Plan, Medicare or any other governmental ~~reimbursement for health care coverage costs~~ such as through Social Security, the Veterans Administration, Military Dependency (TRICARE or CHAMPUS), or the United States Public Health Service; and
3. There is no Third Party Payer.

8.950.2.F Eligible Qualified Provider - A ~~qualified~~-Qualified Provider who is identified by the Department to receive funding from the Primary Care Fund.

8.950.2.G. Established Referral Relationship - A formal, written agreement in the form of a letter, a memorandum of agreement or a contract between two entities which includes:

1. The Comprehensive Primary Care and/or products (e.g., pharmaceuticals, radiology) to be provided by one entity on behalf of the other entity;
2. Any applicable policies, processes or procedures;
3. The guarantee that referred ~~Medically Indigent~~Eligible Patients shall receive services on a Sliding Fee Schedule or at no charge; and
4. Signatures by representatives of both entities.

8.950.2.H. Medical Assistance Program (Medicaid) - As specified in Article 4 of Title ~~26~~25.5, C.R.S.

~~8.950.2.I. Medically Indigent Patient - A patient receiving medical services from a Qualified Provider:~~

- ~~1. Whose yearly family income is below two hundred percent (200%) of the Federal Poverty Level (FPL);~~
- ~~2. Who is not eligible for the Medical Assistance Program, , the Children's Basic Health Plan, Medicare or any other governmental reimbursement for health care costs such as through Social Security, the Veterans Administration, Military Dependency (TRICARE or CHAMPUS), or the United States Public Health Service. (Payments received from the Colorado Indigent Care Program are not considered a governmental reimbursement for health care costs related to a specific patient); and~~
- ~~3. There is no Third Party Payer.~~

8.950.2.~~J~~. Medically Underserved Area - A federal government designation given to a geographical area based on the ratio of medical personnel (physicians, dentists, behavioral health workers, etc.) to the population. These areas have fewer than a generally accepted minimum number of medical personnel per thousand population resulting in insufficient health resources (personnel

and/or facilities) to meet the medical needs of the resident population. Such areas are also defined by measuring the health status of the resident population; an area with an unhealthy population being considered underserved.

8.950.2.~~KJ~~. Medically Underserved Population - A federal government designation given to a human population that does not receive adequate medical attention or have access to health care facilities.

8.950.2.~~LK~~. Outside Entity - A business or professional that is not classified as an employee of the provider or the Department and does not have a direct or indirect financial interest with the provider, ~~but has. The business or professional shall have~~ auditing experience or experience working directly with the Medical Assistance Program or similar services or grants for ~~Medically Indigent~~Eligible Patients.

8.950.2.~~ML~~. Pharmaceutical Services — ~~Services that provide~~ Provides prescription drugs, or coordinates access to or Arranges ~~For client for Eligible Patients~~ to receive prescription drugs prescribed by the Qualified Provider on a Sliding Fee Schedule or at no charge.

8.950.2.~~NM~~. Qualified Provider - An entity that provides Comprehensive Primary Care in Colorado and that:

1. Accepts all patients regardless of their ability to pay and uses a Sliding Fee Schedule for payments or does not charge ~~Medically Indigent~~Eligible Patients for services;
2. Serves a designated Medically Underserved Area or Medically Underserved Population as provided in section 330(b) of the federal "Public Health Service Act", 42 U.S.C. sec. 254b, or demonstrates to the Department that the entity serves a population or area that lacks adequate health care services for low-income, uninsured persons;
3. Has a demonstrated Track Record of providing Cost-Effective Care;
4. Provides or Arranges For the provision of Comprehensive Primary Care to persons of all ages. An entity in a rural area may be exempt from this requirement if they can demonstrate that there are no providers in the community to provide one or more of the Comprehensive Primary Care services;
5. Completes a screening that evaluates eligibility for the Medical Assistance Program, ~~and the Children's Basic Health Plan, and the Colorado Indigent Care Program~~ and refers patients potentially eligible for one of the programs to the appropriate agency (e.g., county departments of human/social services) for eligibility determination if they are not qualified to make eligibility determinations; and
6. Is a community health center, as defined in Section 330 of the federal "Public Health Services Act", 42 U.S.C. Section 254b; or at least 50% of the patients served by the provider are ~~Medically Indigent~~Eligible Patients or patients who are enrolled in the Medical Assistance Program, the Children's Basic Health Plan, or any combination thereof.

8.950.2.~~ON~~. Quality Assurance Program - Formalized plan and processes designed to ensure the delivery of quality and appropriate Comprehensive Primary Care in a defined medical setting. This can be demonstrated by obtaining a certification or accreditation through the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or by the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC). If such certification or accreditation is not available, then at a minimum, the Quality Assurance Program shall be comprised of elements that meet or exceed the following components:

1. Establishment of credentialing/re-credentialing requirements for medical personnel;
2. Surveying and monitoring of patient satisfaction;
3. Establishment of a grievance process for patients, including documentation of grievances and resolutions;
4. Development of clinic operating policies and scheduled performance monitoring;
5. Review of medical records to check for compliance with established policies and to monitor quality of care;
6. Assessment of state and federal regulations to ensure compliance;
7. Establishment of patient safety procedures; and
8. Establishment of infection control practices.

8.950.2.PO. Sliding Fee Schedule - A tiered co-payment system that determines the level of patient's financial participation and guarantees that the patient financial participation is below usual and customary charges. Factors considered in establishing the tiered co-payment system shall only be financial status and the number of members in the patient's family unit.

8.950.2.QP. Third Party Payments or Third Party Payer - Any individual, entity or program with a legal obligation to pay for some or all health-related services rendered to a patient. Examples include the Medical Assistance Program; the Children's Basic Health Plan; Medicare; commercial, individual or employment-related health insurance; court-ordered health insurance (such as that required by non-custodial parents); workers' compensation; automobile insurance; and long-term care insurance. ~~The Colorado Indigent Care Program is not considered a Third Party Payer and payments received from the Colorado Indigent Care Program are not considered Third Party Payments.~~

8.950.2.RQ. Track Record - Evidence of providing Comprehensive Primary Care covering at least a consecutive 52-week period prior to the submission of the application.

8.950.2.SR. Unduplicated User/Patient Count - The sum of patients who have had at least one Visit/Encounter and received at least one of the services under the Comprehensive Primary Care definition during the applicable calendar year, but does not include the same patient more than once. The sum shall be calculated on a specific point-in-time occurring between the end of the applicable calendar year and prior to the submission of the application. Each patient shall be counted once under only one payment source designation (Third Party Payer or ~~Medically Indigent~~Eligible Patient). The patient's payment source designation shall be the payment source designation listed for the patient at the specific point-in-time in which the calculation is made. The sum shall not include:

1. Counting a patient more than once if the same patient returns for additional services (e.g., medical or dental) and/or products (e.g., pharmaceuticals) during the applicable calendar year;
2. Counting a patient more than once if the payment source designation changed during the applicable calendar year;
3. Persons who have only received services through an outreach event, community education program, nurse hotline, or other types of community-based events or programs and were not documented on an individual basis;

4. Persons who have only received services from large-scale efforts such as mass immunization programs, screening programs, and health fairs; or
5. Persons whose only contact with the provider is to receive Special Supplemental Nutrition Program for Women, Infants, and Children (WIC Program) counseling and vouchers are not users and the contact does not generate an encounter.

8.950.2.~~TS~~. Visit/Encounter - An appointment with medical personnel (physicians, physician assistants, dentists, behavioral health workers, etc.) in which the patient received health related services and/or products (e.g., pharmaceuticals or radiology) and the appointment is customarily billable to a Third Party Payer.

8.950.2.~~UT~~. Year-Round Basis - Comprehensive Primary Care provided in a consecutive 52-week period directly by the provider and/or through an established referral relationship with other providers. If an organization is closed for four consecutive weeks or longer in a calendar year on a regularly scheduled basis, it is not considered to directly provide services on a year-round basis.

### 8.950.3 PROVIDER ELIGIBILITY

8.950.3.A. Providers who provide Comprehensive Primary Care to ~~Medically Indigent~~Eligible Patients and who meet all of the requirements established for the Primary Care Fund as of the date the application form is submitted to the Department shall receive moneys appropriated to the Primary Care Fund. Specifically, the provider shall:

1. Meet all of the requirements of a Qualified Provider as specified in Section 8.950.2.~~NM~~;
2. Have a Quality Assurance Program in place as specified in Section 8.950.2.~~ON~~; and
3. Submit a completed application form according to stated guidelines as specified under Section 8.950.4.

### 8.950.4 APPLICATION

8.950.4.A. The application form shall be available to providers annually and posted for public access on the Department's website at least 30 calendar days prior to the response due date.

8.950.4.B. At a minimum, the application form shall require responses that:

1. Demonstrate how the provider meets the criteria of a Qualified Provider as defined in Section 8.950.2.~~NM~~;
2. Provide an Unduplicated User/Patient Count covering the applicable calendar year which, at a minimum, shall include the number of patients eligible for the Medical Assistance Program and the Children's Basic Health Plan and the number of patients considered to be ~~Medically Indigent~~Eligible Patients;
3. Provide certification that the Unduplicated User/Patient Count identified in Section 8.950.4.B.2 has been verified by an Outside Entity; and
4. Provide documentation that the provider has a Quality Assurance Program as defined in Section 8.950.2.~~NQ~~.

8.950.4.C. Providers shall complete and provide a response annually. The response shall be made in compliance with all specifications in the application form, including format, data and

documentation. Responses to the application form shall be submitted directly to the Department by the required response deadline.

- 8.950.4.D. All providers who submit a response to the application form shall be notified within 45 days of the response deadline if the provider met or did not meet the requirements to become an Eligible Qualified Provider.

#### **8.950.5 DISBURSEMENT**

- 8.950.5.A. Eligible Qualified Providers are determined on a state fiscal year basis and shall receive only those moneys appropriated to the Primary Care Fund for that same state fiscal year, subject to the tax amount actually collected for that state fiscal year.

- 8.950.5.B. Payments shall be based on the number of ~~Medically Indigent~~Eligible Patients in each Eligible Qualified Provider's Unduplicated User/Patient Count in an amount proportionate to the total number of ~~Medically Indigent~~Eligible Patients from all Eligible Qualified Providers' Unduplicated User/Patient Counts.

- 8.950.5.C. The schedule for the disbursement of moneys to all Eligible Qualified Providers shall be dependent on actual tax collections allocated to the Primary Care Fund such that:

1. Tax collections for sales in July, August, and September shall be distributed to Eligible Qualified Providers prior to the end of October.
2. Tax collections for sales in October, November, and December shall be distributed to Eligible Qualified Providers prior to the end of January.
3. Tax collections for sales in January, February, and March shall be distributed to Eligible Qualified Providers prior to the end of April.
4. Tax collections for sales in April, May, and June shall be distributed to Eligible Qualified Providers prior to the end of July.
5. For State Fiscal Year 2005-06 only, tax collections for sales in January 2005 through December 2005, shall be distributed to Eligible Qualified Providers prior to the end of February 2006.

#### **8.3000: HEALTHCARE AFFORDABILITY AND SUSTAINABILITY FEE COLLECTION AND DISBURSEMENT**

PURPOSE: Subject to federal approval by the Centers for Medicare and Medicaid Services (CMS), the Colorado Healthcare Affordability and Sustainability Enterprise Act of 2017 (Act), C.R.S. § 25.5-4-402.4, authorizes the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) to assess a healthcare affordability and sustainability fee, pursuant to rules adopted by the State Medical Services Board, to provide business services to hospitals as described in C.R.S. § 25.5-4-402.4(4)(a). These business services include, but are not limited to, obtaining federal financial participation to increase reimbursement to hospitals for care provided under the state medical assistance program (Medicaid) including Disproportionate Share Hospital Payments pursuant to 42 U.S.C. § 1396r-4 and the Colorado Indigent Care Program (CICP); expanding health coverage for parents of Medicaid eligible children, for children and pregnant women under the Child Health Plan Plus (CHP+), and for low-income

adults without dependent children; providing a Medicaid buy-in program for people with disabilities; implementing twelve month continuous eligibility for Medicaid eligible children; paying CHASE's administrative costs of implementing and administering the Act; consulting with hospitals to help them improve cost efficiency, patient safety, and clinical effectiveness; advising hospitals regarding potential changes to federal and state laws and regulations governing Medicaid; providing coordinating services to hospitals to help them adapt and transition to any new or modified performance tracking and payment systems for the Medicaid program; and providing funding for a health care delivery system reform incentive payments program.

### 8.3001: DEFINITIONS

1. "Act" means the Colorado Healthcare Affordability and Sustainability Enterprise Act of 2017, § 25.5-4-402.4, C.R.S.
2. "Alternative Sliding Fee Scale" means a tiered copayment system for a hospital's Qualified Charity Care Program approved by the Department. A Hospital may request to use an Alternative Sliding Fee Scale for its Qualified Charity Care Program as an exception to the Standard Sliding Fee scale. The Alternative Sliding Fee Scale must determine the level of a patient's financial participation by income and household size only and guarantee that the patient financial participation is below that required under Hospital Discounted Care.
3. "CHASE" or "Enterprise" means the Colorado Healthcare Affordability and Sustainability Enterprise described in C.R.S. § 25.5-4-402.4(3).
- ~~3. "CICP" means the Colorado Indigent Care Program, as described in 10 CCR 2505-10, Section 8.900.~~
- ~~4. "CICP Day" means an inpatient hospital day for a recipient enrolled in the CICP.~~
- ~~54.~~ "CMS" means the federal Centers for Medicare and Medicaid Services.
- ~~65.~~ "Critical Access Hospital" means a hospital qualified as a critical access hospital under 42 U.S.C. § 1395i-4(c)(2) and licensed or certified as a critical access hospital by the Colorado Department of Public Health and Environment.
6. "Department" means the Department of Health Care Policy and Financing established pursuant to C.R.S. §section 25.5-1-104, C.R.S.
7. "Disproportionate Share Hospital Payment" or "DSH Payment" means the payments made to qualified hospitals that serve a disproportionate share of Medicaid and uninsured individuals as required under 42 U.S.C. § 1396r-4. Federal law establishes an annual DSH allotment for each state that limits federal financial participation for total statewide DSH payments made to hospitals.
8. "Emergency Hospital Services" means treatment for conditions of an acute, severe nature which are life, limb, or disability threats requiring immediate attention, where any delay in treatment would, in the judgment of the responsible physician, threaten life or loss of function of a patient or viable fetus.
9. "Enterprise Board" means the Colorado Healthcare Affordability and Sustainability Enterprise Board described in C.R.S. § 25.5-4-402.4(7).



- ~~9~~10. "Essential Access Hospital" means a Critical Access Hospital or General Hospital not located within a Metropolitan Statistical Area (MSA) designated by the United States Office of Management and Budget and having 25 or fewer licensed beds.
- ~~40~~11. "Exclusive Provider Organization" or "EPO" means a type of managed care health plan where members are not required to select a primary care provider or receive a referral to receive services from a specialist. EPOs will not cover care provided out-of-network except in an emergency.
- ~~44~~12. "Federal Poverty Guideline" or "FPG" means a measure of income level issued annually by the United States Department of Health and Human Services.
- ~~13.~~ "Fund" means the healthcare affordability and sustainability fee cash fund described in C.R.S. § 25.5-4-402.4(5).
- ~~42~~14. "General Hospital" means a hospital licensed as a general hospital by the Colorado Department of Public Health and Environment.
- ~~43~~15. "High Volume Medicaid ~~and CIGP~~ Hospital" means a hospital with at least ~~395,000~~ Medicaid Days per year ~~that provides over 35% of its total days to Medicaid and CIGP clients.~~
- ~~44~~16. "Health Maintenance Organization" or "HMO" means a type of managed care health plan that limits coverage to providers who work for or contract with the HMO and requires selection of a primary care provider and referrals to receive services from a specialist. HMOs will not cover care provided out-of-network except in an emergency.
- ~~45~~17. "High Medicaid Utilization Hospital" means a hospital with a Medicaid payer mix greater than or equal to twenty-five percent (25%) and a Medicaid non-managed care patient days utilization rate greater than or equal to forty percent (40%).
- ~~46~~18. "Heart Institute Hospital" means a hospital recognized as a HeartCARE Center by the American College of Cardiology (ACC) with at least 25,000 Medicaid Non-Managed Care Days per year.
- ~~19.~~ "Hospital Discounted Care" means Health Care Billing for Indigent Patients as set forth ~~defined in~~ Title 25.5, Article 3, Part 5, C.R.S.
- ~~20.~~ "Hospital-Specific Disproportionate Share Hospital Limit" or "Hospital-Specific DSH Limit" means a hospital's maximum allowable Disproportionate Share Hospital payment eligible for Medicaid federal financial participation allowed under 42 U.S.C. § 1396r-4.
- ~~48~~21. "Hospital Transformation Program Supplemental Medicaid Payments" or "HTP Supplemental Medicaid Payments" means the:
- ~~4~~a. Outpatient Hospital Supplemental Medicaid Payment described in Section 8.3004.B.,
- ~~2~~b. Inpatient Hospital Supplemental Medicaid Payment described in Section 8.3004.C., and
- ~~3~~c. Essential Access Hospital Supplemental Medicaid Payment described in Section 8.3004.E.
- ~~49~~22. The HTP Supplemental Medicaid Payments do not include the Hospital Quality Incentive Payment described in Section 8.3004.F. or Rural Support Program Hospital Supplemental Medicaid Payment described in Section 8.3004.G.



- ~~20~~23. "Independent Metropolitan Hospital" means an independently owned and operated hospital located within a Metropolitan Statistical Area (MSA) designated by the United States Office of Management and Budget with at least 1,500 Medicaid Days per year.
- ~~21~~24. "Inpatient Services Fee" means an assessment on hospitals based on inpatient Managed Care Days and Non-Managed Care Days.
- ~~22~~25. "Inpatient Upper Payment Limit" means the maximum amount that Medicaid can reimburse a provider for inpatient hospital services and still receive federal financial participation.
- ~~23~~26. "Long Term Care Hospital" means a General Hospital that is certified as a long-term care hospital by the Colorado Department of Public Health and Environment.
- ~~24~~27. "Managed Care Day" means an inpatient hospital day for which the primary payer is a managed care health plan, including HMO, PPO, POS, and EPO days.
- ~~25~~28. "Medicaid Day" means a Managed Care Day or Non-Managed Care Day for which the primary or secondary payer is Medicaid.
- ~~29~~26. "Medicaid Managed Care Day" means a Managed Care Day for which the primary payer is Medicaid.
- ~~27~~30. "Medicare Cost Report" means the Medicare hospital cost report, form CMS 2552-96 or CMS 2552-10, or any successor form created by CMS.
- ~~31~~28. "MMIS" means the Medicaid Management Information System, the Department's Medicaid claims payment system.
- ~~32~~29. "MIUR" means Medicaid inpatient utilization rate which is calculated as Medicaid Days divided by total hospital days.
- ~~30~~33. "Neonatal Intensive Care Unit Hospital" or "NICU Hospital" means a hospital with a NICU classification of Level III or IV according to guidelines published by the American Academy of Pediatrics (AAP).
- ~~31~~34. "Non-Managed Care Day" means an inpatient hospital day for which the primary payer is an indemnity insurance plan or other insurance plan not serving as an HMO, PPO, POS, or EPO.
- ~~32~~35. "Non-State-Owned Government Hospital" means a hospital that is either owned or operated by a local government.
- ~~33~~36. "Outpatient Services Fee" means an assessment on hospitals based on outpatient hospital charges.
- ~~34~~37. "Outpatient Upper Payment Limit" means the maximum amount that Medicaid can reimburse a provider for outpatient hospital services and still receive federal financial participation.
- ~~35~~38. "Pediatric Specialty Hospital" means a hospital that provides care exclusively to pediatric populations.
- ~~39~~36. "POS" or "Point of Service" means a type of managed care health plan that charges patients less to receive services from providers in the plan's network and requires a referral from a primary care provider to receive services from a specialist.

4037. "PPO" or "Preferred Provider Organization" means a type of managed care health plan that contracts with providers to create a network of participating providers. Patients are charged less to receive services from providers that belong to the network and may receive services from providers outside the network at an additional cost.
3841. "Privately-Owned Hospital" means a hospital that is privately owned and operated.
3942. "Psychiatric Hospital" means a hospital licensed as a psychiatric hospital by the Colorado Department of Public Health and Environment.
4043. "Qualified Charity Care Program" means a program approved by the Department which at a minimum includes discounted Emergency Hospital Services for uninsured patients with incomes up to and including 250 percent of the federal poverty guidelines FPG throughout the year.
- a. Where ~~an a uninsured~~ patient's copayment is determined by a Qualified Sliding Fee Scale.
- b. Where an ~~uninsured~~ patient's copayment amount is ~~good~~ valid for one year from the date of service or date of income determination, whichever is earlier, and
- c. Which exempts patient debts from permissible collection activities for ~~uninsured~~ patients who were determined eligible for the hospital's Qualified Charity Care Program and have an FPG level at or below 250% or for those eligible patients for whom the hospital failed to meet the Patient Contact Best Effort requirements described in Section 8.922.A.7. ~~or who were not screened for eligibility for the hospital's Qualified Charity Care Program~~
- d. A Hospital's Qualified Charity Care Program must comply with all other requirements under Hospital Discounted Care including but not limited to requirements to provide information in the patient's preferred language, screening and application requirements described in Section 8.922., and allowing patient payment plans not exceeding the amount and duration required in Hospital Discounted Care.
44. "Qualified Sliding Fee Scale" means ~~either the Standard Sliding Fee Scale or an Alternative Sliding Fee Scale approved by the Department. a tiered copayment system approved by the Department that determines the level of an uninsured patient's financial participation and guarantees that the patient financial participation is below that required under Hospital Discounted Care. Factors considered in establishing the patient's copayment shall only be patient's income and household size.~~
45. "Rehabilitation Hospital" means an inpatient rehabilitation facility.
4146. "Respiratory Hospital" means a hospital that primarily specializes in respiratory related diseases.
4247. "Rural Hospital" means a hospital not located within a Metropolitan Statistical Area (MSA) designated by the United States Office of Management and Budget.
4348. "Safety Net Metropolitan Hospital" means a hospital that provides services within the Pueblo, Colorado Metropolitan Statistical Area designated by the United States Office of Management and Budget (Pueblo MSA) with no less than 15,000 Days per year reported on its Medicare Cost Report, Worksheet S-3, Part 1, Column 7 (Title XIX), lines 1-18, and 28 (adult, pediatrics, intensive care, and subunits).
4944. "State-Owned Government Hospital" means a hospital that is either owned or operated by the State.

4550. “Teaching Hospital” means a High-Volume Medicaid ~~and CIGP~~ Hospital which provides supervised teaching experiences to graduate medical school interns and residents enrolled in a state institution of higher education, and in which more than fifty percent (50%) of its credentialed physicians are members of the faculty at a state institution of higher education.

51. “Standard Sliding Fee Scale” means the patient copayments for a hospital’s Qualified Charity Care Program for various health care services by income level as shown in the table and descriptions below.

<u>Percent of FPG</u>	<u>0 - 40% and Homeless</u>	<u>0 - 40%</u>	<u>41 - 62%</u>	<u>63 - 81%</u>	<u>82 - 100%</u>	<u>101 - 117%</u>	<u>118 - 133%</u>	<u>134 - 159%</u>	<u>160 - 185%</u>	<u>186 - 200%</u>
<u>Ambulatory Surgery</u>	<u>\$0</u>	<u>\$15</u>	<u>\$65</u>	<u>\$105</u>	<u>\$155</u>	<u>\$220</u>	<u>\$300</u>	<u>\$390</u>	<u>\$535</u>	<u>\$600</u>
<u>Inpatient Facility</u>	<u>\$0</u>	<u>\$15</u>	<u>\$65</u>	<u>\$105</u>	<u>\$155</u>	<u>\$220</u>	<u>\$300</u>	<u>\$390</u>	<u>\$535</u>	<u>\$600</u>
<u>Hospital Physician</u>	<u>\$0</u>	<u>\$7</u>	<u>\$35</u>	<u>\$55</u>	<u>\$80</u>	<u>\$110</u>	<u>\$150</u>	<u>\$195</u>	<u>\$270</u>	<u>\$300</u>
<u>Emergency Department</u>	<u>\$0</u>	<u>\$15</u>	<u>\$25</u>	<u>\$25</u>	<u>\$30</u>	<u>\$30</u>	<u>\$35</u>	<u>\$35</u>	<u>\$45</u>	<u>\$45</u>
<u>Emergency Transportation</u>	<u>\$0</u>	<u>\$15</u>	<u>\$25</u>	<u>\$25</u>	<u>\$30</u>	<u>\$30</u>	<u>\$35</u>	<u>\$35</u>	<u>\$45</u>	<u>\$45</u>
<u>Outpatient Hospital Services</u>	<u>\$0</u>	<u>\$7</u>	<u>\$15</u>	<u>\$15</u>	<u>\$20</u>	<u>\$20</u>	<u>\$25</u>	<u>\$25</u>	<u>\$35</u>	<u>\$35</u>
<u>Clinic Services</u>	<u>\$0</u>	<u>\$7</u>	<u>\$15</u>	<u>\$15</u>	<u>\$20</u>	<u>\$20</u>	<u>\$25</u>	<u>\$25</u>	<u>\$35</u>	<u>\$35</u>
<u>Specialty Outpatient</u>	<u>\$0</u>	<u>\$15</u>	<u>\$25</u>	<u>\$25</u>	<u>\$30</u>	<u>\$30</u>	<u>\$35</u>	<u>\$35</u>	<u>\$45</u>	<u>\$45</u>
<u>Prescription</u>	<u>\$0</u>	<u>\$5</u>	<u>\$10</u>	<u>\$10</u>	<u>\$15</u>	<u>\$15</u>	<u>\$20</u>	<u>\$20</u>	<u>\$30</u>	<u>\$30</u>
<u>Laboratory</u>	<u>\$0</u>	<u>\$5</u>	<u>\$10</u>	<u>\$10</u>	<u>\$15</u>	<u>\$15</u>	<u>\$20</u>	<u>\$20</u>	<u>\$30</u>	<u>\$30</u>
<u>Basic Radiology &amp; Imaging</u>	<u>\$0</u>	<u>\$5</u>	<u>\$10</u>	<u>\$10</u>	<u>\$15</u>	<u>\$15</u>	<u>\$20</u>	<u>\$20</u>	<u>\$30</u>	<u>\$30</u>
<u>High-Level Radiology &amp; Imaging</u>	<u>\$0</u>	<u>\$30</u>	<u>\$90</u>	<u>\$130</u>	<u>\$185</u>	<u>\$250</u>	<u>\$335</u>	<u>\$425</u>	<u>\$580</u>	<u>\$645</u>

a. Inpatient facility charges are for all non-physician (facility) services received by a patient while receiving care in the hospital setting for a continuous stay of 24 hours or longer.

- b. Ambulatory Surgery charges are for all non-physician (facility) Ambulatory Surgery operative procedures received by a patient who is admitted to and discharged from the hospital setting on the same day. The Clientpatient is also responsible for the corresponding Hospital Physician charges.
- c. Hospital Physician charges are for services provided directly by a physician in the hospital setting, including inpatient, ambulatory surgery, and emergency room care.
- d. Clinic Services charges are for all non-physician (facility) and physician services received by a patient while receiving care in the outpatient clinic setting. Outpatient charges include primary and preventive medical care. This charge does not include radiology or laboratory services performed at the clinic.
- e. Emergency Department charges are for all non-physician (facility) services received by a patient while receiving Emergency Hospital Services or Urgent Care in the hospital setting for a continuous stay less than 24 hours.
- f. Specialty Outpatient charges are for all non-physician (facility) and physician services received by a patient while receiving care in the specialty outpatient setting. These services can be provided in standalone clinics and outpatient hospital settings. Specialty Outpatient charges include distinctive medical care (i.e., oncology, orthopedics, hematology, pulmonary) that is not normally available as primary and preventive medical care. Specialty Outpatient charges do not include radiology, laboratory, emergency room, or ambulatory surgery services provided in a hospital setting.
- g. Emergency Transportation charges are for transportation provided by an ambulance.
- h. Laboratory Service charges are for all laboratory tests received by a patient while receiving care in the outpatient hospital or clinic setting. Laboratory Service charges may not be charged in addition to charges for emergency room or inpatient services provided in the hospital setting.
- i. Basic Radiology and Imaging Service charges are for all radiology and imaging services received by a patient while receiving care in the outpatient hospital or clinic setting. Basic Radiology and Imaging Service charges may not be charged in addition to charges for emergency room or inpatient services provided in the hospital setting.
- j. Prescription charges are for prescription drugs received by a patient at a Qualified Health Care Provider's pharmacy as an outpatient service. To encourage the availability of discounted prescription drugs, providers are allowed to modify (increase or decrease) the Prescription Copayment with the written approval of the Department.
- k. High-Level Radiology and Imaging Service charges are for patients receiving Magnetic Resonance Imaging, Computed Tomography, Positron Emission Tomography or other Nuclear Medicine services, Sleep Studies, or Catheterization Laboratory in the outpatient hospital, emergency room, or clinic setting.
- l. Outpatient Hospital Service charges are for all non-physician (facility) and physician services received by a patient while receiving non-Emergency Care or non-Urgent Care in the outpatient clinic setting. Outpatient Hospital Services charges include primary and preventive medical care. This charge does not include radiology, laboratory, emergency room, or ambulatory surgery services provided in a hospital setting.

m. Patients who are seen in the hospital setting in an observation bed should be charged the emergency room copay if their stay is less than 24 hours and the inpatient facility copay if their stay is 24 hours or longer.

4652. “Supplemental Medicaid Payments” means the:

1a. Outpatient Hospital Supplemental Medicaid Payment described in [Section 8.3004.B.](#),

2b. Inpatient Hospital Supplemental Medicaid Payment described in [Section 8.3004.C.](#),

3c. Essential Access Hospital Supplemental Medicaid Payment described in [Section 8.3004.E.](#),

d4. Hospital Quality Incentive Payment described in [Section 8.3004.F.](#), and

5e. Rural Support Program Hospital Supplemental Medicaid Payment described in [Section 8.3004.G.](#)

4753. “Uninsured Cost” means uninsured days and charges allocated to routine and ancillary cost centers and multiplied by the most recent provider-specific per diem cost and cost-to-charge ratio from the Medicare Cost Report.

4854. “Urban Center Safety Net Specialty Hospital” means a hospital located in a Metropolitan Statistical Area designated by the United States Office of Management and Budget where its Medicaid Days plus ~~CICP-uninsured inpatient d~~Days relative to total inpatient hospital days per year, rounded to the nearest percent, equals, or exceeds 65%.

55. “Urgent Care” means treatment needed because of an injury or serious illness that requires treatment within 48 hours.

### **8.3003: HEALTHCARE AFFORDABILITY AND SUSTAINABILITY FEE**

#### **8.3003.A. OUTPATIENT SERVICES FEE**

1. Federal requirements. The Outpatient Services Fee is subject to federal approval by CMS. The Enterprise shall demonstrate to CMS, as necessary for federal financial participation, that the Outpatient Services Fee is in compliance with 42 U.S.C. §§ 1396b(w), 1396b(w)(3)(E), and 1396b(w)(4).

2. Exempted hospitals. Psychiatric Hospitals, Long Term Care Hospitals and Rehabilitation Hospitals are exempted from the Outpatient Services Fee.

3. Calculation methodology. The Outpatient Services Fee is calculated on an annual basis as 1.6625% of total hospital outpatient charges, with the following exception:

a. High Volume Medicaid ~~and CICP~~ Hospitals’ Outpatient Services Fee is discounted to 1.6485% of total hospital outpatient charges.

4. A one-time Outpatient Services Fee shall be collected from hospitals to increase Inpatient Hospital Supplemental Medicaid Payments and Outpatient Hospital Supplemental Medicaid Payments to 99.25% of the Inpatient Upper Payment Limit and Outpatient Upper Payment Limit for federal fiscal year 2022-23 and federal fiscal year 2023-24.

a. The Outpatient Services Fee is calculated as .0359% of a hospital’s cost report year-end (CRYE) 2022 total hospital outpatient charges, with the following exception:

- i. High Volume Medicaid ~~and CIGP~~ Hospital's Outpatient Services Fee is discounted to .0356% of CRYE 2022 total hospital outpatient charges.

#### **8.3003.B. INPATIENT SERVICES FEE**

1. Federal requirements. The Inpatient Services Fee is subject to federal approval by CMS. The Enterprise shall demonstrate to CMS, as necessary for federal financial participation, that the Inpatient Services Fee is in compliance with 42 U.S.C. §§ 1396b(w), 1396b(w)(3)(E), and 1396b(w)(4).
2. Exempted hospitals. Psychiatric Hospitals, Long Term Care Hospitals and Rehabilitation Hospitals are exempted from the Inpatient Services Fee.
3. Calculation methodology. The Inpatient Services Fee is calculated on an annual per inpatient day basis of \$106.01 per day for Managed Care Days and 473.90 per day for Non-Managed Care Days, with the following exceptions:
  - a. High Volume Medicaid ~~and CIGP~~ Hospitals' Inpatient Services Fee is discounted to \$55.35 per day for Managed Care Days and \$247.42 per day for Non-Managed Care Days, and
  - b. Essential Access Hospitals' Inpatient Services Fee is discounted to 42.40 per day for Managed Care Days and \$189.56 per day for Non-Managed Care Days.
4. A one-time Inpatient Services Fee shall be collected from hospitals to increase Inpatient Hospital Supplemental Medicaid Payments and Outpatient Supplemental Medicaid Payments to 99.25% of the Inpatient Upper Payment Limit and Outpatient Upper Payment Limit for federal fiscal year 2022-23 and federal fiscal year 2023-24.
  - a. The Inpatient Services Fee is calculated as \$2.68 per CRYE 2022 Managed Care Day and \$11.96 per CRYE 2022 Non-Managed Care Day, with the following exceptions:
    - i. High Volume Medicaid ~~and CIGP~~ Hospitals' Inpatient Services Fee is discounted to \$1.40 per CRYE 2022 Managed Care Day and \$6.24 per CRYE 2022 Non-Managed Cared Day, and
    - ii. Essential Access Hospitals' Inpatient Services Fee is discounted to \$1.07 per CRYE 2022 Managed Care Day and \$4.78 per CRYE 2022 Non-Managed Care Day.

#### **8.3004: SUPPLEMENTAL MEDICAID AND DISPROPORTIONATE SHARE HOSPITAL PAYMENTS**

##### **8.3004.D. DISPROPORTIONATE SHARE HOSPITAL SUPPLEMENTAL PAYMENT**

1. Qualified hospitals are hospitals that:-
  - a. Hospitals that hH have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric care for Medicaid clients or are exempt from the obstetrician requirement pursuant to 42 U.S.C. § 1396r-4(d)(2)(A) are qualified to receive this payment, and
  - b. are Colorado Indigent Care Program providersHave a Qualified Charity Care Program, or and have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric care for Medicaid clients or are exempt from the obstetrician

requirement pursuant to 42 U.S.C. § 1396r-4(d)(2)(A) are qualified to receive this payment.

~~bc.~~ ~~Hospitals Have~~with a MIUR equal to or greater than the mean plus one standard deviation of all MIURs for Colorado hospitals, ~~or and have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric care for Medicaid clients or are exempt from the obstetrician requirement pursuant to 42 U.S.C. § 1396r-4(d)(2)(A) are qualified to receive this payment.~~

~~ed.~~ Are Critical Access Hospitals or Rural Hospitals designated as Sole Community Hospitals pursuant to 42 U.S.C. § 1395ww(d)(5)(D)(iii) with at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric care for Medicaid clients or are exempt from the obstetrician requirement pursuant to 42 U.S.C. § 1396r-4(d)(2)(A) are qualified to receive this payment

2. Excluded hospitals. Psychiatric Hospitals are not qualified to receive this payment.

3. Calculation methodology for payment.

a. Total ~~funds for the DSH~~ payments shall equal Colorado's total computable DSH allotment pursuant to 42 U.S.C. § 1396r-4(f)(3) and published in the Federal Register pursuant to 44 U.S.C. § 1504, \$257,231,668.

b. No qualified hospital shall receive a payment greater than 100% of their Hospital-Specific DSH Limit.

c. A qualified hospital with ~~CICP-uninsured patient~~ write-off costs greater than 700% of the state-wide average shall receive a payment equal to a minimum of 96.00% of their Hospital-Specific DSH Limit.

d. A qualified Critical Access Hospital or Rural Hospital shall receive a payment equal to a minimum of 86.00% of their Hospital Specific DSH Limit.

e. A qualified hospital not owned/operated by a healthcare system network within a Metropolitan Statistical Area and having less than 2,700 Medicaid Days shall receive a payment equal to a minimum of 80.00% of their Hospital-Specific DSH Limit.

f. All remaining qualified hospitals shall receive a payment calculated as the percentage of uninsured costs to total uninsured costs for all remaining qualified hospitals, multiplied by the remaining funds.

g. A Low MIUR hospital shall have their Hospital-Specific DSH Limit equal 10.00%.

i. A low MIUR hospital is a hospital with a MIUR less than or equal to 22.50%.

h. The payment percentage of the hospital specific DSH limit shall be published in provider bulletin

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Title of Rule: Revision to the Medical Assistance Act Rule concerning Member Appeals Rule  
Rule Number: MSB 25-01-07-B  
Division / Contact / Phone: Health Policy Officer / Russ Zigler / 303-866-5927

## **SECRETARY OF STATE**

### **RULES ACTION SUMMARY AND FILING INSTRUCTIONS**

#### **SUMMARY OF ACTION ON RULE(S)**

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 25-01-07-B, Revision to the Medical Assistance Act Rule concerning Member Appeals Rule
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):  
Sections(s) 8.057, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No  
If yes, state effective date:  
Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

#### **PUBLICATION INSTRUCTIONS\***

Replace the current text at 8.057 with the proposed text beginning at 8.057 through the end of 8.57.15.A.2. This rule is effective June 30, 2025.



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Title of Rule: Revision to the Medical Assistance Act Rule concerning Member Appeals Rule  
Rule Number: MSB 25-01-07-B  
Division / Contact / Phone: Health Policy Officer / Russ Zigler / 303-866-5927

### STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

Under the current Social Security Act Section 1902(e)(14)(A) waiver (Section 1902(e)(14)(A) waiver) issued to the Department by the Center for Medicare and Medicaid Services (CMS), and current Department rule, members who appeal eligibility or benefit actions no later than sixty (60) days after the date of notice maintain their benefits or services until a final agency decision is rendered after the hearing. The Department received notice in November 2024 that this waiver will expire on June 30, 2025. After the waiver expires on June 30, 2025, the timeframes for requesting an appeal and maintaining, or reinstating, benefits or eligibility on appeal will be governed by existing federal regulation and state statute, as explained below.

Section 25.5-4-207(1)(a)(II), C.R.S., requires the Department to automatically continue benefits if the member files an appeal prior to the effective date of the intended action (eligibility or benefit determinations) until the appeal process is completed, unless the member requests in writing that benefits not continue during the appeal process. The corresponding federal regulation at 42 C.F.R. 431.230(a-b) allows the continuation of benefits (maintaining services) on appeal where the member requests a hearing before the date of action, unless it is determined at the hearing that the sole issue is one of federal or state law or policy and the Department promptly informs the beneficiary in writing that services are to be terminated or reduced pending the hearing decision. In order to comply with existing law after the Section 1902(e)(14)(A) waiver expires on June 30, 2025, the proposed rule aligns section 8.057.5.A with state statute and federal regulation by requiring a member to request an appeal before the date of action in order to maintain benefits during the appeal.

In regard to reinstating and continuing benefits or services after the date of action (eligibility or benefit determinations), Section 25.5-4-207(1)(a)(II), C.R.S., states the Department may, to the extent authorized by federal law, permit continuing benefits until the appeal process is completed, even if the member's appeal is filed after the effective date of intended action. It then lists the circumstances under which the Department must, at a minimum, allow continuation of benefits. The corresponding federal regulation at 42 CFR 431.231(a-b) permits the reinstatement of benefits or services if a member requests a hearing not more than ten (10) days after the date of action ending benefits or services, unless it is determined at the hearing that the sole issue is one of federal state or law or policy. Section 8.057.5.D already allows for the maximum ten (10) days after the date of action to request a

Initial Review  
Proposed Effective Date

**04/11/25**  
**06/30/25**

Final Adoption  
Emergency Adoption

**05/09/25**

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hearing and reinstate benefits or services and allows reinstatement of benefits only where the member documents one of the circumstances listed in Section 25.5-4-207(1)(a)(II), C.R.S., is documented by the member. The proposed rule removes the requirement that one of the circumstances listed in Section 25.5-4-207(1)(a)(II), C.R.S., must be documented by the member to qualify for reinstatement of benefits. By removing that requirement, the proposed rule allows for reinstatement of benefits for any member that files an appeal no more than ten (10) days after the date of action, regardless of circumstance.

The proposed rule complies with federal law and state statute upon the expiration of the Section 1902(e)(14)(A) waiver on June 30, 2025 and allows for the maintenance of services upon appeal, and the reinstatement and continuation of benefits on request for hearing, to the maximum extent allowed under federal law and state statute.

The proposed rule also aligns Department rule with current Office of Administrative Courts policy regarding the modalities an applicant or member may use to request a hearing or withdraw a hearing.

2. An emergency rule-making is imperatively necessary

- ☐ to comply with state or federal law or federal regulation and/or  
☐ for the preservation of public health, safety and welfare.

Explain:

3. Federal authority for the Rule, if any:

42 C.F.R. §§ 431.210, .230(a)(1)-(2), .231(a)-(b), and 42 C.F.R. § 435.923

4. State Authority for the Rule:

CRS §§ 25.5-1-301 to -303  
CRS § 25.5-4-207(1)(a)(II)

Initial Review  
Proposed Effective Date

**04/11/25**  
**06/30/25**

Final Adoption  
Emergency Adoption

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### **REGULATORY ANALYSIS**

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

Members appealing their Medicaid eligibility or benefits actions are affected by the proposed rule. Such members will bear the cost of being required to request a hearing before the date of action to maintain benefits. Such members will benefit from the proposed rule by having the ability to request a hearing and reinstate benefits after the date of action for any reason, regardless of circumstances, so long as the request is made no later than ten (10) days after the intended action (unless it is determined at the hearing that the sole issue is one of federal or state law or policy, as required by federal law). Such members will also benefit from the expanded modalities by which they may request a hearing or withdraw a request for hearing.

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

Members appealing an eligibility or benefit determination will be required to request a hearing before the date of action in order to maintain benefits and services during the course of the appeal, rather than within sixty (60) calendar days after the notice of action as allowed under the current Section 1902(e)(14)(A) waiver.

Under the proposed rule, member benefits must be reinstated if they request a hearing no more than ten (10) days after the intended action, regardless of circumstances. Members appealing an eligibility or benefit determination will no longer be required to document one of the circumstances listed in Section 25.5-4-207(1)(a)(II), C.R.S. is applicable to them in order to have their benefits reinstated.

The proposed rule also expands the modalities by which an applicant or member may request a hearing or withdraw a request for hearing.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

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There are no probable costs to the Department associated with the proposed rule. Given that factors such as the number of members affected by these regulations, length of time required for a final agency decision to be rendered and utilization during the relevant periods cannot be reasonably estimated at this time. Additionally, it is anticipated that any utilization impact stemming from this change would be minimal, making any budget impact minimal. Thus, there is no anticipated effect on state revenues.

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

The probable cost of the proposed rule that members must request an appeal prior to the date of action in order to maintain benefits is zero dollars. The benefit of the proposed rule is compliance with federal and state law following the expiration of the Section 1902(e)(14)(A) waiver and that members will no longer be required to document one of the Section 25.5-4-207(1)(a)(II), C.R.S., circumstances to have their benefits reinstated on appeal (so long as the request for hearing is made not more than ten (10) days after the intended action). Another benefit is the expansion of modalities that members may use to request a hearing or withdraw a request for hearing.

The probable cost of inaction is violating federal law after the expiration of the Section 1902(e)(14)(A) waiver by allowing the maintenance of benefits on appeal beyond the timeframe allowed by 42 C.F.R. § 431.230. Another cost of inaction is maintaining the requirement that members must document one of the Section 25.5-4-207(1)(a)(II), C.R.S., circumstances in order to have their benefits reinstated on appeal after the date of the intended action. There are no benefits of inaction. Finally, another cost of inaction is not aligning Department rule with the federal requirements regarding all of the modalities by which an applicant or member may request a hearing or withdraw a request for hearing.

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

There are no less costly methods or less intrusive methods to comply with federal law upon the expiration of the Section 1902(e)(14)(A) waiver. It may be less costly to the Department to continue to require reinstatement of benefits upon appeal only where the CRS § 25.5-4-207(1)(a)(II) circumstances are documented by the member.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

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There are no alternative methods for complying with federal law upon the expiration of the Section 1902(e)(14)(A) waiver. The Department considered not removing the requirement for members to document one of the Section 25.5-4-207(1)(a)(II), C.R.S., circumstances to have their benefits reinstated after the date of action (so long as the request for appeal is made no later than ten (10) days after the intended action), but the Department rejected that course of action in order to provide the most opportunity possible, under federal and state law, for members to reinstate their benefits on appeal, regardless of circumstance. There are no alternative methods for aligning Department rule with the federal requirements regarding the modalities by which an applicant or member may request a hearing or withdraw a request for hearing.

## 8.057 RECIPIENT-APPLICANT OR MEMBER APPEALS

### 8.057.1 DEFINITIONS

1. Action means a denial, termination, suspension or reduction of Health First Colorado (Colorado Medicaid), eligibility or covered services. It also means determinations by skilled nursing facilities and nursing facilities to transfer or discharge residents and adverse determinations with regard to a Level II Screen finding for the preadmission screening and annual resident review requirements.
2. Adverse determination means a determination with regard to a Level II Screen finding for the preadmission screening and annual review requirements that the individual does not require the level of services provided by a nursing facility or that the individual does or does not require specialized services.
3. Authorized representative means a person or organization designated by the applicant or member to act on their behalf. Such authorization shall be in writing in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy regulations located at 45 C.F.R. parts 160 and 164. A written designated power of attorney may substitute for the HIPAA compliant release.
4. Date of action means the intended date on which a denial, termination, suspension, reduction, transfer or discharge becomes effective. It also means the date of the preadmission screening and annual resident review determination.
5. Notice, other than that required to be provided by a nursing facility seeking to transfer or discharge a resident, means a written statement which contains:
  - a. A statement of what action the Department or its designee intends to take and the effective date of such action;
  - b. The reasons for the intended action;
  - c. The specific regulations that support, or the change in federal or state law that requires the action;
  - d. An explanation of
    - i. The individual's right to request an evidentiary hearing if one is available; or
    - ii. In cases of an action based on a change in law, the circumstances under which a hearing will be granted.
  - e. The method by which the individual may obtain a hearing;
  - f. That the individual may represent themselves or use legal counsel, a relative, a friend, or other representative at the hearing; and
  - g. An explanation of the circumstances under which the Health First Colorado (Colorado Medicaid) eligibility or benefit that is the subject of the appeal is continued if a hearing is requested.

- h. For notices concerning a medical assistance program eligibility determination under section 8.100, an explanation of the applicant's or member's right to a county or service delivery agency dispute resolution conference.
6. Notice required to be provided by a nursing facility seeking to transfer or discharge a resident means a written statement which contains, in addition to the requirements above:
- a. The reason for transfer or discharge;
  - b. The effective date of the transfer or discharge;
  - c. The location to which the resident is to be transferred or discharged;
  - d. The name, address and telephone number of the State long-term care ombudsman;
  - e. For nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and
  - f. For nursing facility residents living with a mental illness, the mailing address and telephone number of the agency responsible for the protection and advocacy of individuals living with a mental illness established under the Protection and Advocacy for Mentally Ill Individuals Act.
7. Request for a hearing means a clear expression by the applicant or member, or their authorized representative that they want an opportunity to present their case to a reviewing authority.
8. Service delivery agency or designated service agency means a ~~department~~Department-designated, certified medical assistance site contracted with the ~~department~~Department to accept and process medical assistance applications approved by the federal Centers for Medicare and Medicaid Services, as authorized by C.R.S. § 25.5-4-205. Service delivery agencies utilize the Colorado Benefits Management System (CBMS) to determine eligibility for Child Health Plan Plus (CHP+) and Health First Colorado (Colorado Medicaid) medical assistance programs.

## **8.057.2 ADVANCE NOTICE**

- 8.057.2.A. Notice shall be mailed at least ten (10) calendar days before the date of ~~the intended~~ action except as permitted in 8.057.2.B and 8.057.2.C. Requirements for the timing of notice before the facility can transfer or discharge a resident shall be governed by 8.057.2.D and 8.057.2.E.
- 8.057.2.B. Notice for any action other than when a nursing facility seeks to transfer or discharge a resident, may be mailed less than ten (10) calendar days before the date of ~~the intended~~ action if:
- 1. The Department or its designee has factual information confirming the death of a ~~recipient~~member;
  - 2. The Department or its designee receives a clear written statement signed by a ~~recipient~~member that
    - a. The ~~recipient~~member no longer wishes services; or

- b. The ~~recipient member~~ gives information that requires termination or reduction of services and indicates that ~~he/she/they~~ understands that this must be the result of supplying that information;
- c. The ~~recipient member~~ has been admitted to an institution where ~~he/she is/they are~~ ineligible for further services;
- d. The ~~recipient's member's~~ whereabouts are unknown and the post office returns agency mail directed to ~~him/her/them~~ indicating no forwarding address;
- e. The ~~recipient member~~ has been accepted for Health First Colorado (Colorado Medicaid) services by another State, territory or commonwealth;
- f. A change in the level of medical care is prescribed by the ~~recipient's member's~~ physician; or
- g. The notice involves an adverse determination made with regard to the preadmission screening and annual resident review requirements.

8.057.2.C. Notice for any action other than when a nursing facility seeks to transfer or discharge a resident, shall be sent five (5) calendar days before the date of the action if:

- 1. The Department or its designee has facts indicating that action should be taken because of probable ~~lye~~ fraud by the ~~recipient member~~; and
- 2. The facts have been verified, if possible, through secondary sources.

8.057.2.D. Except as specified in 8.057.2.E, the required notice when a nursing facility seeks to transfer or discharge a resident shall be mailed at least thirty (30) calendar days before the resident is transferred or discharged.

8.057.2.E. The required notice by a nursing facility before transfer or discharge shall be as soon as practicable when:

- 1. The safety of individuals in the facility would be endangered;
- 2. The health of individuals in the facility would be endangered; or
- 3. The resident's health improves sufficiently to allow a more immediate transfer or discharge because the resident no longer needs the services provided by the facility;

### **8.057.3 OPPORTUNITY FOR HEARING**

**8.057.3.A An individual shall have an opportunity for a hearing where:**

- 1. An application for eligibility or a request for benefits or services is denied or is not acted upon with reasonable promptness;
- 2. The ~~recipient applicant or member~~ requesting the hearing believes the action is erroneous, including a loss of coverage without notice;
- 3. The resident of a nursing facility believes the facility has erroneously determined that ~~he/she/they~~ must be discharged; ~~and-or~~



4. An individual ~~who~~ believes the determination with regard to the preadmission and annual resident review requirements is erroneous.
- 8.057.3.B. An individual does not have the right to an opportunity for hearing if the sole issue is a federal or state law requiring an automatic change adversely affecting some or all ~~recipients~~applicants or members.
- 8.057.3.C. An individual does not have the right to an opportunity for hearing for a preadmission screening and annual resident review Level I Screen finding.
- 8.057.3.D. A provider of medical assistance or any other provider of goods and services to an applicant or ~~recipient~~member, shall not have the right to a hearing concerning an action or an adverse determination to an applicant or ~~recipient~~member.
- 8.057.3.E. A member of a Managed Care Organization ~~shall~~must exhaust the internal appeals process described at 8.209 prior to requesting a fair hearing.
- 8.057.3.F. Opportunity For County or Service Delivery Agency Dispute Resolution Conference. In addition to the opportunity for a hearing, an applicant or member shall have an opportunity to have their medical assistance program eligibility under section 8.100 resolved through an informal dispute resolution conference. An informal dispute resolution does not extend the period of time within which a member can timely file a formal appeal pursuant to 8.057.4.B.; nor does a request for an informal dispute resolution conference result in a continuation of benefits. Filing a formal appeal pursuant to 8.057.4. is the only way to receive a continuation of benefits, if applicable.

County and service delivery agencies shall afford applicants and members the opportunity for informal dispute resolutions as follows:

1. An applicant or member who disagrees with a decision regarding their eligibility may request dispute resolution either in writing or by phone no later than sixty (60) calendar days after the date of the Notice of Action (NOA). If available through the County or service delivery agencies, applicants and members may use email to make a request.
2. No later than ten (10) calendar days after receipt of the request for dispute resolution the County or service delivery agency, after a review of the case for accuracy and completeness, shall notify the applicant or member, in writing, of the date, time, and location of the conference. The notification shall also include the applicant or member's rights to a state level appeal and a deadline date for requesting such an appeal.
3. The County or service delivery agency shall hold the conference ~~within no more no later~~ than twenty-five (25) calendar days from the date the request was received unless both parties agree, in writing, to extend the date of the conference.
4. The applicant or member shall have the choice to have the dispute conference held in person or by phone.
5. The dispute resolution conference facilitator shall, within three (3) business days of the date of making an eligibility finding, notify the applicant or member of the finding from the conference via U.S. Mail.
6. If the finding is that the dispute has been resolved and the applicant or member has already filed an appeal, the County or service delivery agency shall inform the applicant or member of the process for dismissing their appeal.

#### **8.057.4 REQUEST FOR HEARING**

8.057.4.A. The request for a hearing shall be made to the Office of Administrative Courts in one or more of the following modalities: in writing, via the Office of Administrative Courts electronic filing system, by telephone, via mail, electronic mail, or in person, and contain:

1. The ~~recipient member~~ or applicant's name, address and State Identification Number, if applicable;
2. The action, denial or failure to act promptly on which the requested appeal is based; and
3. The reason for appealing the action, denial or failure to act promptly.

8.057.4.B. The request for a hearing shall be filed-submitted in the manner described in 8.057.4.A with the Office of Administrative Courts:

1. No later than sixty (60) calendar days after the date of the Notice of Action.

8.057.4.C. The ~~recipient member~~ or applicant or his/her/their authorized representative shall be entitled to examine the complete case file and any other documents to be used at hearing at a reasonable time before the hearing ~~or-and~~ during the hearing. Documents and information that are confidential as a matter of law shall be exempt from this requirement unless they are to be offered as evidence during the hearing.

8.057.4.D. If the ~~recipient member~~ or applicant makes an oral request for a hearing to the Department or its designee, the Department or its designee shall either prepare a written request for the individual's signature or have the individual prepare such a request.

8.057.4 E. Expedited Hearings

1. An applicant/~~recipient or member~~ may request an expedited hearing if the appeal involves an issue where the application of the standard timeframe for making a decision may seriously jeopardize the applicant or ~~recipient member~~'s life, health or ability to regain, attain, and maintain maximum function.
2. The process for requesting an expedited hearing shall be by the same method as prescribed in 8.057.4.A, B, C, and D.
3. Upon receipt of the request for expedited hearing, the Office of Administrative Courts shall contact the Department's Office of Appeals.
4. Upon notification by the Office of Administrative Courts, the Department's Office of Appeals shall determine whether the application of the standard timeframe for making a decision may seriously jeopardize the applicant/~~recipient's member's~~ life, health or ability to regain, attain, and maintain maximum function.

5. The Office of Appeals must make the decision whether to grant or deny the request for expedited hearing no later than one (1) day after notification.

~~56.~~ Grant of a request. If the Office of Appeals grants a request for expedited hearing, the Office of Appeals must:

~~a. Make the decision to grant an expedited hearing no later than one business day after notification from the Office of Administrative Courts of the request for expedited hearing;~~

~~ba.~~ Give the individual prompt oral notice of this decision; and

~~eb.~~ Subsequently send to the individual at ~~his or her~~their last known address written notice of the decision. This notice may be provided within the written notice of hearing.

~~67.~~ Denial of a request. If the Office of Appeals denies a request for expedited hearing, the Office of Appeals must:

~~a.~~ ~~Make this decision no later than one business day after notification from the Office of Administrative Courts of the request for expedited hearing;~~

~~ba.~~ Give the individual prompt oral notice of the denial that informs the individual of the denial and explains that the Office of Appeals will notify the Office of Administrative Courts to process the request for a non-expedite hearings; and

~~eb.~~ Subsequently send to the individual at ~~his or her~~their last known address and to the Department an equivalent written notice of the decision within ~~three~~ (3) business days after the oral notice.

~~78.~~ ~~The A~~ decision ~~by the Office of Appeals to deny, denying~~ a request for expedited hearing, may not be appealed.

~~89.~~ Timeframe for decision.

a. If the Office of Appeals ~~accepts-grants~~ a request for expedited hearing, the Office of Appeals shall schedule a hearing, as expeditiously as the applicant/~~recipient's~~ member's health condition requires, but no later than the end of the day after the decision to grant the hearing was made.

b. ~~A-If the decision involves a benefit appeal, a~~ decision on the hearing shall be made as expeditiously as the applicant/~~recipient's-member's~~ health condition requires, but no later than three (3) business days after the Office of Appeals receives the request for an expedited appeal.

c. If the decision involves an eligibility issue, pursuant to 8.100, the decision on the hearing shall be made as expeditiously as the individual's health condition requires, but no later than seven (7) business days after the Office of Appeals receives the request for an expedited appeal.

d. These time limits shall not apply if the Department cannot reach a decision because the applicant/~~recipient-member~~ requests a delay or fails to take a required action, or if there is an administrative or other emergency beyond the Department's control. The Department must document the reasons for any delay in the record.

~~910.~~ Hearing.

a. The scheduled hearing may be held in person, by video conference, or telephone or by phone and shall be recorded.

b. The Department's Executive Director, Medicaid Director, Medical Director or their designees may preside over the hearing.

~~4011.~~ Hearing Decision.

- a. The Department's Executive Director, Medicaid Director, Medical Director or their designees shall make a decision within the required timeframe.
- b. The Department's Executive Director, Medicaid Director, Medical Director or their designees shall give the individual prompt oral notice of this decision; and
- c. Subsequently send to the applicant/~~recipient~~ or member at ~~his or her~~their last known address written notice of the decision.
- d. The hearing decision shall constitute a Final Agency Decision for purposes of requesting judicial review, and Section 8.057.11 shall apply.

#### **8.057.5 MAINTAINING, REINSTATING, AND CONTINUING BENEFITS AND SERVICES**

8.057.5.A. Where the member requests a hearing ~~no later than 60 calendar days after the date of the Notice before the date of action, in accordance with Section 8.057.4.B.1.,~~ the member's benefits or services may not be terminated or reduced until a final agency decision is rendered after the hearing ~~unless:~~

1. ~~If a member requests a hearing after the date of action and no later than 60 calendar days after the date of Notice, in accordance with Section 8.057.4.B.1., benefits will be continued from the date of action. It is determined at the hearing that the sole issue is one of federal or state law or policy; and-~~
2. If it is determined at the hearing that the sole issue is one of federal or state law in accordance with section 8.057.5.A.1., the member must be promptly informed in writing that services are to be terminated or reduced pending the hearing decision.

8.057.5.B2. A request for an informal dispute resolution conference concerning eligibility determinations, in accordance with Section 8.057.3.F., does not maintain services or continue benefits.

8.057.5.C. Continued Benefits During an SSA Appeal. If an individual receiving Medicaid based upon disability is determined by SSA not to be disabled, and ~~he or she is~~they are not eligible for Medicaid on some other basis, Medicaid is continued during the sixty (60)-day period within which an SSA appeal may be filed. If the individual does not appeal the SSA decision within the sixty (60)-day period, Medicaid shall be terminated.

If an SSA hearing is requested within the sixty (60)-day period, Medicaid may not be terminated until a final decision is made after the SSA hearing. A final administrative decision occurs when the Medicaid ~~recipient~~member has no right to further administrative appeal with the SSA. The Department shall provide ten (10)-days notice to the individual that Medicaid shall be terminated after the sixty (60)-day period if the individual fails to appeal the SSA decision.

8.057.5.D. ~~Continuation or~~ Reinstatement and Continuation of Benefits After ~~t~~The Effective Date ~~Of~~ of The the Action. Where the ~~recipient~~member requests a hearing not more than ten (10) days after the date of ~~the intended~~ action, the ~~recipient~~ member's services ~~may be continued or reinstated~~must be reinstated back to the date of action and continued until a final agency decision is rendered after the hearing, unless it is determined at the hearing that the sole issue is one of federal or state law or policy if the recipient provides verification, in the form of a signed statement with supporting documentation, of one of the following circumstances.

1. ~~The recipient's life, health, or safety will be impacted by the loss of benefits~~A member's services must be reinstated and continued until a hearing decision is rendered after a hearing if:-
  - a. Action is taken without the advance notice required in section 8.057.2.A.
  - b. The member requests a hearing within ten (10) days from the date that the individual receives the notice of action. The date on which the notice is received is considered to be five (5) days after the date on the notice, unless the member attests that they did not receive the notice within the five (5) day period by submitting a written statement with their appeal request, filed no later than sixty (60) days from the date of notice in accordance with section 8.057.4.B.1. to the Office of Administrative Courts, and
  - c. The Department determines that the action resulted from other than the application of federal or state law or policy.
- ~~2. The recipient was unable to request a hearing before the date of action due to the recipient's disability or employment.~~
- ~~3. The recipient's caregiver or their authorized representative was unable to request a hearing before the date of action due to their health or employment.~~
- ~~4. The recipient did not receive the County's or designated service agencies notice prior to the effective date of the intended action.~~

#### **8.057.6 DENIAL OR DISMISSAL OF REQUEST FOR HEARING**

8.057.6.A. The request for hearing shall be denied or dismissed if:

1. The applicant or ~~recipient-member~~ withdraws the request in one or more of the following modalities: in writing, via the Office of Administrative Courts electronic filing system, by telephone, via mail, electronic mail, or in person; or
  - a. For telephonic hearing withdrawals, the Office of Administrative Courts must record the application or member's statement.
  - b. For telephonic, online and other electronic withdrawals, the Office of Administrative Courts must send the affected applicant or member written confirmation, via regular mail or electronic notification.
2. The applicant or ~~recipient-member~~ fails to appear at a scheduled hearing without good cause. Good cause shall mean a sudden severe illness, an accident, or other particular occurrence which, by its emergent nature and drastic effect, prevented appearance at the hearing.

8.057.6.B. The applicant or ~~recipient-member~~ shall have ten (10) calendar days from the date of the notice of dismissal of scheduled hearing to explain, in a letter to the Administrative Law Judge, the reason for ~~his/her~~their failure to appear. If the Administrative Law Judge finds that there was good cause for the nonappearance, the Administrative Law Judge shall schedule another hearing date.

#### **8.057.7 FAIR HEARINGS**

8.057.7.A. A hearing shall cover:

1. Action, denial, or failure to act with reasonable promptness regarding eligibility, benefits, or services;
2. Decisions regarding changes in the type or amount of benefits or services;
3. Decision by a nursing facility to transfer or discharge a resident; and
4. Determination with regard to the preadmission screening and annual resident review requirements.

8.057.7.B. Conference telephone hearings may be conducted as an alternative to face-to-face hearings. All applicable provisions of the face-to-face hearing shall apply to telephone hearings.

8.057.7.C. Upon receipt of notice of a Department hearing of an appeal, the county department shall arrange for a suitable hearing room appropriate to accommodate the number of persons, including witnesses, who are expected to be in attendance.

8.057.7.D. Except as otherwise specifically provided in these rules, the provisions of Section 24-4-105, C.R.S., as amended, shall apply to the conduct of fair hearings.

8.057.7.E. Hearings related to an applicant or ~~recipient's member's~~ disability determination, level of care determination or target group eligibility shall be held within twenty (20) calendar days after the Office of Administrative Courts receives the request for a fair hearing unless the ~~client~~ applicant or member demonstrates good cause for postponement of the hearing. Under no circumstances shall the hearing be conducted more than forty-five (45) calendar days after receipt of the request for a fair hearing.

8.057.7.F. In hearings which involve medical issues such as those concerning a diagnosis, an examining physician's report or a medical review team's decision, the Administrative Law Judge may order a medical assessment other than that in the record of the Department or its designee making the disability determination if the Administrative Law Judge considers such medical assessment necessary. The assessment shall be at the expense of the Department or its designee and shall be made part of the record.

8.057.7.G. The hearing shall be private unless the applicant or ~~recipient member~~ requests, on the record, that the hearing be open to the public.

8.057.7.H. If the appellant is not fluent in English or has a language difficulty, the Department will arrange with county assistance to have present at the hearing a qualified interpreter who will be sworn to translate correctly.

#### **8.057.8 INITIAL DECISIONS**

8.057.8.A. The Administrative Law Judge shall promptly prepare and issue a written Initial Decision and file it with the Office of Appeals of the Department. Initial decisions shall be based exclusively on evidence introduced at the hearing.

8.057.8.B. The Administrative Law Judge shall issue the Initial Decision following a disability determination hearing, a level of care denial hearing or a target group eligibility hearing within twenty (20) calendar days of the hearing date.

8.057.8.C. The Initial Decision shall be in writing and shall:

1. Summarize the facts;

2. Identify the regulations and evidence supporting the decision;
3. Advise the applicant or ~~recipient~~member that failure to file exceptions to the provisions of the Initial Decision shall waive the right to seek judicial review of a final agency decision affirming those provisions.

8.057.8.D. The Administrative Law Judge shall be bound by the Department's interpretation of statutes where the Department has regulations implementing such statutes.

8.057.8.E. The Administrative Law Judge shall have no jurisdiction or authority to determine issues of constitutionality or legality of the Department's regulations.

8.057.8.F. In hearings concerning disability determinations, the only factual issue to be determined by the Administrative Law Judge is whether the applicant or ~~recipient~~member meets the Health First Colorado (Colorado Medicaid) definition of disability or blindness set forth in section 8.100.1. The Administrative Law Judge's determination shall be limited to whether or not the applicant or ~~recipient~~member met the definition of disability or blindness on the date that the disability determination was completed.

8.057.8.G. In hearings concerning level of care determinations, the only factual issue to be determined by the Administrative Law Judge is whether the applicant or ~~recipient~~member meets the level of care screen applicable to the program at issue. The Administrative Law Judge's determination shall be limited to whether or not the applicant or ~~recipient~~member met the level of care on the date that the level of care determination was completed.

#### **8.057.9 REVIEW BY THE OFFICE OF APPEALS**

8.057.9.A. The Department's Office of Appeals shall promptly serve the Initial Decision upon each party to the fair hearing by first class mail. Party shall include the Department even if the Department has not previously appeared as a party to the appeal.

8.057.9.B. Any party seeking to reverse, modify or remand the Initial Decision shall file exceptions with the Office of Appeals within fifteen (15) calendar days, plus three (3) calendar days for mailing, of the date the Initial Decision is mailed to the parties.

8.057.9.C. Exceptions to Initial Decisions shall be in writing and shall state the specific grounds for reversal, modification, or remand of the Initial Decision.

8.057.9.D. A written transcript of the hearing is required where the party filing the exceptions asserts that the findings of evidentiary fact in the Initial Decision are not supported by the weight of the evidence.

1. The party requiring a written transcript of the hearing shall request the written transcript from the Office of Administrative Courts prior to the filing of exceptions. If the written transcript is not filed with the exceptions, the exceptions shall state that a written transcript has been requested. The party shall comply with all applicable due dates. Prior to the due date for filing exceptions, the party may request, in writing, an extension of time to file either exceptions or the written transcript.
2. In cases where the applicant or ~~recipient~~member (Appellant) requests a written transcript in order to file exceptions based on findings of evidentiary fact, the Department shall pay the transcribing agency for the cost of one original transcript for the Office of Appeals, and one copy for the requesting applicant or ~~recipient~~member.



3. While review of the ~~initial-Initial decision-Decision~~ is pending, the submitted written transcript of the hearing shall be available for examination by any party to the appeal, during regular business hours of the Office of Appeals.

8.057.9.E. The Office of Appeals shall promptly serve a copy of the exceptions on each party by first class mail. Each party may file a written response to an exception filed by another party within ten (10) calendar days from the date the exceptions were mailed to the parties.

8.057.9.F. The parties shall not have the right to oral argument to the Office of Appeals.

#### **8.057.10 FINAL AGENCY DECISIONS**

8.057.10.A. The Final Agency Decision shall be based on the record except that the Office of Appeals may remand for rehearing if a party establishes in its exceptions that material evidence has been discovered which the party could not, with reasonable diligence, have produced at the hearing.

8.057.10.B. The record shall consist only of:

1. The written transcript of testimony and exhibits,
2. All papers and requests filed in the proceeding;
3. The ~~initial-Initial decision-Decision~~ of the ~~administrative-Administrative~~ Law Judge; and
4. Any exceptions and requests filed in response to the ~~initial-Initial decision-Decision~~ of the ~~administrative-Administrative law-Law judgeJudge~~.

8.057.10.C. The applicant or ~~recipient-member~~ shall have access to the record at a convenient place and time.

8.057.10.D. The Office of Appeals shall issue a Final Agency Decision within ninety (90) calendar days, except as stipulated in 8.057.10.E, from the date the request for a hearing is received unless an extension has been granted to the applicant or ~~recipient-member~~ in which case the ninety (90) calendar day period shall be increased accordingly.

8.057.10.E. The Office of Appeals shall issue a Final Agency Decision within three (3) calendar days from the date the request for an expedited hearing is received.

#### **8.057.11 NOTIFICATION OF DECISION**

8.057.11.A. The applicant or ~~recipient-member~~ shall be provided, in writing, with:

1. A copy of the Final Agency Decision; and
2. Notification of ~~his/her~~their right to seek judicial review and the effective date of the Final Agency Decision for purposes of requesting judicial review.

8.057.11.B. For purposes of requesting judicial review, the effective date of the Final Agency Decision shall be the third day after the date the decision is mailed to the parties, even if the third day falls on Saturday, Sunday or a legal holiday.

#### **8.057.12 CORRECTIVE ACTION**



8.057.12.A. If the Final Agency Decision is favorable to the applicant or recipientmember, corrective action shall be taken, within three (3) working days after the effective date of the Final Agency Decision, retroactive to the date the incorrect action was taken.

#### **8.057.13 RECONSIDERATION OF FINAL AGENCY DECISION**

8.057.13.A. A party may file a motion for reconsideration of a Final Agency Decision with the Office of Appeals:

1. Upon a showing of good cause for failure to file exceptions to the Initial Decision within the allowed fifteen (15) calendar day period; or
2. Upon a showing that the Final Agency Decision is based upon a clear or plain error of fact or law.

8.057.13.B. The motion for reconsideration shall be filed, in writing, with the Office of Appeals within fifteen (15) calendar days of the date that the Final Agency Decision is mailed to the parties. The motion shall state the specific grounds for reconsideration.

8.057.13.C. The Office of Appeals shall promptly serve a copy of the motion for reconsideration on each party by first class mail. Each party may file a written response to a motion for reconsideration filed by another party within ten (10) calendar days from the date the motion was mailed to the parties.

8.057.13.D. The Office of Appeals shall promptly serve a copy of its decision on the motion for reconsideration on all parties by first class mail.

#### **8.057.14 INFORMAL CLIENT-APPLICANT OR MEMBER CONFERENCE IN DISABILITY DETERMINATIONS**

8.057.14.A. Prior to the issuance of an action regarding an applicant or recipient's-member's disability determination, the Department or the entity designated to conduct the disability determination shall provide the applicant or recipient-member with the opportunity for an informal conference, in person or by telephone, at which time the applicant or recipient-member may provide new or additional information relevant to the applicant or recipient's-member's claim of disability or blindness.

8.057.14.B. If ~~an action issues from the Department or the designated entity~~ the Department or designated entity issues an action, the appeal procedures set forth in section 8.057, Recipient Applicant or Member Appeals, shall apply to disability determinations.

#### **8.057.15 ALTERNATIVES TO INSTITUTIONAL CARE**

8.057.15.A. Recipients-Members who are determined to be likely to require a level of care available in an institution shall have the right to request a hearing where:

1. The recipient-member is not given the choice of home and community-based services as an alternative to the institutional care or
2. The recipient-member is denied the service of their choice or available provider of their choice.

**DO NOT PUBLISH THIS PAGE**

Title of Rule: Revision to the Medical Assistance Act Rule concerning Remote Patient Monitoring, Section 8.096  
Rule Number: MSB 24-12-31-B  
Division / Contact / Phone: Health Policy Office / Erica Schaler / 303-803-5607

**SECRETARY OF STATE**

**RULES ACTION SUMMARY AND FILING INSTRUCTIONS**

**SUMMARY OF ACTION ON RULE(S)**

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 24-12-31-B, Revision to the Medical Assistance Act Rule concerning Remote Patient Monitoring, Section 8.096
3. This action is an adoption of: new rule
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):  
Sections(s) 8.096, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No  
If yes, state effective date: N/A  
Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

**PUBLICATION INSTRUCTIONS\***

Insert the newly proposed text beginning at 8.096 through the end of 8.096.5.A. This rule is effective June 30, 2025.

**DO NOT PUBLISH THIS PAGE**

Title of Rule: Revision to the Medical Assistance Act Rule concerning Remote Patient Monitoring, Section 8.096

Rule Number: MSB 24-12-31-B

Division / Contact / Phone: Health Policy Office / Erica Schaler / 303-803-5607

**STATEMENT OF BASIS AND PURPOSE**

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

This rule adds Remote Patient Monitoring as section 8.096 of the Department's rules per Senate Bill 24-168. Remote Patient Monitoring means the outcoming remote assessment and monitoring of clinical data through technological equipment in order to detect changes in a member's clinical status, which allows health-care providers to intervene before a health condition exacerbates and requires emergency intervention or inpatient hospitalization.

2. An emergency rule-making is imperatively necessary

- ☐ to comply with state or federal law or federal regulation and/or  
☐ for the preservation of public health, safety and welfare.

Explain:

N/A

3. Federal authority for the Rule, if any:

N/A

4. State Authority for the Rule:

C.R.S. 25.5-5-337 through 338  
Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2024)

Initial Review  
Proposed Effective Date

**04/11/25**  
**07/01/25**

Final Adoption  
Emergency Adoption

**05/09/25**

**DOCUMENT**

## **DO NOT PUBLISH THIS PAGE**

Title of Rule: Revision to the Medical Assistance Act Rule concerning Remote Patient Monitoring, Section 8.096

Rule Number: MSB 24-12-31-B

Division / Contact / Phone: Health Policy Office / Erica Schaler / 303-803-5607

### **REGULATORY ANALYSIS**

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

The classes of persons affected by the proposed rule include Medicaid members with Diabetes, COPD, Heart Failure, Asthma, Pneumonia, or are carrying a high-risk pregnancy. Remote Patient Monitoring will benefit these classes as it is designed to prevent the member's admission or readmission to a hospital, Emergency Department, nursing facility, or other clinical setting.

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

This rule will likely reduce the overall cost of inpatient hospitalization as it is designed to prevent admission or readmission to a hospital, Emergency Department, nursing facility, or other clinical setting. This rule will have a positive impact on those with the conditions listed above by keeping these members in a community setting reducing overall cost to the member, to providers, and to facilities.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

There are no probable costs to the Department associated with this rule change, as all costs related to implementing Remote Monitoring services were accounted for in the fiscal note for SB 24-168.

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

There is no probable cost associated with the proposed rule – however the state legislature allocated funds specifically for this benefit. The benefit of the proposed rule is to reduce the instance of inpatient care for individuals with the listed conditions. This will reduce overall costs to the state for inpatient care. There is no benefit for inaction.

**DO NOT PUBLISH THIS PAGE**

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

There are no less costly methods or less intrusive methods for achieving the purpose of Remote Patient Monitoring.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

There were no alternative methods for achieving the purpose of the proposed rule considered.

## **8.095 Telemedicine**

### **8.095.1.A DEFINITIONS**

1. Electronic Consultation (eConsult) means an asynchronous dialogue initiated by a Treating Practitioner seeking a Consulting Practitioner's expert opinion without a face-to-face member encounter with the Consulting Practitioner.
2. Electronic Consultation Platform (eConsult Platform) means a web-based and application-based electronic system authorized by the Department that allows for an asynchronous exchange between a Treating Practitioner and a Consulting Practitioner to securely share health information and discuss member care. An eConsult Platform may be either:
  - a. State Platform: A platform contracted with the Department as the state's eConsult Platform.
  - b. Approved Platform: Any platform other than the State Platform that meets the criteria identified by the Department.
3. Electronic Health Entity (eHealth Entity) means a group practice that delivers services exclusively through telemedicine and is enrolled in a provider type that has an eHealth specialty. eHealth entities:
  - a. Cannot be Primary Care Medical Providers;
  - b. Can be either in-state or out-of-state.
4. Facilitated Visit means a Telemedicine visit where the rendering provider is at a distant site and the member is physically present with a support staff team member who can assist the provider with in-person activities.
5. HIPAA means the federal "Health Insurance Portability and Accountability Act of 1996", PUB. L. 104-191, as amended.
6. Primary Care Medical Provider (PCMP) means an individual physician, advanced practice nurse or physician assistant, who contracts with a Regional Accountable Entity (RAE) in the Accountable Care Collaborative (ACC), with a focus on primary care, general practice, internal medicine, pediatrics, geriatrics, or obstetrics and gynecology.
7. Consulting Practitioner means a provider who has education, training, or qualifications in a specialty field other than primary care
8. Telemedicine means the delivery of medical and health-care services and any diagnosis, consultation, or treatment using interactive audio (including but not limited to telephone and relay calls), interactive video (including but not limited to interactive audiovisual modalities), or interactive data communication (including but not limited to live chat and excluding text messaging, electronic mail, and facsimile transmission).
9. Treating Practitioner means a member's treating physician or other qualified health care practitioner who is a primary care provider contracted with a Regional Accountable Entity to participate in the Accountable Care Collaborative as a Network Provider.

### **8.095.2 CLIENT ELIGIBILITY**

8.095.2.A. All Colorado Medicaid clients are eligible for medical and behavioral services delivered by telemedicine.

### **8.095.3 PROVIDER ELIGIBILITY**

8.095.3.A. Any licensed provider enrolled with Colorado Medicaid is eligible to provide telemedicine services within the scope of the provider's practice.

8.095.3.B. Providers that meet the definition of an eHealth Entity shall enroll as the eHealth specialty.

### **8.095.4 COVERED SERVICES**

8.095.4.A. Covered Telemedicine services must:

1. Meet the same standard of care as in-person care;
2. Be compliant with state and federal regulations regarding care coordination;
3. Be services the Department has approved for delivery through Telemedicine;
4. Be within the provider's scope of practice and for procedure codes the provider is already eligible to bill;
5. Be provided only where contact with the provider was initiated by the member for the services rendered; and
6. Be provided only after the member's consent, either verbal or written, to receive telemedicine services is documented.

8.095.4.B. eHealth Entities shall only provide:

1. Covered Telemedicine services, including Facilitated Visits.

8.095.4.C. Beginning February 1, 2024, a Treating Practitioner may request an eConsult with a Consulting Practitioner. eConsult services must:

1. Be requested by the Treating Practitioner through an eConsult Platform;
2. Be responded to by the Consulting Practitioner through an eConsult Platform;
  - a. The Consulting Practitioner may send the eConsult to another Consulting Practitioner in a different specialty practice through an eConsult Platform, when clinically appropriate.
3. The Consulting Practitioner must, when clinically appropriate, provide clinical guidance pertaining to the eConsult electronically to the requesting Treating Practitioner through an eConsult Platform; and,
4. All dialogue between the Treating Practitioner and the Consulting Practitioner pertaining to an eConsult must be through an eConsult Platform.

### **8.095.5 PRIOR AUTHORIZATION REQUIREMENTS**

8.095.5.A. The use of Telemedicine does not change prior authorization requirements for the underlying services provided.

#### **8.095.6 RECORDKEEPING.**

8.095.6.A. eHealth Entities must maintain a Release of Information in compliance with current HIPAA standards to facilitate communication with the member's PCMP.

#### **8.095.7 REIMBURSEMENT**

8.095.7.A Pursuant to C.R.S. § 25.5-5-320(2) (2022), the reimbursement rate for a Telemedicine service shall, as a minimum, be set at the same rate as the Colorado Medicaid rate for a comparable in-person service.

8.095.7.B. eConsults

1. eConsults are reimbursed after the eConsult is closed by the requesting Treating Practitioner and the following conditions are met:
  - a. The eConsult is conducted instead of face-to-face in-person visit referral to a Consulting Practitioner;
  - b. The eConsult is provided to the Treating Practitioner by the Consulting Practitioner through an eConsult Platform, with clinical guidance where appropriate; and,
  - c. The eConsult is closed after the Treating Practitioner reviews the care plan provided by the Consulting Practitioner.
2. Treating Practitioners may directly submit a procedure code specific fee-for-service claim for reimbursement.
3. Consulting Practitioners who utilize an Approved Platform may directly submit a procedure code specific fee-for-service claim for reimbursement for all closed eConsults that meet the criteria in Section 8.095.7.B.1.
4. Consulting Practitioners who utilize the State Platform must only be reimbursed through the State Platform for all closed eConsults that meet the criteria in Section 8.095.7.B.1.
5. eConsults must be delivered through an eConsult Platform to be eligible for reimbursement.

#### **8.095.8 NON-COVERED SERVICES**

8.095.8.A Services not otherwise covered by Colorado Medicaid are not covered when delivered through Telemedicine.

8.095.8.B eConsults that are not delivered, and responded to, through an eConsult Platform.

### **8.096 TELEHEALTH REMOTE MONITORING (REMOTE PATIENT MONITORING)**

#### **8.096.1.A DEFINITIONS**

1. Telehealth Remote Monitoring means the ongoing remote assessment and monitoring of clinical data through technological equipment in order to detect changes in a member's



clinical status, which allows health care providers to intervene before a health condition exacerbates and requires emergency intervention or inpatient hospitalization.

### **8.096.2 MEMBER ELIGIBILITY**

8.096.2.A. A member is eligible if the member's health care provider determines that Remote Patient Monitoring (RPM) is medically necessary based on the member's medical condition or status and; that RPM would likely prevent the member's admission or readmission to a hospital, Emergency Department, nursing facility, or other clinical setting and have one of the following conditions:

1. Diabetes;
2. COPD;
3. Heart Failure;
4. Asthma;
5. Pneumonia; or
6. Members who are pregnant and carrying a high-risk pregnancy.

8.096.2.B. The member is cognitively and physically capable of operating the telehealth remote monitoring device or equipment or the member has a caregiver who is able and willing to assist with the telehealth remote monitoring device or equipment.

8.096.2.C. The member resides in a setting that is suitable for telehealth remote monitoring and does not have health care staff on site.

### **8.096.3 PROVIDER ELIGIBILITY**

8.096.3.A. Remote Patient Monitoring services must be rendered and supervised in accordance with the scope of practice for the enrolled provider.

8.096.3.B. Remote Patient Monitoring must be performed by one of the following licensed health care professionals:

1. Physician (MD/DO);
2. Podiatrist;
3. Advanced Practice Registered Nurse (APRN);
4. Physician Assistant (PA);
5. Respiratory Therapist;
6. Pharmacist; or
7. Licensed health care professional working under the supervision of a medical director.

8.096.3.C. Rural Health Clinics (refer to section 8.740.7.E) for reimbursement requirements.

### **RHC 8.740.7.E**

#### **8.096.4 COVERED SERVICES**

8.096.4.A. Covered Remote Patient Monitoring services include the ongoing remote assessment and monitoring of clinical data through technological equipment in order to detect changes in a member's clinical status.

8.096.4.B. Criteria for the technological equipment required for Remote Patient Monitoring is as follows:

1. FDA-certified or UL listed, and used according to the manufacturer's instructions;
2. Maintained in good repair and free from safety hazards;
3. Sanitized before utilization in the member's home per the manufacturer's instructions;
4. HIPAA requires healthcare software to meet the security standards related to patient health information. All healthcare software companies and service providers must follow HIPAA requirements to protect patient data confidentiality, integrity, and availability. A
5. Equipment must be capable of automatically uploading data without the member needing to manually self-report or self-record the data.

#### **8.096.5 PRIOR AUTHORIZATION REQUIREMENTS**

8.096.5.A. Remote Patient Monitoring does not require prior authorization.

Title of Rule: Revision to the Medical Assistance Special Financing Rule Concerning Colorado Dental Health Care Program for Low-Income Seniors, Section 8.960  
Rule Number: MSB 25-02-12-B  
Special Financing / Alondra Yanez / 303-866-6536

## **SECRETARY OF STATE**

### **RULES ACTION SUMMARY AND FILING INSTRUCTIONS**

#### **SUMMARY OF ACTION ON RULE(S)**

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 25-02-12-B, Revision to the Medical Assistance Special Financing Rule Concerning Colorado Dental Health Care Program for Low-Income Seniors, 10 CCR 2505-10, Section 8.960.
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):  
Sections(s) 8.960, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No  
If yes, state effective date:  
Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

#### **PUBLICATION INSTRUCTIONS\***

Replace the current text at 8.960 with the proposed text beginning at 8.960.A through the end of Schedule A. This rule is effective June 30, 2025.

Title of Rule: Revision to the Medical Assistance Special Financing Rule Concerning Colorado Dental Health Care Program for Low-Income Seniors, Section 8.960  
Rule Number: MSB 25-02-12-B  
Special Financing / Alondra Yanez / 303-866-6536

## STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

This rule change incorporates revisions made to the Colorado Dental Health Care Program for Low-Income Seniors (Senior Dental Program) Schedule A. The Senior Dental Program staff presented current changes to descriptions and reimbursement timelines in the Medicaid fee schedule and code descriptions in the 2025 ADA CDT Book of Current Dental Terminology to the Senior Dental Advisory Committee (DAC) for discussion on which changes they wanted to recommend to be incorporated into Schedule A. The DAC recommended adding three new codes to the Endodontics section and one new code to the Adjunctive General Services section of Schedule A. The Endodontic codes are D3346 Retreatment of Previous Root Canal Therapy - Anterior, D3347 Retreatment of Previous Root Canal Therapy - Premolar, and D3348 Retreatment of Previous Root Canal Therapy - Molar. The Adjunctive General Service code is D9222 Deep sedation/general anesthesia first 15 minutes. This rule change is necessary to incorporate the DAC's recommendations to Schedule A.

2. An emergency rule-making is imperatively necessary

- ☐ to comply with state or federal law or federal regulation and/or  
☐ for the preservation of public health, safety and welfare.

Explain: N/A

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2024);  
25.5-3-401 through 25.5-3-406, C.R.S. (2024)

Initial Review  
Proposed Effective Date

**04/11/25**  
**06/30/25**

Final Adoption  
Emergency Adoption

**05/09/25**

**DOCUMENT #**

Title of Rule: Revision to the Medical Assistance Special Financing Rule Concerning Colorado Dental Health Care Program for Low-Income Seniors, Section 8.960

Rule Number: MSB 25-02-12-B

Special Financing / Alondra Yanez / 303-866-6536

## **REGULATORY ANALYSIS**

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

This rule incorporates changes made to the procedure name and code descriptions in the Senior Dental Program Schedule A, as well as the addition of four new procedure codes, as recommended by the Senior Dental Advisory Committee (DAC). The new procedure codes include three new endodontics codes, D3345, D3347, and D3349, which are retreatment of previous root canal therapy for anterior, premolar, and molar teeth, respectively; and one new adjunctive general services code, D9222, which is the first 15 minutes of deep sedation/general anesthesia.

Seniors will benefit from the addition of the three retreatment codes, as they may allow seniors to avoid more invasive procedures, like extractions. Some seniors who take anti-resorptive medications, which are used to treat conditions such as osteoporosis and bone metastases from cancer, develop Medication Related Osteonecrosis of the Jaw (MRONJ). These seniors are at higher risk of developing osteonecrosis of the jaw if they undergo invasive dental procedures like extractions. As such, less invasive procedures like root canals are preferred.

Senior Dental Grantees will benefit from the addition of D9222, as they currently cannot bill the program for the first 15 minutes of deep sedation/general anesthesia provided to the seniors under the program. This addition will ensure that Grantees are paid for the first 15 minutes of patient treatment.

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

The revisions in this proposed rule do not include any changes to fees or payments for the current procedure codes contained within Schedule A. The addition of the three Endodontics codes will ensure that seniors who need retreatment of root canals will be able to receive those treatments at a heavily discounted cost to the senior, and that the Senior Dental Program Grantees will be able to bill the program for reimbursement instead of charging the full amount to the senior, who in many cases would not be able to afford the treatment on their own. The addition of the

Adjunctive General Services code will ensure that Senior Dental Program Grantees can bill the program for the first 15 minutes of sedation for the seniors they serve.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

The Senior Dental Program has a fixed appropriation. The updates to the code descriptions and the addition of these services will not increase the Department's administrative costs for the program. There is no anticipated effect on state revenues.

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

Many of the revisions to the existing procedure code guidelines include aligning the timelines that procedures are reimbursable by the Senior Dental Program with recently updated Medicaid reimbursement timelines. There were a few codes that the Senior Dental Advisory Committee recommended to keep as is instead of aligning with recent Medicaid changes, namely the fourteen codes that cover dentures (D5110 through D5226). The alignment of the reimbursement timelines for codes included in Schedule A with Medicaid reimbursement timelines will ensure that there is less confusion on when a procedure would be reimbursable under the Senior Dental Program versus Medicaid. The recommendation not to update the guidelines for the denture codes was made by the DAC after discussion related to what would be best for the population the Senior Dental Program serves.

The incorporation of the new endodontics codes ensures the eligible seniors can receive retreatment for root canals when retreatment is in the best interest for the senior to avoid more invasive procedures like extractions. Not adding the three retreatment codes puts certain seniors at risk of developing osteonecrosis of the jaw by undergoing more invasive procedures than advisable if they are unable to afford the retreatment outside of the Senior Dental Program. The addition of the adjunctive general services code ensures that Senior Dental Program Grantees can be paid for the first 15 minutes of anesthesia provided to seniors eligible for the Senior Dental Program. Not adding this code would mean that Senior Dental Program Grantees, who already provide these services through the Senior Dental Program at a much lower rate than they would otherwise, would have to continue to provide this service with no reimbursement.

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

As the Senior Dental Program has a fixed appropriation and the Department sees no increase in administrative costs, no less costly methods were considered.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

The Department did not consider alternatives to amending the existing rule.

## 8.960 COLORADO DENTAL HEALTH CARE PROGRAM FOR LOW-INCOME SENIORS

### 8.960.A Definitions

1. Arrange For or Arranging For means demonstrating established relations with Qualified Providers for any of the Covered Dental Care Services not directly provided by the applicant.
2. Covered Dental Care Services include Diagnostic Imaging, Emergency Services, Endodontic Services, Evaluation, Oral and Maxillofacial Surgery, Palliative Treatment, Periodontal Treatment, Preventive Services, Prophylaxis, Removable Prosthesis, and Restorative Services as listed by alphanumeric procedure code in [ScheduleAppendix A](#).
3. C.R.S. means the Colorado Revised Statutes.
4. Dental Health Professional Shortage Area or Dental HPSA means a geographic area, population group, or facility so designated by the Health Resources and Services Administration of the U.S. Department of Health and Human Services.
5. Dental Prosthesis means any device or appliance replacing one or more missing teeth and associated structures if required.
6. Department means the Colorado Department of Health Care Policy and Financing established pursuant to title 25.5, C.R.S. ~~(2020)~~.
7. Diagnostic Imaging means a visual display of structural or functional patterns for the purpose of diagnostic evaluation.
8. Economically Disadvantaged means a person whose Income is at or below 250% of the most recently published federal poverty level for a household of that size.
9. Eligible Senior or ~~Client~~patient means an adult who is 60 years of age or older, who is Economically Disadvantaged, who is not eligible for dental services under Medicaid or the Old Age Pension Health and Medical Care Program, and who does not have private dental insurance. An Eligible Senior or ~~client~~patient is not ineligible solely because he/she is receiving dental benefits under Medicare or Medicare Advantage Plans.
10. Emergency Services means the need for immediate intervention by a Qualified Provider to stabilize an oral cavity condition.
11. Endodontic Services means services which are concerned with the morphology, physiology and pathology of the human dental pulp and periradicular tissues, including pulpectomy.
12. Evaluation means an assessment that may include gathering of information through interview, observation, examination, and use of specific tests that allows a dentist to diagnose existing conditions.
13. Federally Qualified Health Center means a federally funded nonprofit health center or clinic that serves medically underserved areas and populations as defined in 42 U.S.C. section 1395x (aa)(4).
14. Income means any cash, payments, wages, in-kind receipt, inheritance, gift, prize, rents, dividends, or interest that are received by an individual or family. Income may be self-declared. Resources are not included in Income.



15. Max Allowable Fee means the total reimbursement listed by procedure for Covered Dental Care Services under the Colorado Dental Health Care Program for Low-Income Seniors in [ScheduleAppendix A](#). The Max Allowable Fee is the sum of the Program Payment and the Max ~~Client~~Patient Co-Pay.

16. Max ~~Client~~Patient Co-Pay means the maximum amount that a Qualified Provider may collect from an Eligible Senior listed by procedure in [ScheduleAppendix A](#) for Covered Dental Services under the Colorado Dental Health Care Program for Low-Income Seniors.

17. Medicaid means the Colorado medical assistance program as defined in article 4 of title 25.5, C.R.S. ~~(2020)~~.

18. Medicare means the federal health insurance program for people who are 65 or older; certain younger people with disabilities; or people with End-Stage Renal Disease.

19. Medicare Advantage Plans mean the plans offered by Medicare-approved private companies that must follow rules set by Medicare and may provide benefits for services Medicare does not, such as vision, hearing, and dental care.

20. Old Age Pension Health and Medical Care Program means the program described at ~~10 CCR 2505-10, s~~Section 8.940 et. seq. and as defined in sections 25.5-2-101 and 26-2-111(2), C.R.S. ~~(2020)~~.

21. Oral and Maxillofacial Surgery means the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects involving both the functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial region.

22. Palliative Treatment for dental pain means emergency treatment to relieve the ~~client~~patient of pain; it is not a mechanism for addressing chronic pain.

23. Periodontal Treatment means the therapeutic plan intended to stop or slow periodontal disease progression.

24. Preventive Services means services concerned with promoting good oral health and function by preventing or reducing the onset and/or development of oral diseases or deformities and the occurrence of oro-facial injuries.

25. Program Payment means the maximum amount by procedure listed in [ScheduleAppendix A](#) for Covered Dental Care Services for which a Qualified Grantee may invoice the Department under the Colorado Dental Health Care Program for Low-Income Seniors. Program Payment must not be less than the reimbursement schedule for fee-for-service dental fees under the medical assistance program established in Articles 4, 5, and 6 of 10 CCR 2505-10.

26. Prophylaxis means the removal of dental plaque and calculus from teeth, in order to prevent dental caries, gingivitis and periodontitis.

27. Qualified Grantee means an entity that can demonstrate that it can provide or Arrange For the provision of Covered Dental Care Services and may include but is not limited to:

- a. An Area Agency on Aging, as defined in section 26-11-201, C.R.S. ~~(2020)~~;
- b. A community-based organization or foundation;
- c. A Federally Qualified Health Center, safety-net clinic, or health district;
- d. A local public health agency; or

e. A private dental practice.

28. Qualified Provider means a licensed dentist or dental hygienist in good standing in Colorado or a person who employs a licensed dentist or dental hygienist in good standing in Colorado and who is willing to accept reimbursement for Covered Dental Services. A Qualified Provider may also be a Qualified Grantee if the person meets the qualifications of a Qualified Grantee.

29. Removable Prosthesis means complete or partial Dental Prosthesis, which after an initial fitting by a dentist, can be removed and reinserted by the eligible senior.

30. Restorative Services means services rendered for the purpose of rehabilitation of dentition to functional or aesthetic needs of the ~~client~~patient.

31. Senior Dental Advisory Committee means the advisory committee established pursuant to section 25.5-3-406, C.R.S.-(2020).

#### **8.960.B Legal Basis**

8.960.B.1 The Colorado Dental Health Care Program for Low-Income Seniors is authorized by state law at part 4 of article 3 of title 25.5, C.R.S.-(2020).

#### **8.960.C Request of Grant Proposals and Grant Award Procedures**

##### **8.960.C.1. Request for Grant Proposals**

8.960.C.1.a Grant awards shall be made through an application process. The request for grant proposals form shall be issued by the Department and posted for public access on the Department's website at <https://www.colorado.gov/hcpf/research-data-and-grants> at least 30 days prior to the due date.

##### **8.960.C.2 Evaluation of Grant Proposals**

8.960.C.2.a Proposals submitted for the Colorado Dental Health Care Program for Low-Income Seniors will be evaluated by a review panel in accordance with the following criteria developed under the advice of the Senior Dental Advisory Committee.

1) The review panel will be comprised of individuals who are deemed qualified by reason of training and/or experience and who have no personal or financial interest in the selection of any particular applicant.

2) The sole objective of the review panel is to recommend to the Department's executive director those proposals which most accurately and effectively meet the goals of the program within the available funding.

3) Preference will be given to grant proposals that clearly demonstrate the applicant's ability to:

a) Outreach to and identify Eligible Seniors;

b) Collaborate with community-based organizations; and

c) Serve a greater number of Eligible Seniors or serve Eligible Seniors who reside in a geographic area designated as a Dental HPSA.

4) The review panel shall consider the distribution of funds across the state in recommending grant proposals for awards. The distribution of funds should be based on the estimated

percentage of Eligible Seniors in the state by Area Agency on Aging region as provided by the Department.

### **8.960.C.3 Grant Awards**

8.960.C.3.a The Department's executive director, or his or her designee, shall make the final grant awards to selected Qualified Grantees for the Colorado Dental Health Care Program for Low-Income Seniors.

### **8.960.C.4 Qualified Grantee Responsibilities**

8.960.C.4.a A Qualified Grantee that is awarded a grant under the Colorado Dental Health Care Program for Low-Income Seniors is required to:

- 1) Identify and outreach to Eligible Seniors and Qualified Providers;
- 2) Demonstrate collaboration with community-based organizations;
- 3) Ensure that Eligible Seniors receive Covered Dental Care Services efficiently without duplication of services;
- 4) Maintain records of Eligible Seniors serviced, Covered Dental Care Services provided, and moneys spent for a minimum of six (6) years;
- 5) For Eligible Seniors with dental coverage through a Medicare Advantage Plan, bill the Medicare Advantage Plan for dental procedures covered by the Medicare Advantage Plan prior to seeking payment from the Department. The Colorado Dental Health Care Program is secondary to the Medicare Advantage Plan dental coverage;
- 6) Distribute grant funds to Qualified Providers in its service area or directly provide Covered Dental Care Services to Eligible Seniors;
- 7) Expend no more than seven (7) percent of the amount of its grant award for administrative purposes; and
- 8) Submit an annual report as specified under section 8.960.3.F.

### **8.960.C.5 Invoicing**

8.960.C.5.a A Qualified Grantee that is awarded a grant under the Colorado Dental Health Care Program for Low-Income Seniors shall submit invoices on a form and schedule specified by the Department. Covered Dental Care Services shall be provided before a Qualified Grantee may submit an invoice to the Department.

- 1) Invoices shall include the number of Eligible Seniors served, the alphanumeric code and procedure description as listed in [ScheduleAppendix A](#), and any other information required by the Department.
- 2) The Department will pay no more than the established Program Payment per procedure rendered, as listed in [ScheduleAppendix A](#).
- 3) Eligible Seniors shall not be charged more than the Max ~~Client~~Patient Co-Pay as listed in [ScheduleAppendix A](#).

- 4) Qualified Grantees shall not bill the Department for any procedures covered by Medicare Advantage Plans that have been billed and paid by the Medicare Advantage Plans;
- 5) Qualified Grantees shall indicate on the invoice if the Eligible Senior has dental coverage through a Medicare Advantage Plan and any claim to the Medicare Advantage Plan was adjudicated prior to billing the Department;
- 6) Qualified Grantees may invoice for no more than seven (7) percent of the Program Payment for administrative costs.

**8.960.C.6      Annual Report**

8.960.C.6.a      On or before September 1, 2016, and each September 1 thereafter, each Qualified Grantee receiving funds from the Colorado Dental Health Care Program for Low-Income Seniors shall submit a report to the Department following the state fiscal year contract period.

8.960.C.6.b      The annual report shall be completed in a format specified by the Department and shall include:

- 1) The number of Eligible Seniors served;
- 2) The types of Covered Dental Care Services provided;
- 3) An itemization of administrative expenditures;
- 4) The procedures and amounts billed to Medicare Advantage Plans for Eligible Seniors;  
and
- 5) Any other information deemed relevant by the Department.

**10 CCR 2505-10 § 8.960 SCHEDULE APPENDIX A: COLORADO DENTAL HEALTH CARE PROGRAM FOR LOW-INCOME SENIORS COVERED SERVICES AND PROCEDURE CODES**

Capitalized terms within this [schedule appendix](#) shall have the meaning specified in the Definitions section.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max <del>Client</del> Patient Co-Pay	<u>Teeth or</u> <u>Quadrant</u> <u>nt</u> <u>Covered</u>	PROGRAM GUIDELINES
Periodic oral evaluation established - <u>clientpatient</u>	D0120	\$46.00	\$46.00	\$0.00		Evaluation performed on a <u>clientpatient</u> of record to determine any changes in the <u>clientpatient</u> 's dental and medical health status since a previous comprehensive or periodic evaluation. This includes an oral cancer evaluation, periodontal screening where indicated, and may require interpretation of information acquired through additional diagnostic procedures. The findings are discussed with the <u>clientpatient</u> . Report additional diagnostic procedures separately. Frequency: <del>One time per 6 month period per client.</del> <u>Two of D0120, D0150, D0180 per 12 months per patient.</u>

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max <del>Client</del> Patient Co-Pay	Teeth or <del>Quadra</del> nt Covered	PROGRAM GUIDELINES
Limited oral evaluation - problem focused	D0140	\$63.14	\$53.14	\$10.00		<p><del>This code must be used in association with a specific oral health problem or complaint and is not to be used to address situations that arise during multi-visit treatments covered by a single fee, such as, endodontic or post-operative visits related to treatments including prosthesis. Specific problems may include dental emergencies, trauma, acute infections, etc. Cannot be used for adjustments made to prosthesis provided within previous 6 months. Cannot be used as an encounter fee. An evaluation limited to a specific oral health problem or complaint. This may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately. Definitive procedures may be required on the same date as the evaluation. Typically, patients receiving this type of evaluation present with a specific problem and/or dental emergencies, trauma, acute infections, etc.</del></p> <p>Frequency: Two of D0140 per <del>year</del> 12 months per grantee <u>per patient</u>. Not reimbursable on the same date as D0120, <del>or</del> D0150, <u>or D0180</u>. Dental hygienists may only provide for an established <del>client</del> <u>patient</u> of record.</p>

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadra nt Covered	PROGRAM GUIDELINES
Comprehensive oral evaluation - new or established <del>client</del> patient	D0150	\$81.00	\$81.00	\$0.00		<p>Evaluation used by general dentist <u>and/or</u> a specialist when evaluating a <del>client</del>patient comprehensively. Applicable to new <del>clients</del>patients; established <del>clients</del>patients with significant health changes or other unusual circumstances <u>by report</u>; or established <del>clients</del>patients who have been absent from active treatment for three or more years. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. <u>It may require interpretation of information acquired through additional diagnostic procedures. Additional diagnostic procedures should be reported separately. This includes an evaluation for oral cancer, the</u> <del>and an</del> evaluation and recording of the <del>client</del>patient's dental and medical history and general health assessment. <del>A periodontal evaluation, oral cancer evaluation, diagnosis and treatment planning should be included.</del> <u>It may include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, existing prostheses, occlusal relationships, periodontal conditions (including periodontal screening and/or charting), hard and soft tissue anomalies, etc.</u> Frequency: <del>1 per 3 years per client. Cannot be charged on the same date as D0180.</del> <u>One of D0150 per 36 months per grantee per patient. Two of D0120, D0150, D0180 per 12 months per grantee per patient.</u></p>

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Comprehensive periodontal evaluation - new or established <del>client</del> patient	D0180	\$88.00	\$88.00	\$0.00		<del>Evaluation for clients presenting</del> This procedure is indicated for patients showing signs & symptoms of periodontal disease & <del>clients</del> patients with risk factors such as smoking or diabetes. It includes evaluation of periodontal conditions, probing and charting, <u>an evaluation for oral cancer</u> , evaluation and recording of the <del>client</del> patient's dental and medical history and general health assessment. It may include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, <u>and</u> occlusal relationships <del>and oral cancer evaluation</del> . Frequency: <del>1 per 3 years per client. Cannot be charged on the same date as D0150.</del> One of D0180 per 36 months per patient. Two of D0120, D0150, D0180 per 12 months per patient.



Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Intraoral comprehensive series of radiographic images	D0210	\$125.00	\$125.00	\$0.00		<p>Radiographic survey of whole mouth, intended to display the crowns &amp; roots of all teeth, periapical areas, interproximal areas and alveolar bone including edentulous areas. Panoramic radiographic image <u>D0330</u> &amp; bitewing radiographic images <u>D0270-D0277</u> taken on the same date of service shall not be billed as a D0210. <u>Minimum of 12-20 films is required.</u> Payment for additional periapical radiographs within 60 days of a full <del>month</del><u>mouth</u> series <u>D0277</u> or a panoramic film <u>D0330</u> is not covered unless there is evidence of trauma. Frequency: <del>1 per 5 years per client.</del><u>One of D0210, D0277, D0330 per 60 months per patient.</u> Any combination of x-rays taken on the same date of service that equals or exceeds the max allowable fee for D0210 must be billed and reimbursed as D0210. <del>Should not be charged in addition to panoramic film D0330. Either D0330 or D0210 per 5 year period.</del></p>
Intraoral periapical radiographic image - first	D0220	\$25.00	\$25.00	\$0.00		<p>Six of D0220 per 12 months per <del>client</del><u>patient</u>. Report additional radiographs as D0230. Working and final endodontic treatment films are not covered. <u>Not covered if billed with D3310, D3320, D3330.</u> Any combination of D0220 through D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210. <u>Not allowed on the same day as D0210.</u></p>

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Intraoral periapical - each additional radiographic image	D0230	\$23.00	\$23.00	\$0.00		D0230 must be utilized for additional films taken beyond D0220. Working and final endodontic treatment films are included in the endo codes. Not covered if billed with D3310, D3320, or D3330. <u>Not allowed on the same day as D0210.</u> Any combination of D0220 through D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.
Bitewing - single radiographic image	D0270	\$26.52	\$26.52	\$0.00		Frequency: <u>1 in a 12 month period.</u> One of D0270, D0272, D0273, D0274 per 12 months per patient. Any combination of D0220 through D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.
Bitewings - two radiographic images	D0272	\$42.00	\$42.00	\$0.00		Frequency: <u>1 time in a 12 month period.</u> One of D0270, D0272, D0273, D0274 per 12 months per patient. Any combination of D0220 through D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.
Bitewings - three radiographic images	D0273	\$52.00	\$52.00	\$0.00		Frequency: <u>1 time in a 12 month period.</u> One of D0270, D0272, D0273, D0274 per 12 months per patient. Any combination of D0220 through D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.
Bitewings - four radiographic images	D0274	\$60.00	\$60.00	\$0.00		Frequency: <u>1 time in a 12 month period.</u> One of D0270, D0272, D0273, D0274 per 12 months per patient. Any combination of D0220 through D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max <del>Client</del> Patient Co-Pay	<del>Teeth or</del> <u>Quadrant</u> Covered	PROGRAM GUIDELINES
Vertical bitewings – seven to eight radiographic images	D0277	\$68.32	\$68.32	\$0.00		Frequency: <del>1 time in a 12-month period.</del> One of D0210, D0277, D0330 per 60 months per patient. Counts as a full mouth series. Counts as an intraoral complete series. Counts as an intraoral complete series. Any combination of D0220 through D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.
Panoramic radiographic image	D0330	\$63.00	\$63.00	\$0.00		Frequency: <del>1 per 5 years per client.</del> One of D0210, D0277, D0330 per 60 months per grantee per patient. Counts as a full mouth series. <del>Cannot be charged in addition to full mouth series D0210. Either D0330 or D0210 per 5 years.</del>

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max <del>Client</del> <u>Patient</u> Co-Pay	<u>Teeth or</u> <u>Quadrant</u> <u>Covered</u>	PROGRAM GUIDELINES
Prophylaxis - adult	D1110	\$97.50	\$97.50	\$0.00		<p>Removal of plaque, calculus and stains from the tooth structures <u>and implants in the permanent and transitional dentition. It is intended—with intent</u> to control local irritational factors. Frequency:</p> <ul style="list-style-type: none"> <li><del>1 time per 6 calendar months; 2 week window accepted.</del> <u>Two of D1110, D4346, D4910 per 12 months per patient.</u></li> <li><del>May be billed for routine prophylaxis.</del></li> <li><del>D1110 may be billed with D4341 and D4342 one time during initial periodontal therapy for prophylaxis of areas of the mouth not receiving nonsurgical periodontal therapy. When this option is used, individual should still be placed on D4910 for maintenance of periodontal disease. D1110 can only be charged once, not per quadrant, and represents areas of the mouth not included in the D4341 or D4342 being reimbursed.</del></li> <li>May be alternated with D4910 for maintenance of periodontally-involved individuals.</li> <li>D1110 cannot be billed on the same day as <del>D4346</del> <u>D4341 – D4910.</u></li> <li><del>Cannot be used as 1 month re-evaluation following nonsurgical periodontal therapy.</del> <u>Only allowed for cases with a history of surgical or non-surgical periodontal treatment, excluding D4355.</u></li> </ul>
Topical application of fluoride varnish	D1206	\$52.00	\$52.00	\$0.00		<p>Topical fluoride application is to be used in conjunction with prophylaxis or preventive appointment. Should be applied to whole mouth. Frequency: up to four <del>(4)</del> times per 12 calendar months. Cannot be used with D1208.</p>

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Topical application of fluoride - excluding varnish	D1208	\$52.00	\$52.00	\$0.00		Any fluoride application, including swishing, trays or paint on variety, to be used in conjunction with prophylaxis or preventive appointment. Frequency: one <del>(1)</del> time per 12 calendar months. Cannot be used with D1206. D1206 varnish should be utilized in lieu of D1208 whenever possible.
Application of caries arresting medicament – per tooth	D1354	\$54.53	\$54.53	\$0.00	<u>Teeth 1-32</u>	<u>Conservative treatment of an active, non-symptomatic carious lesion by topical application of a caries arresting or inhibiting medicament and without mechanical removal of sound tooth structure. Frequency:</u> Two of D1354 per 12 months per patient per tooth for <del>primary and</del> permanent teeth. Not to exceed 4 times per tooth in a lifetime. Cannot be billed on the same day as D1355 <u>or D3110 or D3120</u> or any D2000 series code (D2140–D2954). Must Report tooth number.
Caries preventive medicament application – per tooth	D1355	\$5.74	\$5.74	\$0.00	<u>Teeth 1-32</u>	For primary prevention or remineralization. Medicaments applied do not include topical fluorides. Medicaments that may be applied during the delivery of D1355 procedure include Silver Diamine Fluoride (SDF), Silver Nitrate (SN), thymol-CHX varnish, and topical povidone iodine (PVP-I). Cannot be billed on the same day as: D1206, D1208, D1354, D0140, D9110, or any restoration codes on the same day or within 12 months of D2140 thru D2954. Maximum of four D1355 per tooth per lifetime. Must report tooth number.
Amalgam - one surface, primary or permanent	D2140	\$120.02	\$110.02	\$10.00	<u>Teeth 1-32</u>	Frequency: <del>36 months for the same restoration. See Explanation of Restorations.</del> <u>One of D2140 – D2394 per 36 months per patient per tooth per surface.</u>

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Amalgam - two surfaces, primary or permanent	D2150	\$150.59	\$140.59	\$10.00	<u>Teeth 1-32</u>	Frequency: <del>36 months for the same restoration.</del> See <del>Explanation of Restorations.</del> One of D2140 – D2394 per 36 months per patient per tooth per surface.
Amalgam - three surfaces, primary or permanent	D2160	\$182.40	\$172.40	\$10.00	<u>Teeth 1-32</u>	Frequency: <del>36 months for the same restoration.</del> See <del>Explanation of Restorations.</del> One of D2140 – D2394 per 36 months per patient per tooth per surface.
Amalgam - four or more surfaces, primary or permanent	D2161	\$218.93	\$208.93	\$10.00	<u>Teeth 1-32</u>	Frequency: <del>36 months for the same restoration.</del> See <del>Explanation of Restorations.</del> One of D2140 – D2394 per 36 months per patient per tooth per surface.
Resin-based composite - one surface, anterior	D2330	\$116.82	\$106.82	\$10.00	<u>Teeth 6 - 11, 22 - 27</u>	Frequency: <del>36 months for the same restoration.</del> One of D2140 – D2394 per 36 months per patient per tooth per surface. See Explanation of Restorations.
Resin-based composite - two surfaces, anterior	D2331	\$146.00	\$136.00	\$10.00	<u>Teeth 6 - 11, 22 - 27</u>	Frequency: <del>36 months for the same restoration.</del> One of D2140 – D2394 per 36 months per patient per tooth per surface. See Explanation of Restorations.
Resin-based composite - three surfaces, anterior	D2332	\$179.00	\$169.00	\$10.00	<u>Teeth 6 - 11, 22 - 27</u>	Frequency: <del>36 months for the same restoration.</del> One of D2140 – D2394 per 36 months per patient per tooth per surface. See Explanation of Restorations.
Resin-based composite - four or more surfaces <del>or involving incisal angle</del> (anterior)	D2335	\$212.00	\$202.00	\$10.00	<u>Teeth 6 - 11, 22 - 27</u>	<del>Incisal angle to be defined as one of the angles formed by the junction of the incisal and the mesial or distal surface of an anterior tooth.</del> Frequency: <del>36 months for the same restoration.</del> One of D2140 – D2394 per 36 months per patient per tooth per surface. See Explanation of Restorations.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Resin-based composite - one surface, posterior	D2391	\$134.00	\$124.00	\$10.00	<u>Teeth 1 - 5, 12 - 21, 28 - 32</u>	Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure. Frequency: <del>36 months for the same restoration.</del> <u>One of D2140 – D2394 per 36 months per patient per tooth per surface.</u> See Explanation of Restorations.
Resin-based composite -two surfaces, posterior	D2392	\$176.00	\$166.00	\$10.00	<u>Teeth 1 - 5, 12 - 21, 28 - 32</u>	Frequency: <del>36 months for the same restoration.</del> <u>One of D2140 – D2394 per 36 months per patient per tooth per surface.</u> See Explanation of Restorations.
Resin-based composite - three surfaces, posterior	D2393	\$218.00	\$208.00	\$10.00	<u>Teeth 1 - 5, 12 - 21, 28 - 32</u>	Frequency: <del>36 months for the same restoration.</del> <u>One of D2140 – D2394 per 36 months per patient per tooth per surface.</u> See Explanation of Restorations.
Resin-based composite - four or more surfaces, posterior	D2394	\$268.00	\$258.00	\$10.00	<u>Teeth 1 - 5, 12 - 21, 28 - 32</u>	Frequency: <del>36 months for the same restoration.</del> <u>One of D2140 – D2394 per 36 months per patient per tooth per surface.</u> See Explanation of Restorations.
Crown - porcelain/ceramic	D2740	\$899.16	\$849.16	\$50.00	<u>Teeth 2 - 15, 18 - 31</u>	<del>Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794.</del> Frequency: <u>One of D2740 – D2794 per 84 months per patient per tooth.</u> Second molars are only covered if it <u>meets criteria and</u> is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Crown - porcelain fused to high noble metal	D2750	\$891.06	\$841.06	\$50.00	<u>Teeth 2 - 15, 18 - 31</u>	<del>Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Frequency: One of D2740 – D2794 per 84 months per patient per tooth.</del> Second molars are only covered if it <u>meets criteria and</u> is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - porcelain fused to predominantly base metal	D2751	\$817.03	\$767.03	\$50.00	<u>Teeth 2 - 15, 18 - 31</u>	<del>Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Frequency: One of D2740 – D2794 per 84 months per patient per tooth.</del> Second molars are only covered if it <u>meets criteria and</u> is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - porcelain fused to noble metal	D2752	\$848.29	\$798.29	\$50.00	<u>Teeth 2 - 15, 18 - 31</u>	<del>Only one the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Frequency: One of D2740 – D2794 per 84 months per patient per tooth.</del> Second molars are only covered if it <u>meets criteria and</u> is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.



Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Crown - 3/4 cast predominantly base metal	D2781	\$780.00	\$730.00	\$50.00	<u>Teeth 2 - 15, 18 - 31</u>	<del>Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Frequency: One of D2740 – D2794 per 84 months per patient per tooth. Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.</del>
Crown - 3/4 cast noble metal	D2782	\$780.00	\$730.00	\$50.00	<u>Teeth 2 - 15, 18 - 31</u>	<del>Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Frequency: One of D2740 – D2794 per 84 months per patient per tooth. Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.</del>
Crown - 3/4 porcelain/ceramic	D2783	\$780.00	\$730.00	\$50.00	<u>Teeth 1 - 32</u>	<del>Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. This procedure does not include facial veneers. Frequency: One of D2740 – D2794 per 84 months per patient per tooth. Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.</del>

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Crown - full cast high noble metal	D2790	\$918.62	\$868.62	\$50.00	<u>Teeth 2 - 15, 18 - 31</u>	<del>Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Frequency: One of D2740 – D2794 per 84 months per patient per tooth. Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.</del>
Crown - full cast predominantly base metal	D2791	\$780.00	\$730.00	\$50.00	<u>Teeth 2 - 15, 18 - 31</u>	<del>Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Frequency: One of D2740 – D2794 per 84 months per patient per tooth. Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.</del>
Crown - full cast noble metal	D2792	\$780.00	\$730.00	\$50.00	<u>Teeth 2 - 15, 18 - 31</u>	<del>Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Frequency: One of D2740 – D2794 per 84 months per patient per tooth. Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.</del>

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Crown - titanium and titanium alloys	D2794	\$886.88	\$836.88	\$50.00	Teeth 2 - 15, 18 - 31	<del>Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Frequency: One of D2740 – D2794 per 84 months per patient per tooth. Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.</del>
Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	D2910	\$87.00	\$77.00	\$10.00	Teeth 1 - 32	Not allowed within 6 months of placement.
Re-cement or re-bond crown	D2920	\$89.00	\$79.00	\$10.00	Teeth 1 - 32	Not allowed within 6 months of placement.
Placement of Interim Direct Restoration	D2940	\$65.21	\$55.21	\$10.00	Teeth 1 - 32	<u>Direct placement of a restorative material to protect tooth and/or tissue form. This procedure may be used to relieve pain, promote healing, manage caries, create a seal for endodontic isolation, or prevent further deterioration until definitive treatment can be rendered. Not to be used for endodontic access closure, or as a base or liner under restoration. One of D2940 per lifetime per tooth. RDH's will receive reimbursement when used for telehealth dentistry in partnership with treating dentist.</u>

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Core buildup, including any pins when required	D2950	\$225.00	\$200.00	\$25.00	<u>Teeth 2 - 15, 18 - 31</u>	<del>Only one of the following will be reimbursed per 84 months per client per tooth. D2950, D2952, or D2954.</del> Refers to building up of coronal structure when there is insufficient retention for a separate extracoronar restorative procedure. A core buildup is not a filler to eliminate any undercut, box form, or concave irregularity in a preparation. <u>Frequency: One of D2950, D2952, D2954 per 84 months per patient per tooth. Refers to building up of anatomical crown when restorative crown will be placed.</u> Not payable on the same tooth and same day as D2951.
Pin retention - per tooth, <u>in addition to restoration</u>	D2951	\$50.00	\$40.00	\$10.00	<u>Teeth 2 - 15, 18 - 31</u>	Pins placed to aid in retention of restoration. Can only be used in combination with a multi-surface amalgam.
<del>Cast</del> Post and core in addition to crown, <u>indirectly fabricated</u>	D2952	\$332.00	\$307.00	\$25.00	<u>Teeth 2 - 15, 18 - 31</u>	<del>Only one of the following will be reimbursed per 84 months per client per tooth. D2950, D2952, or D2954.</del> Post and core are custom fabricated as a single unit. <u>Frequency: One of D2950, D2952, D2954 per 84 months per patient per tooth.</u> Refers to building up of anatomical crown when restorative crown will be placed. Not payable on the same tooth and same day as D2951.
Prefabricated post and core in addition to crown	D2954	\$269.00	\$244.00	\$25.00	<u>Teeth 2 - 15, 18 - 31</u>	<del>Only one of the following will be reimbursed per 84 months per client per tooth. D2950, D2952, or D2954.</del> Core is built around a prefabricated post. This procedure includes the core material. <u>Frequency: One of D2950, D2952, D2954 per 84 months per patient per tooth.</u> <del>and</del> <u>Refers to building up of anatomical crown when restorative crown will be placed.</u> Not payable on the same tooth and same day as D2951.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
<u>Application of Hydroxyapatite Regeneration Medicament - per tooth</u>	<u>D2991</u>	<u>\$66.30</u>	<u>\$56.30</u>	<u>\$10.00</u>	<u>Teeth 1 - 32</u>	<u>Preparation of tooth surfaces and topical application of a scaffold to guide hydroxyapatite regeneration. One of D2991 per lifetime per patient per tooth. Cannot be billed on the same day/same tooth as any other D2000's codes or D1354.</u>
Endodontic therapy, anterior tooth (excluding final restoration)	D3310	\$849.76	\$799.76	\$50.00	<u>Teeth 6 - 11, 22 - 27</u>	Frequency: One D3310 per lifetime per <del>client</del> <u>patient</u> per tooth. Teeth covered: 6-11 and 22-27.
Endodontic therapy, premolar tooth (excluding final restoration)	D3320	\$967.71	\$917.71	\$50.00	<u>Teeth 4, 5, 12, 13, 20, 21, 28, 29</u>	Frequency: One D3320 per lifetime per <del>client</del> <u>patient</u> per tooth. Teeth covered: 4, 5, 12, 13, 20, 21, 28, and 29.
Endodontic therapy, molar tooth (excluding final restoration)	D3330	\$1,159.31	\$1,109.31	\$50.00	<u>Teeth 2, 3, 14, 15, 18, 19, 30, 31</u>	Frequency: One D3330 per lifetime per <del>client</del> <u>patient</u> per tooth. <u>Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.</u> Teeth covered: 2, 3, 14, 15, 18, 19, 30, and 31.
<u>Retreatment of Previous Root Canal Therapy-Anterior</u>	<u>D3346</u>	<u>\$961.61</u>	<u>\$911.61</u>	<u>\$50.00</u>	<u>Teeth 6 - 11, 22 - 27</u>	<u>Includes all appointments necessary to complete treatment; also includes intra-operative radiographs. Does not include diagnostic evaluation and necessary radiographs/diagnostic images. One of D3346 per lifetime per patient per tooth. Only reimbursable if original treatment not paid by Senior Dental Program.</u>
<u>Retreatment of Previous Root Canal Therapy-Premolar</u>	<u>D3347</u>	<u>\$1,094.12</u>	<u>\$1044.12</u>	<u>\$50.00</u>	<u>Teeth 4, 5, 12, 13, 20, 21, 28, 29</u>	<u>Includes all appointments necessary to complete treatment; also includes intra-operative radiographs. Does not include diagnostic evaluation and necessary radiographs/diagnostic images. One of D3347 per lifetime per patient per tooth. Only reimbursable if original treatment not paid by Senior Dental Program</u>

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
<u>Retreatment of Previous Root Canal Therapy-Molar</u>	<u>D3348</u>	<u>\$1,296.06</u>	<u>\$1,246.06</u>	<u>\$50.00</u>	<u>Teeth 2, 3, 14, 15, 18, 19, 30, 31</u>	<u>Includes all appointments necessary to complete treatment; also includes intra-operative radiographs. Does not include diagnostic evaluation and necessary radiographs/diagnostic images. One of D3348 per lifetime per patient per tooth. Only reimbursable if original treatment not paid by Senior Dental Program. Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.</u>

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Periodontal scaling & root planing - four or more teeth per quadrant	D4341	\$276.51	\$266.51	\$10.00	Per Quadrant LL, LR, UL, or UR	<p><del>†</del>This procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. <u>It is indicated for patients</u><del>For clients</del> with periodontal disease and is therapeutic, not prophylactic, <u>in nature</u>. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and/or as part of pre-surgical procedures in others. Frequency:</p> <ul style="list-style-type: none"> <li><del>1 time per quadrant per 36 month interval.</del> <u>One of D4341, D4342 per 36 months per patient per quadrant. A minimum of four affected teeth in the quadrant.</u></li> <li><del>No more than 2 quadrants may be considered in a single visit.</del> <u>Maximum of two quadrants per date of service</u> in a non-hospital setting.</li> <li>Cannot be charged on same date as <del>D4346</del> <u>D1110</u>.</li> <li>Any follow-up and re-evaluation are included in the initial reimbursement.</li> </ul>

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Periodontal scaling & root planing - one to three teeth per quadrant	D4342	\$189.68	\$189.68	\$0.00	Per Quadrant LL, LR, UL, or UR	<p>†This procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. <del>For clients</del>It is indicated for patients with periodontal disease and is therapeutic, not prophylactic, in nature. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and/or as part of pre-surgical procedures in <u>others</u>. Current periodontal charting must be present in <del>client</del>patient chart documenting active periodontal disease. Frequency:</p> <ul style="list-style-type: none"> <li><del>1 time per quadrant per 36 month interval.</del>One of D4341, D4342 per 36 months per patient per quadrant. A maximum of three teeth in the affected quadrant.</li> <li><del>No more than 2 quadrants may be considered in a single visit.</del>Maximum of two quadrants per date of service in a non-hospital setting.. Documentation of other treatment provided at same time will be requested.</li> <li>Cannot be charged on same date as <del>D4346</del>D1110.</li> <li>Any follow-up and re-evaluation are included in the initial reimbursement.</li> </ul>



Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	D4346	\$102.00	\$92.00	\$10.00		<p>The removal of plaque, calculus, and stains from supra- and sub-gingival tooth surfaces when there is generalized moderate or severe gingival inflammation in the absence of periodontitis. It is indicated for patients who have swollen, inflamed gingiva, generalized suprabony pockets, and moderate to severe bleeding on probing. Should not be reported in conjunction with prophylaxis, scaling and root planing, or debridement procedures. Frequency: <del>once in a lifetime</del>. <u>Two of D1110, D4346 per 12 months per patient. Not reimbursed when billed on the same date of service as D1110, D4341, D4342, D4355, D4910.</u></p> <ul style="list-style-type: none"> <li>Any follow-up and re-evaluation are included in the initial reimbursement.</li> <li><del>Cannot be charged on the same date as D1110, D4341, D4342, or D4910.</del></li> </ul>
Full mouth debridement to enable a comprehensive <del>oral</del> <u>periodontal</u> evaluation and diagnosis on a subsequent visit	D4355	\$100.04	\$90.04	\$10.00		<p>One of (D4335) per <del>3-year(s)</del><u>36 months</u> per patient. <del>Prophylaxis D0150, D0160, D0180</del> D1110 is not reimbursable when provided on the same day of service as D4355. D4355 is not reimbursable if patient record indicates D1110 or D4910 have been provided in the previous 12 month period. Other D4000 series codes are not reimbursable when provided on the same date of service as D4355.</p>

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Periodontal maintenance procedures	D4910	\$149.01	\$149.01	\$0.00		<p><u>This procedure is instituted</u> following periodontal therapy and continues at varying intervals, determined by the clinical evaluation of the dentist, for the life of the dentition or any implant replacements. It includes removal of the bacterial plaque and calculus from supragingival and subgingival regions, site specific scaling and root planing where indicated and polishing the teeth. <u>If new or recurring periodontal disease appears, additional diagnostic and treatment procedures must be considered.</u> Frequency:</p> <ul style="list-style-type: none"> <li>• Up to four times per fiscal year per <u>client/patient</u>.</li> <li>• Cannot be charged on the same date as D4346.</li> <li>• Cannot be charged within the first three months following active periodontal treatment.</li> </ul>
Complete denture - maxillary	D5110	\$931.41	\$851.41	\$80.00		<p>Reimbursement made upon delivery of a complete maxillary denture to the <u>client/patient</u>. D5110 or D5120 cannot be used to report an immediate denture, D5130 or D5140. Routine follow-up adjustments/reline within 6 months are to be anticipated and are included in the initial reimbursement. A complete denture is made after teeth have been removed and the gum and bone tissues have healed - or to replace an existing denture. This can vary greatly depending upon <u>client/patient</u>, oral health, overall health, and other confounding factors. Frequency: Program will only pay for one per every <u>five-years60 months</u> - documentation that existing prosthesis cannot be made serviceable must be maintained.</p>

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Complete denture - mandibular	D5120	\$932.94	\$852.94	\$80.00		Reimbursement made upon delivery of a complete mandibular denture to the <del>client</del> patient. D5110 or D5120 cannot be used to report an immediate denture, D5130, D5140. Routine follow-up adjustments/relines within 6 months are to be anticipated and are included in the initial reimbursement. A complete denture is made after teeth have been removed and the gum and bone tissues have healed - or to replace an existing denture. This can vary greatly depending upon <del>client</del> patient, oral health, overall health, and other confounding factors. Frequency: Program will only pay for one per every <del>five years</del> 60 months - documentation that existing prosthesis cannot be made serviceable must be maintained.
Immediate denture maxillary	D5130	\$931.41	\$851.41	\$80.00		Reimbursement made upon delivery of an immediate maxillary denture to the <del>client</del> patient. Routine follow-up adjustments/soft tissue condition relines within 6 months are to be anticipated and are included in the initial reimbursement. An immediate denture is made prior to teeth being extracted and is inserted same day of extraction of remaining natural teeth. Frequency: D5130 can be reimbursed only once per lifetime per <del>client</del> patient. Complete denture, D5110, may be considered <del>5 years</del> 60 months after immediate denture was reimbursed. Documentation that existing prosthesis cannot be made serviceable must be maintained. Immediate Denture Form must be on file.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Immediate denture mandibular –	D5140	\$932.94	\$852.94	\$80.00		Reimbursement made upon delivery of an immediate mandibular denture to the <del>client</del> patient. Routine follow-up adjustments/soft tissue condition relines within 6 months are to be anticipated and are included in the initial reimbursement. An immediate denture is made prior to teeth being extracted and is inserted same day of extraction of remaining natural teeth. Frequency: D5140 can be reimbursed only once per lifetime per <del>client</del> patient. Complete dentures, D5120, may be considered <del>5—years</del> 60 months after immediate denture was reimbursed – documentation that existing prosthesis cannot be made serviceable must be maintained. Immediate Denture Form must be on file.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	D5211	\$700.00	\$640.00	\$60.00		Reimbursement made upon delivery of a complete partial maxillary denture to the <del>client</del> patient. D5211 and D5212 are considered definitive treatments. Routine follow-up adjustments or relines within 6 months are to be anticipated and are included in the initial reimbursement. A partial resin base denture can be made right after having teeth extracted (healing from only a few teeth is not as extensive as healing from multiple). A partial resin base denture can also be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appointments may be necessary and are included in the cost. Frequency: Program will only pay for one resin maxillary per every <del>3—years</del> 36 months - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	D5212	\$778.00	\$718.00	\$60.00		Reimbursement made upon delivery of a complete partial mandibular denture to the <del>client</del> patient. D5211 and D5212 are considered definitive treatment. Routine follow-up adjustments/relines within 6 months are to be anticipated and are included in the initial reimbursement. A partial resin base denture can be made right after having teeth extracted (healing from only a few teeth is not as extensive as healing from multiple). A partial resin base denture can also be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appointments may be necessary and are included in the cost. Frequency: Program will only pay for one <del>resin mandibular per</del> every <del>3—years</del> 36 months - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Maxillary partial denture – cast metal framework with resin denture bases (including <del>any—conventional clasps</del> <u>retentive/clasping materials</u> , rests and teeth)	D5213	\$900.48	\$840.48	\$60.00		Reimbursement made upon delivery of a complete partial maxillary denture to the <del>client</del> <u>patient</u> . D5213 and D5214 are considered definitive treatment. Routine follow-up adjustments or relines within 6 months are to be anticipated and are included in the initial reimbursement. A partial cast metal base can also be made right after having teeth extracted (healing from only a few teeth is not as extensive as healing from multiple). A partial cast metal base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and “try-in” appointments may be necessary and are included in the cost. Frequency: Program will only pay for one maxillary per every <del>five—years</del> <u>60 months</u> - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max <del>Client</del> Patient Co-Pay	<del>Teeth or</del> <del>Quadra</del> <del>nt</del> Covered	PROGRAM GUIDELINES
Mandibular partial denture – cast metal framework with resin denture bases (including <del>any—conventional clasps</del> <u>retentive/clasping materials</u> , rests and teeth)	D5214	\$900.48	\$840.48	\$60.00		Reimbursement made upon delivery of a complete partial mandibular denture to the <del>client</del> patient. D5213 and D5214 are considered definitive treatment. Routine follow-up adjustments or relines within 6 months are to be anticipated and are included in the initial reimbursement. A partial cast metal base can be made right after having teeth extracted (healing from only a few teeth is not as extensive as healing from multiple). A partial cast metal base denture can also be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and “try-in” appointments may be necessary and are included in the cost. Frequency: Program will only pay for one mandibular per every <del>five—years</del> <u>60 months</u> - documentation that existing prosthesis cannot be made serviceable must be maintained.



Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadra nt Covered	PROGRAM GUIDELINES
Immediate maxillary partial denture – resin base (including <del>any—conventional clasps</del> <u>retentive/clasping materials</u> , rests and teeth)	D5221	\$646.83	\$586.83	\$60.00		Reimbursement made upon delivery of an immediate partial maxillary denture to the <del>client</del> <u>patient</u> . D5221 can be reimbursed only once per lifetime per <del>client</del> <u>patient</u> and must be on the same date of service as the extraction. Routine follow-up adjustments or relines within 6 months is to be anticipated and are included in the initial reimbursement. An immediate partial resin base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and “try-in” appointments may be necessary and are included in the cost. Frequency: A maxillary partial denture may be considered <del>3—years</del> <u>36 months</u> after immediate partial denture was reimbursed. Documentation that existing prosthesis cannot be made serviceable must be maintained. Immediate Denture Form must be on file.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Immediate mandibular partial denture – resin base (including <del>any—conventional clasps</del> <u>retentive/clasping materials</u> , rests and teeth)	D5222	\$646.83	\$586.83	\$60.00		Reimbursement made upon delivery of an immediate partial mandibular denture to the <del>client</del> <u>patient</u> . D5222 can be reimbursed only once per lifetime per <del>client</del> <u>patient</u> and must be on the same date of service as the extraction. Routine follow-up adjustments or relines within 6 months is to be anticipated and are included in the initial reimbursement. An immediate partial resin base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and “try-in” appointments may be necessary and are included in the cost. Frequency: A mandibular partial denture may be considered <del>3—years</del> <u>36 months</u> after immediate partial denture was reimbursed. Documentation that existing prosthesis cannot be made serviceable must be maintained. Immediate Denture Form must be on file.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Immediate maxillary partial denture – cast metal framework with resin denture bases (including <del>any—conventional clasps</del> <u>retentive/clasping materials</u> , rests and teeth)	D5223	\$900.48	\$840.48	\$60.00		Reimbursement made upon delivery of an immediate partial maxillary denture to the <del>client</del> <u>patient</u> . D5223 can be reimbursed only once per lifetime per <del>client</del> <u>patient</u> and must be on the same date of service as the extraction. Routine follow-up adjustments or relines within 6 months is to be anticipated and are included in the initial reimbursement. An immediate partial cast metal framework with resin base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and “try-in” appointments may be necessary and are included in the cost. Frequency: A maxillary partial denture may be considered <del>5—years</del> <u>60 months</u> after immediate partial denture was reimbursed. Documentation that existing prosthesis cannot be made serviceable must be maintained. Immediate Denture Form must be on file.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Immediate mandibular partial denture – cast metal framework with resin denture bases (including <del>any—conventional clasps</del> <u>retentive/clasping materials</u> , rests and teeth)	D5224	\$900.48	\$840.48	\$60.00		Reimbursement made upon delivery of an immediate partial mandibular denture to the <del>client</del> <u>patient</u> . D5224 can be reimbursed only once per lifetime per <del>client</del> <u>patient</u> and must be on the same date of service as the extraction. Routine follow-up adjustments or relines within 6 months are to be anticipated and are included in the initial reimbursement. An immediate partial cast metal framework with resin base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and “try-in” appointments may be necessary and are included in the cost. Frequency: A mandibular partial denture may be considered <del>5—years</del> <u>60 months</u> after immediate partial denture was reimbursed. Documentation that existing prosthesis cannot be made serviceable must be maintained. Immediate Denture Form must be on file.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Maxillary partial denture – flexible base (including retentive/clasping materials, rests, and teeth)	D5225	\$798.83	\$738.83	\$60.00		Reimbursement made upon delivery of a partial maxillary denture to the <del>client</del> patient. D5225 and D5226 are considered definitive treatment. Routine follow-up adjustments or relines within 6 months are to be anticipated and are included in the initial reimbursement. A partial flexible base can be made right after having teeth extracted (healing from only a few teeth is not as extensive as healing from multiple). A partial flexible base denture can also be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and “try-in” appointments may be necessary and are included in the cost. Frequency: Program will only pay for one maxillary per every <del>three years</del> 36 months - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Mandibular partial denture – flexible base (including retentive/clasping materials, rests, and teeth)	D5226	\$798.83	\$738.83	\$60.00		Reimbursement made upon delivery of a partial mandibular denture to the <del>client</del> patient. D5225 and D5226 are considered definitive treatment. Routine follow-up adjustments or relines within 6 months are to be anticipated and are included in the initial reimbursement. A partial flexible base can be made right after having teeth extracted (healing from only a few teeth is not as extensive as healing from multiple). A partial flexible base denture can also be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and “try-in” appointments may be necessary and are included in the cost. Frequency: Program will only pay for one mandibular per every <del>three years</del> 36 months - documentation that existing prosthesis cannot be made serviceable must be maintained.
<u>Adjust Complete Denture - maxillary</u>	<u>D5410</u>	<u>\$54.41</u>	<u>\$44.41</u>	<u>\$10.00</u>		<u>Adjust complete maxillary denture. Frequency: two of D5410 per 12 months per client. Cannot be charged on a denture provided in last six months. Cannot be charged in addition to a rebase or reline in a 12 month period.</u>
<u>Adjust Complete Denture - mandibular</u>	<u>D5411</u>	<u>\$54.41</u>	<u>\$44.41</u>	<u>\$10.00</u>		<u>Adjust complete maxillary denture. Frequency: two of D5411 per 12 months per client. Cannot be charged on a denture provided in last six months. Cannot be charged in addition to a rebase or reline in a 12 month period.</u>

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
<u>Adjust Partial Denture - maxillary</u>	<u>D5421</u>	<u>\$54.41</u>	<u>\$44.41</u>	<u>\$10.00</u>		<u>Adjust complete maxillary denture. Frequency: two of D5421 per 12 months per client. Cannot be charged on a denture provided in last six months. Cannot be charged in addition to a rebase or reline in a 12 month period.</u>
<u>Adjust Partial Denture - mandibular</u>	<u>D5422</u>	<u>\$54.41</u>	<u>\$44.41</u>	<u>\$10.00</u>		<u>Adjust complete maxillary denture. Frequency: two of D5422 per 12 months per client. Cannot be charged on a denture provided in last six months. Cannot be charged in addition to a rebase or reline in a 12 month period.</u>
Repair broken complete denture base, mandibular	D5511	\$131.84	\$121.84	\$10.00		Repair broken complete mandibular denture base. Frequency: <del>Two</del> of D5511 per 12 months per <del>client</del> patient.
Repair broken complete denture base, maxillary	D5512	\$131.84	\$121.84	\$10.00		Repair broken complete maxillary denture base. Frequency: <del>Two</del> of D5512 per 12 months per <del>client</del> patient.
Replace missing or broken teeth - complete denture - <del>(each per tooth)</del>	D5520	\$98.85	\$88.85	\$10.00	<u>Teeth 1 - 32</u>	Replacement/repair of missing or broken teeth. Teeth 1 – 32 and must report tooth number.
Repair resin partial denture base, mandibular	D5611	\$99.55	\$89.55	\$10.00		Repair resin partial mandibular denture base. Frequency: <del>Two</del> of D5611 per 12 months per <del>client</del> patient.
Repair resin partial denture base, maxillary	D5612	\$99.55	\$89.55	\$10.00		Repair resin partial maxillary denture base. Frequency: <del>Two</del> of D5612 per 12 months per <del>client</del> patient.
Repair cast partial framework, mandibular	D5621	\$129.27	\$119.27	\$10.00		Repair cast partial mandibular framework. Frequency: <del>Two</del> of D5621 per 12 months per <del>client</del> patient.
Repair cast partial framework, maxillary	D5622	\$129.27	\$119.27	\$10.00		Repair cast partial maxillary framework. Frequency: <del>Two</del> of D5622 per 12 months per <del>client</del> patient.
Repair or replace broken retentive/clasping materials – per tooth	D5630	\$139.66	\$129.66	\$10.00	<u>Teeth 1 - 32</u>	Repair of broken clasp on partial denture base – per tooth. Teeth 1 – 32, report tooth number(s). <u>Frequency: One of D5630 per 12 months per patient per tooth.</u>

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Replace <u>missing or</u> broken teeth-per tooth	D5640	\$100.04	\$90.04	\$10.00	<u>Teeth 1 - 32</u>	Repair/replacement of missing tooth. Teeth 1 – 32, report tooth number(s). <u>Frequency: One of D5640 per 12 months per patient per tooth.</u>
Add tooth to existing partial denture <u>– per tooth</u>	D5650	\$109.00	\$99.00	\$10.00	<u>Teeth 1 - 32</u>	Adding tooth to partial denture base. <u>Frequency: One of D5650 per 12 months per patient per tooth.</u> Documentation may be requested when charged on partial delivered in last 12 months. Teeth 1 – 32, report tooth number(s).
Add clasp to existing partial denture <u>– per tooth</u>	D5660	\$145.08	\$135.08	\$10.00	<u>Teeth 1 - 32</u>	Adding clasp to partial denture base – per tooth. <u>Frequency: One of D5660 per 12 months per patient per tooth.</u> Documentation may be requested when charged on partial delivered in last 12 months. Teeth 1 – 32, report tooth number(s).
Rebase complete maxillary denture	D5710	\$322.00	\$297.00	\$25.00		Frequency: <u>eOne</u> time per 12 months. Completed at laboratory. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a reline in a 12 month period.
Rebase complete mandibular denture	D5711	\$322.00	\$297.00	\$25.00		Frequency: <u>eOne</u> time per 12 months. Completed at laboratory. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a reline in a 12 month period.
Rebase maxillary partial denture	D5720	\$304.00	\$279.00	\$25.00		Frequency: <u>eOne</u> time per 12 months. Completed at laboratory. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a reline in a 12 month period.
Rebase mandibular partial denture	D5721	\$304.00	\$279.00	\$25.00		Frequency: <u>eOne</u> time per 12 months. Completed at laboratory. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a reline in a 12 month period.



Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Reline complete maxillary denture (chairside/ <u>direct</u> )	D5730	\$190.08	\$180.08	\$10.00		Frequency: One time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Reline complete mandibular denture (chairside/ <u>direct</u> )	D5731	\$190.08	\$180.08	\$10.00		Frequency: One time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Reline maxillary partial denture (chairside/ <u>direct</u> )	D5740	\$187.69	\$177.69	\$10.00		Frequency: <u>e</u> One time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Reline mandibular partial denture (chairside/ <u>direct</u> )	D5741	\$189.49	\$179.49	\$10.00		Frequency: <u>e</u> One time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Reline complete maxillary denture (laboratory/ <u>indirect</u> )	D5750	\$253.13	\$228.13	\$25.00		Frequency: <u>e</u> One time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Reline complete mandibular denture (laboratory/ <u>indirect</u> )	D5751	\$254.31	\$229.31	\$25.00		Frequency: <u>e</u> One time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Reline maxillary partial denture (laboratory/ <u>indirect</u> )	D5760	\$251.33	\$226.33	\$25.00		Frequency: <u>e</u> One time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Reline mandibular partial denture (laboratory/ <u>indirect</u> )	D5761	\$251.33	\$226.33	\$25.00		Frequency: <u>e</u> One time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	D7140	\$119.07	\$109.07	\$10.00	<u>Teeth 1 - 32</u>	<del>Includes</del> removal of tooth structure, minor smoothing of socket bone, and closure as necessary. Frequency: One of D7140 per lifetime per <del>client</del> patient per tooth. Teeth 1 – 32.
Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	D7210	\$184.54	\$174.54	\$10.00	<u>Teeth 1 - 32</u>	Includes related cutting of gingiva and bone, removal of tooth structure, minor smoothing of socket bone and closure. Frequency: One of D7210 per lifetime per <del>client</del> patient per tooth. Teeth 1 - 32
Removal of impacted tooth-soft tissue	D7220	\$220.66	\$200.66	\$20.00	<u>Teeth 1 - 32</u>	Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation. Teeth 1-32. Frequency: One of D7220 per <del>4</del> lifetime per <del>client</del> patient per tooth.
Removal of impacted tooth-partially bony	D7230	\$272.40	\$252.40	\$20.00	<u>Teeth 1 - 32</u>	Part of crown covered by bone; requires mucoperiosteal flap elevation and bone removal. Teeth 1-32. Frequency: One of D7230 per <del>4</del> lifetime per patient per tooth
Removal of impacted tooth-completely bony	D7240	\$316.18	\$296.18	\$20.00	<u>Teeth 1 - 32</u>	Most or all of crown covered by bone; requires mucoperiosteal flap elevation and bone removal. Teeth 1-32. Frequency: One of D7240 per <del>4</del> lifetime per patient per tooth.
Removal of impacted tooth-completely bony, with unusual surgical complications	D7241	\$415.64	\$395.64	\$20.00	<u>Teeth 1 - 32</u>	Most or all of crown covered by bone; unusually difficult or complicated due to factors such as nerve dissection required, separate closure of maxillary sinus required or aberrant tooth position. Teeth 1-32. Frequency: One of D7241 per lifetime per patient per tooth.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Removal of residual tooth roots (cutting procedure)	D7250	\$194.64	\$184.64	\$10.00	<u>Teeth 1 - 32</u>	Includes cutting of soft tissue and bone, removal of tooth structure, and closure. Cannot be charged for removal of broken off roots for recently extracted tooth. Teeth 1 – 32 Frequency: One <u>of</u> D7250 per lifetime per patient per tooth. <u>Will not be paid to the dentists or group that removed the tooth.</u>
Primary closure of a sinus perforation	D7261	\$485.35	\$475.35	\$10.00		Subsequent to surgical removal of tooth, exposure of sinus requiring repair, or immediate closure of oroantral or oronasal communication in absence of fistulous tract. Narrative of medical necessity may be required and if the sinus perforation was caused by a current grantee or provider of the program.
Incisional biopsy of oral tissue - hard (bone, tooth)	D7285	<del>\$196.673.04</del>	<del>\$186.673.04</del>	\$10.00		For partial removal of specimen only. This procedure involves biopsy of osseous lesions and is not used for apicectomy/periradicular surgery. This procedure does not entail an excision. Only covered if there is a suspicious lesion. Must have a pathology report in file.
Incisional biopsy of oral tissue-soft	D7286	\$391.00	\$381.00	\$10.00		For partial removal of an architecturally intact specimen only. <del>D7286</del> <u>This procedure</u> is not used at the same time as codes for apicoectomy/periradicular curettage. <u>This procedure</u> <del>and</del> does not entail an excision. Treatment notes must include documentation and proof that biopsy was sent for evaluation. <u>Only covered if there is a suspicious lesion.</u>

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	D7310	\$150.00	\$140.00	\$10.00	Per Quadrant LL, LR, UL, UR	<del>D7310</del> The alveoloplasty is distinct (separate procedure) from extractions. Usually in preparation for prosthesis or other treatments such as radiation therapy and transplant surgery. Frequency: One of D7310 or D7311 per lifetime per patient per quadrant. <del>Reported per quadrant.</del> <u>Minimum of 4 extractions in the affected quadrant.</u>
Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	D7311	\$148.69	\$138.69	\$10.00	Per Quadrant LL, LR, UL, UR	<del>D7311</del> The alveoloplasty is distinct (separate procedure) from extractions. Usually in preparation for a prosthesis or other treatments such as radiation therapy and transplant surgery. Frequency: One of D7311 or D7310 per lifetime per patient per quadrant. <del>Reported per quadrant.</del> <u>Maximum of 3 extractions in the affected quadrant.</u>
Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	D7320	\$214.11	\$204.11	\$10.00	Per Quadrant LL, LR, UL, UR	No extractions performed in an edentulous area. See D7310 if teeth are being extracted concurrently with the alveoloplasty. Usually in preparation for prosthesis or other treatments such as radiation therapy and transplant surgery. Frequency: One of D7320 or D7321 per lifetime per patient per quadrant. <del>Reported per quadrant.</del>
Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	D7321	\$214.11	\$204.11	\$10.00	Per Quadrant LL, LR, UL, UR	No extractions performed in an edentulous area. See D7311 if teeth are being extracted concurrently with the alveoloplasty. Usually in preparation for prosthesis or other treatments such as radiation therapy and transplant surgery. Frequency: One of D7320 or D7321 per lifetime per patient per quadrant. <del>Reported per quadrant.</del>
Excision of benign Lesion up to 1.25 cm	D7410	<del>\$200.90</del> <u>\$190.90</u> <del>7.16</del>	<del>\$190.90</del> <u>\$180.90</u> <del>7.16</del>	\$10.00		Must have a pathology report in file.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Removal of benign nonodontogenic cyst or tumor-lesion diameter up to 1.25 cm	D7460	<del>\$253.4748</del> 70	<del>\$243.473</del> 8.70	\$10.00		Must have a pathology report in file.
Removal of lateral exostosis (maxilla or mandible)	D7471	\$310.17	\$300.17	\$10.00	<u>Per Arch LA, UA</u>	Limited to the removal of exostosis, including the removal of tori, osseous tuberosities, and other osseous protuberances, when the mass prevents the seating of denture and does not allow denture seal. <del>Reported per arch (LA or UA)</del>
Removal of torus palatinus	D7472	\$364.79	\$354.79	\$10.00	<u>Per Quadrant LL, LR, UL, UR</u>	Limited to the removal of exostosis, including the removal of tori, osseous tuberosities, and other osseous protuberances, when the mass prevents the seating of denture and does not allow denture seal. <del>Must list quadrant.</del>
Removal of torus mandibularis	D7473	\$355.79	\$345.79	\$10.00	<u>Per Quadrant LL, LR, UL, UR</u>	Limited to the removal of exostosis, including the removal of tori, osseous tuberosities, and other osseous protuberances, when the mass prevents the seating of denture and does not allow denture seal. <del>Must list quadrant.</del>
Incision & drainage of abscess - intraoral soft tissue	D7510	\$196.66	\$186.66	\$10.00	<u>Teeth 1 - 32</u>	Incision through mucosa, including periodontal origins. One of D7510 per lifetime per <del>client</del> <u>patient</u> per tooth. <del>Report per tooth.</del>

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Palliative treatment of dental pain – per visit	D9110	\$82.04	\$57.04	\$25.00		<del>Emergency treatment to alleviate pain/discomfort. This code cannot be used for filing claims or writing or calling in a prescription to the pharmacy or to address situations that arise during multi-visit treatments covered by a single fee such as surgical or endodontic treatment. Report per visit, no procedure. Frequency: Limit 1 time per year. Maintain documentation that specifies problem and treatment. Treatment that relieves pain but is not curative; services provided do not have distinct procedure codes. Not allowed with any other services other than radiographs. Cannot be billed when the only other service is writing a prescription.</del>
Evaluation for moderate sedation, deep or sedation general anesthesia	D9219	\$43.83	\$43.83	\$0.00		One of D9219 <del>or D9310</del> per 12 month(s) per grantee <u>per patient.</u>
<u>Deep sedation/general anesthesia - first 15 minutes</u>	<u>D9222</u>	<u>\$124.76</u>	<u>\$114.76</u>	<u>\$10.00</u>		<u>One of D9222 per 1 day per patient.</u>
Deep sedation/general anesthesia-each <u>subsequent</u> 15 minute increment	D9223	\$110.09	\$100.09	\$10.00		<del>Nine of D9223 per 1 day per patient.</del> Not allowed with D9243

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Intravenous moderate (conscious) sedation/analgesia-first 15 minutes	D9239	\$124.76	\$114.76	\$10.00		Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties. The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetic effects upon the central nervous system and not dependent upon the route of administration. One of D9239 per 1 day per patient.
Intravenous moderate (conscious) sedation/analgesia-each subsequent 15 minute increment	D9243	\$110.09	\$100.09	\$10.00		Thirteen of D9243 per 1 day per patient. Not allowed with D9223

EXPLANATION OF RESTORATIONS		
Location	Number of Surfaces	Characteristics
Anterior - <b>Mesial, Distal, Incisal, Lingual, or Facial (or Labial)</b>	1	Placed on one of the five surface classifications. .
	2	Placed, without interruption, on two of the surface classifications.
	3	Placed, without interruption, on three of the surface classifications.
	4 or more	Placed, without interruption, on four or more of the surface classifications.
Posterior – <b>Mesial, Distal, Occlusal, Lingual, or Buccal</b>	1	Placed on one of the five surface classifications.
	2	Placed, without interruption, on two of the surface classifications.
	3	Placed, without interruption, on three of the surface classifications.
	4 or more	Placed, without interruption, on four or more of the surface classifications.

**NOTE:** Tooth surfaces are reported using the letters in the following table.

Surface	Code
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Buccal	B
Distal	D
Facial (or Labial)	F
Incisal	I
Lingual	L
Mesial	M
Occlusal	O



**DO NOT PUBLISH THIS PAGE**

Title of Rule: Revision to the Medical Assistance Eligibility Rules Concerning  
Redetermination of Eligibility Section 8.100.3.P

Rule Number: MSB 24-11-07-A

Division / Contact / Phone: Eligibility Policy Section / Ana Bordallo / 4416

**SECRETARY OF STATE**

**RULES ACTION SUMMARY AND FILING INSTRUCTIONS**

**SUMMARY OF ACTION ON RULE(S)**

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: MSB 24-11-07-A, Revision to the Medical Assistance Eligibility Rules  
Concerning Redetermination of Eligibility, Section 8.100.3.P.

3. This action is an adoption of: an amendment

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

Sections(s) 8.100.3.P, Colorado Department of Health Care Policy and Financing, Staff  
Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? No

If yes, state effective date:

Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

**PUBLICATION INSTRUCTIONS\***

Replace the current text at 8.100.3.P with the proposed text beginning at 8.100.3.P.1  
through the end of 8.100.3.P.5.b. This rule is effective June 30, 2025.

## **DO NOT PUBLISH THIS PAGE**

Title of Rule: Revision to the Medical Assistance Eligibility Rules Concerning  
Redetermination of Eligibility Section 8.100.3.P

Rule Number: MSB 24-11-07-A

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### **STATEMENT OF BASIS AND PURPOSE**

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

The proposed rule will amend 10 CCR 2505-10 8.100.3.P to incorporate federal regulations and to integrate feedback received during the Department's Regulatory Efficiency Review. This will align the enrollment and renewal requirements for members enrolled in Medicaid. The Centers for Medicare and Medicaid Services provided states with additional guidance on these federal regulations and timelines that states must comply with. The Department took the opportunity to update section 8.100.3.P, enhancing the flow of the rules and providing clearer guidance on the renewal process. The updated rule will also address when a member submits documentation for renewal before their eligibility period ends, ensuring that their benefits continue until a final determination is made. This update impacts renewals as per federal regulation §435.916 and the new federal regulation §435.930(b). The proposed rule will ensure continuity of coverage for members, ensuring they have access to necessary medical services during the renewal process.

2. An emergency rule-making is imperatively necessary

- ☐ to comply with state or federal law or federal regulation and/or  
☐ for the preservation of public health, safety and welfare.

Explain:

3. Federal authority for the Rule, if any:

42 CFR §435.916(b)(2) and 42 CFR §435.930(b)

4. State Authority for the Rule:

Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2024);  
25.5-4-205.

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Title of Rule: Revision to the Medical Assistance Eligibility Rules Concerning  
Redetermination of Eligibility Section 8.100.3.P

Rule Number: MSB 24-11-07-A

Division / Contact / Phone: Eligibility Policy Section / Ana Bordallo / 4416

### **REGULATORY ANALYSIS**

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

With the proposed rule, members of Medical Assistance may be affected. This rule outlines the requirement for members who submit the necessary documentation on time before the end of their eligibility period. Meeting this requirement will continue their benefits until a final determination is made. This proposed rule will benefit members in a positive way.

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

The proposed rule will ensure continuity of coverage for members, ensuring they have access to necessary medical services during the renewal process.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

There are no probable costs to the Department associated with these renewal policy changes. Given that factors such as the number of members affected by these regulations, length of time required for an eligibility determination to be made and utilization during the relevant periods cannot be determined, a budget impact cannot be determined. Additionally, it is likely that any utilization that occurs during this period that would be minimal, making any budget impact minimal. There is no anticipated effect on state revenues.

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

There are no probable costs associated with the proposed policy changes. The probable benefits of the proposed policy changes include compliance with federal regulations, as well as ensuring that members who are eligible for coverage maintain the appropriate coverage.

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The cost of inaction is being out of compliance with federal regulations, as well as possibly failing to provide coverage to eligible members. There are no benefits to inaction.

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

There are no less costly methods or less intrusive methods for achieving the purpose of the proposed policy change because there are no costs associated with the proposed policy change.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

There were no alternative methods considered for the proposed rule.

### 8.100.3. Medical Assistance General Eligibility Requirements

#### 8.100.3.P. Redetermination of Eligibility

1. "Redetermination of eligibility" ~~is means~~ a case review and/or the request for necessary verification to determine whether a member individual enrolled in a ~~the~~ Medical Assistance Program ~~member~~ continues to be eligible ~~to receive Medical Assistance~~.

~~"Reconsideration period" means the 90-day period following termination of eligibility.~~

~~Eligibility shall be redetermined at least every twelve (12) months since a member's the last eligibility determination. Beginning on the case approval date, a redetermination of eligibility shall be completed accomplished at least every 12 months for Title XIX Medical Assistance only cases. An eligibility site may redetermine Eligibility may be redetermined through telephone, mail, or online electronically means. Prior to making a determination of ineligibility, the eligibility site must review on all bases of Medical Assistance eligibility for a member.~~

2. ~~The eligibility site shall promptly redetermine eligibility when:~~

- a. ~~it receives and verifies information which indicates a change in a member's circumstances which may affect continued eligibility for Medical Assistance; or~~
- b. ~~it receives direction to do so from the Department.~~

~~The eligibility site shall redetermine eligibility according to timelines defined by the Department.~~

23. ~~"Ex Parte Review" is a redetermination of eligibility for a member n individual without requesting verification by utilizing available information from the member's account, or electronic sources, and other assistance programs. another assistance program or verifying information through electronic verification systems. Ex -parte Reviews will be conducted as follows:~~

~~A redetermination form will not be sent to the member if all current eligibility requirements can be verified by reviewing information from another assistance program or if this information can be verified through an electronic verification system — this process is referenced as Ex Parte Review. The use of telephonic or electronic redeterminations shall be noted in the case record. When applicable, the eligibility site shall redetermine eligibility based solely on information already available. a. If verified verification or information is available for any of the six months prior to the redetermination month, and the member individual meets all other eligibility requirements ~~are met~~, then an approval notice will be sent ~~to for~~ all eligible members of the household who are requesting assistance. This approval notice shall include directions on how to view the information used to determine eligibility and the member is not required to sign and return such notice if all information provided~~

on such notice is accurate. A redetermination form is sent to those members whose required information is not available at the ex parte review.

4. b. If all required information is not available and/or the information on file received does not support a finding of eligibility, a redetermination form, as described in Section 8.100.3.P.3., and/or a verification form will be issued to the household at least 30 days before the end of the eligibility period. The household will be sent a prepopulated redetermination form with the current information on file and a notice of required verifications needed to determine eligibility at least 30 days prior to the end of the eligibility period.
3. R~~The~~ redetermination forms shall direct members to verify that the information provided on the form is accurate or to report any changes to the information. ~~Members must complete and return the redetermination with the necessary verifications and the signature form. If a member fails to sign the signature form or comply with any of these requirements, the member will be terminated from the program for failure to complete the redetermination process.~~

The following procedures pertain~~relate~~ to the mail-out~~redetermination~~ forms:

- a. ~~a.~~ A r~~R~~edetermination f~~F~~orm shall be sentmailed to the member alongtogether with any required verifications other forms to be completed.;
- a-b. The member must complete and return the redetermination with the necessary verifications and the signature form.
- cb. If ~~When~~ the member is unable to complete the redetermination forms due to a disability (a physical or, mental impairment that substantially limits one or more major life activity) or emotional disabilities, or other good cause, in response to a request from the member, and has no one to help him/her, the eligibility site shall either assist the member, or refer the member him/her to a legal or another resource. When initial arrangements or a change in arrangements are being made, an extension of up to thirty days shall be allowed. ~~The action of the eligibility site shall in assist the member in accordance with its Civil Rights Plan as described in Section 10 CCR 2505-5 1.020.7.1.d. and~~ For referralthe assistance of the eligibility site shall be recorded in the case record and CBMS case comments.
- de. The redetermination form shall require that a recipient and community spouse of a recipient of HCBS, PACE, or institutional services disclose a description of any interest the member or community spouse has in an annuity or similar financial instrument regardless of whether the annuity is irrevocable or treated as an asset. The redetermination form shall include a statement that the Department shall be a remainder beneficiary for any annuity or similar financial instrument purchased on or after February 8, 2006, or institutional services disclose a description of any interest the memberindividual or community spouse has in an annuity or similar financial instrument regardless of whether the annuity is irrevocable or treated as an asset. The redetermination form shall include a statement that the Department shall be a remainder beneficiary for any annuity or similar financial instrument purchased on or after February 8, 2006 for the total amount of Medical Assistance provided to the memberindividual.
- e. The eligibility site shall notify in writing the issuer of any annuity or financial instrument that the Department is a preferred remainder beneficiary in the annuity or similar financial instrument for the total amount of Medical Assistance provided to the member. This notice shall require the issuer to notify the eligibility site when there is a change in the amount of income or principal that is being withdrawn from the annuity.-

- f. If the member submits the redetermination form and/or verification information before the end of the eligibility period, the member must maintain coverage until the eligibility site can make a final determination.
- g. If the member submits the redetermination form and/or verification information after the end of the eligibility period, the member will not maintain coverage.
- h. If a member fails to sign the signature form or comply with any of these requirements, the member will be terminated from the program for failure to complete the redetermination process.
- d. The eligibility site shall notify in writing the issuer of any annuity or financial instrument that the Department is a preferred remainder beneficiary in the annuity or similar financial instrument for the total amount of Medical Assistance provided to the member individual. This notice shall require the issuer to notify the eligibility site when there is a change in the amount of income or principal that is being withdrawn from the annuity.
- e. Members who return properly completed redetermination forms and requested information during the reconsideration period shall not be required to submit a new application for eligibility. If redetermination forms and requested information are not returned within 90 days after termination, the member must submit a new application to obtain enrollment in the program.
- f. For individuals who are determined to be eligible for Medical Assistance within the reconsideration period, the effective date of coverage will be the first day of the month in which the redetermination form was returned. If the member has a gap in coverage due to submitting the redetermination within the reconsideration period, the member can request up to three months in retroactive coverage.

45. When the redetermination verification information is received by the eligibility site, it shall be date stamped. Within fifteen working days, the form and/or verification information shall be thoroughly reviewed for completeness, accuracy, and consistency. All factors shall be evaluated as to their effect on eligibility at that time. Verifications shall be documented in the case file and CBMS case comments. The case file shall be used as a checklist in the redetermination process, and shall be used to keep track of matters requiring further action. When additional information is needed:

- a. Date-stamp all submitted documentation upon receipt to ensure accurate processing timeliness.
- b. Thoroughly review the submitted documentation for completeness, accuracy, and consistency.
- c. Document verifications in the case file and CBMS case comments. The case file shall be used as a checklist in the redetermination process and shall be used to keep track of matters requiring further action.
- d. ~~Before the end of the eligibility period~~ Determine eligibility 30 calendar days from the date of receiving the redetermination form and/or verification information.

information after the end of the eligibility period

- e. a. ~~if incomplete information is submitted is provided~~ or a member reports new changes, a worker must contact the member by telephone or in writing to provide request required documents or requested verifications. If requested verifications are needed, the

eligibility site must send a form with a letter specifying the items that require completion. The member shall return the completed request form to the eligibility site no later than ten working days. The eligibility site will have fifteen working days from the date the documents are received to make a final determination.

~~A form with a letter specifying the items that require completion needs to be mailed to the member. The Medical Assistance member shall return the completed request form to the eligibility site no later than ten working days.;~~T

b. ~~if incomplete, inaccurate or inconsistent data is reported, the Medical Assistance member shall be contacted by telephone or in writing so that the worker may secure the proper information according to timelines defined by the Department.5. "Reconsideration period" is the 90-day -time period -allowed- after a member's eligibility is terminated due to failure to return the redetermination with the necessary verifications and the signature. The member's eligibility must be reconsidered if the member submits the requested information within 90 days following termination of eligibility.~~

a. ~~Members who return properly completed redetermination forms and requested information during the reconsideration period shall will not be required to submit a new application for eligibility. If redetermination forms and requested information are not returned within 90 days after the termination, the member must submit a new application to obtain for enrollment in the program.~~

b. ~~For members individuals who are determined to be eligible for Medical Assistance within the reconsideration period, the effective date of coverage will be the first day of the month in which the redetermination form was returned. If the member has a gap in coverage due to submitting the redetermination within the reconsideration period, the member can request up to three months in retroactive coverage.~~

6. ~~Due to the federal Coronavirus COVID-19 Public Health Emergency, the Department will continue eligibility for all Medical Assistance categories, regardless of a redetermination and/or reported change for these members individuals to ensure continuity of eligibility for Medical Assistance coverage. Effective May 11, 2023 the Coronavirus COVID-19 Public Health Emergency has been declared to end. To ensure the Department maintains access to State and Federal funding provided by the Federal "Families First Coronavirus Response Act" Pub.L. 116-127, and the Federal "Consolidated Appropriations Act, 2023", the Department will process eligibility redeterminations and/or changes for all members whose eligibility was maintained during the emergency declaration and take appropriate action including termination if no longer meeting eligibility criteria. Through the renewal process, a member may be disenrolled or their eligibility category may be changed based on information obtained by the state through electronic verifications, information provided by the member through the renewal, or the member's failure to respond to the renewal. A member's eligibility will no longer be maintained as it was during Public Health Emergency once their renewal due month has passed, and their renewal has been processed.~~