COLORADO
Department of Health Care Policy & Financing

Community First Choice and Community Connector Rule Revision Draft for Stakeholder Review

*** Please note that this is a draft of the rule revisions that will go to the Medical Services Board in February 2026 as emergency rules. Language in the draft may change.**

{Added:} = Added language

[Deleted:] = Deleted Language

8.520 Home Health Services

8.520.1. Definitions

8.520.1.R. {Added: [Intentionally omitted]} [Deleted ~~[] 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.Y. {Added: [Intentionally omitted]} [Deleted ~~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. []~~]

8.520.8.C. Long-Term Home Health

3. {Added: [Intentionally omitted]} [Deleted: ~~Long-Term Home Health Services require the completion of the Skilled Care Acuity Assessment to reliably provide consistent information, and 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.~~]

4. The complete formal written PAR shall include:

d. Any other medical information which will document the Medical Necessity 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. {Added: Support for Medical Necessity must be documented in the PAR submission to be considered in the PAR review and any subsequent appeal.};

8.520.9 Reimbursement

8.520.9.A. 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), [Deleted: ~~Physical Therapist (PT), Occupational Therapist (OT), Speech Therapist (ST),~~] or Certified Nursing Assistant (CNA) may be {Added: scheduled or} reimbursed for more than 16 hours of care per day for one or more members collectively {Added: across Personal Care, Homemaker, Health Maintenance Activities, Private Duty Nursing, and/or Long-Term Home Health services except in a documented emergency situation.

4. No individual Nurse (RN/LPN) or Certified Nursing Assistant (CNA) shall be scheduled or reimbursed for more than 56 hours of direct care per week per member across Personal Care, Homemaker, Health Maintenance Activities, LTHH-Home Health Aide, and/or LTHH-Nursing Services except in a documented emergency situation.}

8.540 Private Duty Nursing Services

8.540.1 Definitions

F. {Added: [Intentionally omitted]} [Deleted: ~~[Nurse Assessor Vendor means a third-party vendor contracted by the Department to complete the Skilled Care Acuity Assessment for specific skilled care services.]~~

L. {Added: [Intentionally omitted]} [Deleted: ~~[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.]~~

8.540.5.C. Provider Responsibilities

1. A certified HHA that provides PDN services shall meet all of the following:

h.~~[~~ {Added: [Intentionally omitted]} [Deleted: ~~Ensure that members have a current Skilled Care Acuity Assessment or, if there is not a current assessment, make timely referral to the Nurse Assessor for an assessment.]~~

8.540.6 Prior Authorization Procedures

8.540.6.C The PAR shall include the following:

1. {Added: Support for Medical Necessity must be documented in the PAR submission to be considered in the PAR review and any subsequent appeal.} [Deleted: ~~A current Skilled Care Acuity~~

~~Assessment completed by the Nurse Assessor. The assessment results are one component to be used to determine medical necessity but do not independently determine whether the requested services are medically necessary.~~]

8.7500 HCBS Benefits and Services Requirements

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

O. 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.

W. Legally Responsible Person means any person who has legal responsibility to care for another person. {Added: For children, this includes} [Deleted: ~~such as~~] the parent or {Added: legal} guardian of a minor child. {Added: For adults, this is limited to}[Deleted: ~~or~~] the member's spouse {Added: (by marriage or Common Law Marriage as defined at 10 CCR 2505-10 8.100) and does not include the parent or legal guardian of an adult.}

{Added:

HH. Age-Appropriate Task Standards for Children are task times that correspond to the degree of assistance, participation, or contribution expected of children within defined age ranges, between the ages of 0 to 18, consistent with typical developmental milestones and abilities. Task Standards cover Homemaker, Personal Care, and Health Maintenance Activities. The Task Standards include service and task definitions, the length of time appropriate per task, and the maximum time permitted per task.

II. 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.

JJ. Task Standards for Adults are the task times that reflect the level of assistance, effort, or support an adult is reasonably expected to require or contribute to complete tasks. Task Standards are based on typical functional abilities for adults without impairments. Task Standards cover Homemaker, Personal Care and Health Maintenance Activities services. Task Standards include service and task definitions, the length of time appropriate per task, and the maximum time permitted per task.

KK. Parental or Legal Guardian Responsibility means the legal rights and duties held by a parent or by a court-appointed legal guardian to provide for the physical, emotional, developmental, and functional well-being of a child under age 18, including the responsibility to assist with or oversee activities of daily living and instrumental activities of daily living necessary for the child's development. When determining service needs for children, Case Managers must utilize Age-Appropriate Task Standards for Children, if applicable, and distinguish between care that is typical for a child of the same age and care that exceeds age-appropriate expectations. Only supports that rise above normal

developmental caregiving, and meet the definition of Extraordinary Care, may be authorized as CFC or waiver services.}

8.7514 Community Connector Services

8.7514.A Community Connector Services Eligibility

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

   a. Children's Extensive Support Waiver

   b. Children's Habilitation Residential Program Waiver

{Added: **8.7514.B Community Connector Definition**

1. Community Connector services shall be delivered on a one-to-one basis to a Member school-aged (6) and older who demonstrates an exceptional need that exceeds age-typical parental or legal guardian responsibilities and requires support to engage with, integrate into, and utilize natural community resources. Community Connector services shall facilitate the Member's active and consistent engagement, meaningful participation, and contribution to community life.}

8.7514. {Added: C}[Deleted: ~~B~~] Community Connector Services Inclusions

1. {Added: This service can only be authorized when an extraordinary need is present, and the service is necessary to enable the Member to develop and maintain relationships with community members without disabilities and to acquire the skills to independently navigate and participate in community settings.}[Deleted: ~~Community Connector services shall the Member in integrating into the Member's community and access naturally occurring resources. Community Connector services shall:~~

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

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

   ~~c. Be provided one-on-one, to a single Member, in a variety of settings within the community in which Members interact with individuals without disabilities other than the individual who is providing the service to the Member.~~

   ~~d. The targeted behaviors, measurable goal(s), and plan to address those behaviors must be clearly articulated in a care plan.~~]

{Added:

2. This service uses community settings as learning environments to actively build relationships and natural supports with non-paid community members without disabilities,

3. Community Connector shall be used to develop skills necessary for the Member to actively and consistently engage throughout the majority of a typical, age-appropriate community activity.

4. Service must be delivered under a Person-Centered Support Plan that specifies targeted skills/behaviors, measurable goals, and strategies.

5. Be authorized solely when an exceptional need is demonstrated that goes beyond age-appropriate and ordinarily expected Parental or Legal Guardian Responsibilities as defined at section 8.7502.KK.}

8.7514.[Deleted: ~~C~~]{Added: D} **Community Connector Services Exclusions and Limitations**

1. {Added: This service is limited to 1040 units per Person-Centered Support Plan year. This unit limit applies to Community Connector services provided by either a Legally Responsible Person(s), another service provider, or a combination.

   a. Units can only be authorized based on the Member's appropriate, exceptional-need-related activities and the reasonable amount of time necessary to complete those activities on a weekly basis.

   b. Case Managers may request additional units for Community Connector above 1040 units per Person-Centered Support Plan year through the Department prescribed Exception Process. The Department may approve additional units on a case-by-case basis when a demonstrated need is documented by the Member's case manager. The exception process shall be implemented in a uniform manner applied equally to Members statewide, but outcomes shall be based on individual assessed needs and circumstances.}

[Deleted: ~~The cost of admission to professional or minor league sporting events, movies, theater, concert tickets, or any activity that is entertainment in nature or any food or drink items are specifically excluded and shall not be reimbursed.~~]

2. Telehealth Community Connector services cannot be provided by the member's Legally Responsible Person(s).

3. {Added: This service is limited to school aged children (6) and older.}

[Deleted: ~~HCBS- CES and CHRP Waivers - This service is limited to 2080 units per support plan year, unless otherwise authorized by the Department.~~]

{Added: 4. Activities excluded from this service:

   a. Activities with only brief or incidental interaction with community members who are not paid staff. This includes any activities in which the Member is passive, observational, or minimally engaged, or where the Member does not have meaningful, ongoing interaction with non-paid community members or participation within community settings.
   b. Typical age-standard activities that are a Parental or Legal Guardian Responsibility as defined at section 8.7502.KK.
   c. Specialized or segregated activities involving only or mostly individuals with disabilities.
   d. The cost of admission or any food/drink items are specifically excluded and shall not be reimbursed.}

8.7515 Consumer Directed Attendant Support Services (CDASS)

8.7515.B CDASS Definitions

[Deleted: ~~12.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.~~]

12. {Added: [Intentionally omitted.]}

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.

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.

{Added:

5. All CDASS tasks must meet Age-Appropriate Task Standards for Children for Members under 18 or Task Standards for Adults for Members age 18 and older.

6. Authorization of CDASS tasks must be limited to services that exceed those considered part of Parental or Legal Guardian Responsibility.

7. Members shall not be authorized for more than 19,000 fifteen-minute units of Health Maintenance Activities, 10,000 fifteen-minute units of Personal Care, and/or 4,500 fifteen-minute units of Homemaker services per Person-Centered Support Plan year. Case Managers may request additional units through the Department prescribed exception process outlined in section 8.7607.2.

8. Attendants must adhere to the Per Week Limit and Per Day Hourly Limit as defined at Section 8.7???.

9. Legally Responsible Persons shall not be reimbursed for more than 260 hours of homemaker services annually.}

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).

{Added: 2. An AR shall not be employed as an Attendant for the same Member for whom they are an AR.}

[Deleted: ~~b. 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.~~]

{Added: 3.}[Deleted: ~~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.

{Added: 4.}[Deleted: ~~e.~~] Attendant timesheets submitted for approval must be accurate and reflect time worked.

{Added: 5.}[Deleted: ~~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.

{Added: 6.}[Deleted: ~~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.

{Added: 7.}[Deleted: ~~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.

{Added: 8.}[Deleted: ~~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.

{Added: 9.}[Deleted: ~~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 session based on their personal assistance needs. Attendants may not be present during the budgeting portion of the orientation or coaching.

8.7515.Q CDASS Case Management Functions

{Added:

12. Case Managers must review all tasks against Age-Appropriate Task Standards for Children for Members under 18 or Task Standards for Adults for Members age 18 and older when conducting service planning.}

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. 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.

        ii. A Member of the Member's household may only be paid to furnish extraordinary care{Added:, as defined at section 8.7502.II,} as determined by the Case Manager. [Deleted: ~~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 [Deleted: ~~520~~]{Added: 260} 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).

8.7523 Health Maintenance Activities Self-Directed

8.7523.B Health Maintenance Activities Definition

1. Health Maintenance means {Added: routine and repetitive health-related tasks furnished to a member in the community or in the member's home that is necessary for the health and normal bodily functioning that a person with a disability is physically unable to carry out. "Health maintenance activities" include skilled tasks typically performed by a certified nursing assistant or a licensed nurse that does not require the clinical assessment and judgment of a licensed nurse.} [Deleted: ~~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. {Added: Member's record must include clinical documentation to substantiate any Health Maintenance Activities on the Care Plan.} ~~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.~~]

{Added:

8.7523.D Health Maintenance Activities Exclusions and Limitations

1. Attendants must adhere to the Per Week Limit and Per Day Hourly Limit as defined at Section 8.7???.

2. Members shall not be authorized for more than 19,000 fifteen-minute units of Health Maintenance Activities per Person-Centered Support Plan year. Case Managers may request additional units through the Department prescribed exception process as defined at section 8.7607.2.}

8.7527 Homemaker Services

8.7527.C Homemaker Services Inclusions

{Added:

3. All tasks must meet Age-Appropriate Task Standards for Children for Members under 18 or Task Standards for Adults for Members age 18 and older.

4. Authorization of Homemaker tasks for members under age 18 must be limited to services that exceed those considered part of Parental or Legal Guardian Responsibility.}

8.7527.D Homemaker Services Exclusions and Limitations

1. The CFC Homemaker service may NOT include:

a. Personal care services.

b. Services the person can perform independently.

c. Homemaker services provided in Uncertified Congregate Facilities are not a benefit.

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

e. 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.

f. 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 {Added: 8.7502.II.} [Deleted: ~~8.7514.B.11..~~]

b. Legally Responsible Persons shall not be reimbursed for more than [Deleted: ~~520~~]{Added: 260} hours of homemaker services annually.

{Added:

3. Members shall not be authorized for more than 4,500 fifteen-minute units of Homemaker services per Person-Centered Support Plan year. Case Managers may request additional units through the Department prescribed exception process as defined at section 8.7607.2.

4. Caregivers must adhere to the Per Week Limit and Per Day Hourly Limit as defined at Section 8.7???}

8.7527.E Homemaker Services Provider Agency Requirements

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

2. 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. Tasks included in Section 8.7527.C Homemaker Inclusions.

b. Proper food handling and storage techniques.

c. Basic infection control techniques including Universal Precautions.

d. Informing staff of policies concerning emergency procedures.

3. 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. Train staff on Agency policies and procedures.

   b. Arrange and document training.

   c. Oversee scheduling and notify Members of schedule changes.

   d. 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. Supervision should be flexible to the needs of the member and may be conducted via phone, video conference, telecommunication, or in-person.

         1) If there is a safety concern with the services, the Provider Agency must make every effort to conduct an in-person Assessment.

         2) 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.

{Added:

4. Agencies shall ensure that Caregivers adhere to the Per Week Limit and Per Day Hourly Limit as defined at Section 8.7???.}

8.7527.F Homemaker Provider Services Reimbursement Requirements:

1. 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. Payment does not include travel time to or from the Member's residence.

3. 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. 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 [Deleted: ~~520~~]{Added: 260} hours of homemaker services annually. {Added: A Member may have up to two Legally Responsible Persons that are paid to provide Homemaker Services.

6. Caregivers must adhere to the Per Week Limit and Per Day Hourly Limit as defined at Section 8.7???.}

8.7528 In-Home Support Services (IHSS)

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. 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:

   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. {Added: All tasks must meet Age-Appropriate Task Standards for Children for Members under 18 or Task Standards for Adults for Members age 18 and older. Authorization of IHSS tasks must be limited to services that exceed those considered part of Parental or Legal Guardian Responsibility.}

   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 {Added: as defined at section 8.7502.II.}

   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.

{Added: 2. Members shall not be authorized for more than 19,000 fifteen-minute units of Health Maintenance Activities, 10,000 fifteen-minute units of Personal Care, and/or 4,500 fifteen-minute units of Homemaker services per Person-Centered Support Plan year. Case Managers may request additional units through the Department prescribed exception process as defined at 8.7607.2.}

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. {Added: Backup Attendants must be employed, scheduled, and supplied directly by the IHSS Agency.} 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.

{Added: i. Members, Authorized Representatives (ARs), and/or family members are not responsible for providing or securing backup Attendant supports. Backup coverage must be arranged and supplied solely by the IHSS Agency.}

4. [Deleted: ~~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.~~] {Added: IHSS Agencies shall ensure that Attendants adhere to the Per Week Limit and Per Day Hourly Limit as defined at Section 8.7???.}

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. {Added: IHSS Agencies shall ensure that Attendants adhere to the Per Week Limit and Per Day Hourly Limit as defined at Section 8.7???.} [Deleted: ~~An In-Home Support Services (IHSS) Agency shall not be reimbursed for more than 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 [Deleted: ~~520~~]{Added: 260} hours of homemaker services annually.

8. Payment does not include travel time to or from the Member's residence.

8.7538 Personal Care

8.7538.C Personal Care Inclusions

{Added:

2. All tasks must meet Age-Appropriate Task Standards for Children for Members under 18 or Task Standards for Adults for Members age 18 and older.
3. Authorization of Personal Care tasks for members under 18 must be limited to services that exceed those considered part of Parental or Legal Guardian Responsibility.}

8.7538.D Personal Care Exclusions and Limitations

1. 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. [Deleted: ~~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. 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. Family Members must provide personal care in accordance with the following:

   a. Family Members may be employed by 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.

   b. The Family Member shall meet all requirements for employment by a Personal 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.

   c. 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. 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.

      ii. When 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.

[Deleted: ~~d. Documentation of services provided shall indicate that the provider is a relative when services are provided by a Family Member.~~]

5. 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.

{Added:

6. Caregivers must adhere to the Per Week Limit and Per Day Hourly Limit as defined at Section 8.7???.

7. Members shall not be authorized for more than 10,000 fifteen-minute units of Personal Care per Person-Centered Support Plan year. Case Managers may request additional units through the Department prescribed exception process as defined at section 8.7607.2.}

8.7538.E Personal Care Provider Agency Requirements

1. 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.

    a. 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.

b. 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.

{Added:

2. A personal care/homemaker agency may be denied or terminated from Medicaid participation if:

a. The agency scheduled or reimbursed for more than 56 hours of direct care per week per member across Personal Care, Homemaker, Health Maintenance Activities, LTHH-Home Health Aide, and/or LTHH-Nursing Services except in an emergency situation.

b. The agency scheduled or reimbursed for more than 16 hours of care in a calendar day across Personal Care, Homemaker, Health Maintenance Activities, Private Duty Nursing, and/or Long-Term Home Health except in an emergency situation.}

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:

[Deleted: ~~a. Electronic Monitoring as defined at Section 8.7520, et seq.~~]

{Added: a. CFC Direct Care Services:

i. Health Maintenance Activities as described at Section 8.7523, et seq.

ii. Homemaker as defined at Section 8.7527, et seq.

iii. Personal Care as defined at Section 8.7538, et seq.}

{Added: b. Electronic Monitoring as defined at Section 8.7520, et seq.}

c. Home Delivered Meals as defined at Section 8.7526, et seq.

d. [Deleted: ~~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.

{Added: 2. Case Managers may request additional units for CFC Direct Care Services above the outlined unit limitations found in 8.7523.E, 8.7527.E, and 8.7538.E through the Department prescribed CFC Direct Care Services Exception Process. The Department may approve additional units on a case-by-case basis when a demonstrated need is documented by the Member's case manager. The exception process for CFC Direct Care Services shall be implemented in a uniform manner applied equally to Members statewide, but outcomes shall be based on individual assessed needs and circumstances.}

NEW SECTION: Numbering will be determined at a later date.

{Added:
8.7??? Caregiver Limits for HCBS Services and Department Enforcement

A. Definitions

1. Caregiver means any individual that is paid to provide Qualifying Services as defined at Section 8.7???.A.4.

2. Per Day Hourly Limit means the maximum number of hours a Caregiver can work, and be reimbursed for, to one member or more members collectively on any day, from 12:00 AM to 11:59 PM. This limit is set forth at Section 8.7???.B.2.

3. Per Week Limit means the maximum number of hours a Caregiver can provide to one member in any week, Sunday to Saturday. This limit is set forth at Section 8.7???.B.1.

4. Qualifying Services are:

   a. Nursing Services as defined at Section 8.520.5.A.

   b. Certified Nurse Aide Services as defined at Section 8.520.5.B.

   c. Consumer Directed Attendant Support Services (CDASS) as defined at Section 8.7515.

   d. Health Maintenance Activities as defined at Section 8.7523

   e. Homemaker Services as defined at section 8.7527

   f. In-Home Support Services (IHSS) as defined at Section 8.7528

   g. Personal Care as defined at Section 8.75385.

5. Plan of Correction means a formal, written response from an individual or service provider to the Department on identified areas of non-compliance with requirements listed in section 8.????.

6. Provider Agency means an Agency certified by the Department and which is authorized by the Department to provide one or more of the services listed in 8.7???.B.

7. Caregiver Attestation refers to the individual or service provider's requirement to submit the time worked attestation form to the Department upon request. This form should reflect detailed number of hours worked, days worked, and the number of members served by the Caregiver during the requested time period.

8. Caregiver Compliance Attestation refers to the Provider Agency or FMS vendor's requirement to obtain and maintain a signed statement from each individual Caregiver stating they will not work more than the Per Day Hourly Limit or Per Week Limit except in a documented emergency situation.

9. Caregiver Compliance Review refers to the Department's oversight to ensure individuals and service providers are complying with State laws and regulations.

10. Enforcement means withholding of claim payments and/or recoupment of Medicaid funds for noncompliance with this rule.

11. Payment Hold Enforcement refers to the Department withholding claim payments to individuals or service providers for noncompliance with this rule.

12. False Representation means an inaccurate statement made by the Caregiver or Provider Agency that is relevant to a claim for reimbursement.

13. Mismanagement means the process of managing something badly or incorrectly.

14. Reckless Disregard for Truth means failing to maintain accurate records or failing to become familiar with rules and regulations issued by the Department or State.

A. Caregiver Limits

1. Except in a documented emergency situation, individual Caregivers may not be scheduled or reimbursed for more than 56 hours of direct care per week per member across all Qualifying Services collectively.

2. Individual Caregivers may not be scheduled or reimbursed for more than 16 hours of care in a calendar day across:

   a. Personal Care as defined at Section 8.7538,

   b. Homemaker as defined at Section 8.7527,

   c. Health Maintenance Activities as defined at Section 8.7523,

   d. Private Duty Nursing as defined at Section 8.540, and/or

   e. Long-Term Home Health as defined at Section 8.520.

B. Provider Agency Responsibilities

1. Provider Agencies shall ensure that individual Caregivers are not scheduled or reimbursed for more than 16 hours of care in a calendar day across Personal Care, Homemaker, Health Maintenance Activities, Private Duty Nursing, and/or Long-Term Home Health except in a documented emergency situation.

2. Provider Agencies shall ensure that individual Caregivers are not scheduled or reimbursed for more than 56 hours of direct care per week per member across Personal Care, Homemaker, Health Maintenance Activities, LTHH-Home Health Aide, and/or LTHH-Nursing Services except in a documented emergency situation.

a. A Caregiver that renders qualifying service(s) accepts responsibility to ensure accurate time tracking and billing for rendered services. This includes not exceeding the daily hourly limit and the weekly hours limit. Any limit exceptions must be supported by documented emergency situation.

3. Provider agencies must ensure that contact information within the Department's billing system is accurate. Provider billing account maintenance includes updating licenses, addresses, phone numbers, email addresses, etc. Provider billing accounts should be closed if no longer serving HCBS members.

4. Provider agencies shall submit specific information regarding each Caregiver working hours, work location, services provided, members served, documented emergency situations to support exceeding the limit if applicable, and any other related information as requested by the Department. Provider agencies shall submit the requested information within the Department-specified timeframe and in the format requested by the Department. Submitted information must be complete, clear, understandable, readable, and auditable.

5. Provider Agencies and Caregivers shall keep true and accurate records to support and demonstrate that the Per Day Hourly Limit and the Per Week Limit are not exceeded. Any additional hours must be supported by documented emergency situation.

6. Provider Agencies shall retain records in accordance with sections 8.130.2 and 8.7405. In addition to the documentation required by 8.130.2 and 8.7405, provider agencies shall retain:

   a. Caregiver Compliance Attestation and Caregiver Attestation forms.

   b. Documentation to support an emergency situation that requires an exception to the limit.

   c. Paystubs reflecting at least hours worked, pay period, and year.

   d. Independent Contractor documents or agreements.

   e. Accounting records such as accounts receivable and accounts payable.

   f. Provider agencies shall make records available for inspection by the Department upon request.

C. Provider Agency Reporting and Auditing Requirements

1. The Department has ongoing discretion to request information from Provider Agencies to demonstrate that daily and weekly limits are not exceeded. All records related to the time limit requirements for the Qualifying Services and specified date range shall be made available to the Department upon request, within specified deadlines.

2. Provider Agencies shall respond to the Department's request for records to demonstrate compliance within the timelines and format specified by the Department. Incomplete or invalid submissions will be returned for corrections.

3. Failure to submit information as required or failure to provide adequate documents and timely responses may result in the Department suspending payment of claims to the Provider Agency or Caregiver until the requested information is received and reviewed by the Department.

4. The Department may perform Caregiver Compliance Reviews related to Caregiver Compliance Attestations, Caregiver Attestations, and/or submitted documents. Failure to submit information as required or failure to provide adequate documentation within the specified timeframe may result in the Provider Agency being required to submit a Plan of Correction and/or be subject to an overpayment or penalty recovery. If a Plan of Correction is requested by the Department, the Provider Agency shall submit the Plan of Correction by the date specified by the Department. The Provider Agency must notify the Department in writing within ten (10) business days of receipt of the request if they will not be able to meet the deadline. The Provider Agency must explain the reason for the delay. The Department may or may not grant an extension in writing.

5. Upon the Department's receipt of the Plan of Correction, the Department will accept, request modifications, or reject the proposed Plan of Correction. Modifications or rejections will be accompanied by a written explanation. If a Plan of Correction is rejected, the Provider Agency must resubmit a new Plan of Correction along with any requested documentation to the Department for review within ten (10) business days of notification. Failure to complete the Plan of Correction as required may result in a payment hold, an overpayment or penalty recovery, or termination from participation in Colorado Medicaid.

6. If the Department determines the limits were exceeded without a documented emergency situation, the Department will issue an adverse action letter to the Provider Agency. The Provider Agency shall have no more than 30 calendar days to respond to the letter with payment or an informal reconsideration request. The Provider Agency will also have appeal rights before any recoupment by the Department is made.

D. The Department is authorized under C.R.S. Section 25.5-6-201(1)(a) to assess, enforce, and collect penalties for noncompliance with statutes and regulations including but not limited to the following:
   1. License revocation or provisional license according to the provisions of C.R.S. section 25-3-103.
   2. Fraudulent acts to assist any person in obtaining public assistance, vendor payments, medical assistance, or childcare assistance to which the person is not entitled to as outlined in C.R.S. section 25.5-4-301.
   3. Overpayments or incorrect payments due to omission, error or fraud as outlined in C.R.S. section 25.5-4-301(2).
   4. Crimes against at-risk persons as outlined in C.R.S. section 18-6.5-103.
   5. Rules as defined in this section.

E. The Department may recover claims payments that are identified as an overpayment when an agency or Caregiver is not in compliance with this section.

   1. Per C.R.S. 25.5-4-301(2) an overpayment is the result of the Provider Agency providing inaccurate statements that are relevant to a claim for reimbursement or deliberate ignorance of or with Reckless Disregard for the Truth by failing to maintain records required by the Department or failing to become familiar with rules, manuals, and bulletins issued by the Department or the Department's fiscal agent.

   2. Noncompliance issues include but are not limited to the following, which can result in a claim payment hold, an overpayment recoupment, or termination from participation in Colorado Medicaid:
      a. Failure to meet Department specified deadlines for submitting documentation and/or responses to Department requests for information.
      b. Failure to maintain supporting documentation as required.
      c. Failure to submit supporting documentation that is readable, auditable, complete, or in the requested format.
      d. Failure to create and submit a Plan of Correction if requested by the Department.
      e. Failure to accurately bill Medicaid for rendered services.}