Application for

Section 1915(b) (4) Waiver
Fee-for-Service
Selective Contracting Program

July 2026

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Application for Section 1915(b) (4) Waiver
Fee-for-Service (FFS) Selective Contracting Program

Facesheet

The **State** of Colorado requests a waiver/amendment under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.

The **name of the waiver program** is Colorado Home and Community-Based Services Case Management Waiver.

Type of request. This is:
___ an initial request for new waiver. All sections are filled.
X__ a request to amend an existing waiver, which modifies Section/Part : **Section A – Waiver Program Description, Part I: Program Overview; Part II: B. Provider Capacity Standards; C. Utilization Standards; Part III: Quality, A. Quality Standards and Contract Monitoring;**
_____ **a renewal request**

Section A is:
___ replaced in full
___ carried over with no changes
__x__ changes noted in **BOLD**.

Section B is:
___ replaced in full
___ changes noted in **BOLD**.

Effective Dates: This amendment is requested for a period of **two (2) years beginning July 1, 2026 and ending June 30, 2028.**

State Contact: The State contact person for this waiver is Julie Masters or Angela Goodell and can be reached by telephone at (303) 866-3684, or fax at (303) 866-4411, or e-mail atJulie.Masters@state.co.us or Angela.Goodell@state.co.us.

Section A – Waiver Program Description

Part I: Program Overview

- **Tribal Consultation:**

Describe the efforts the State has made to ensure that Federally-recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.

Department Response: The Department of Health Care Policy and Financing (the Department) has a formal consultation agreement with American Indian health programs in Colorado. The parties to the consultation agreement include the Southern Ute Indian Tribe, the Ute Mountain Ute Tribe, Denver Indian Health and Family Services, the Colorado Department of Public Health and Environment, the Office of the Lieutenant Governor of Colorado, and the Department. The Department uses the following process, as described in the consultation agreement, to seek advice on a regular, ongoing basis from the parties:

Programmatic Action Log Update:
On a bi-monthly basis (approximately every sixty days) each State Agency [the Department of Public Health and Environment and the Department of Health Care Policy and Financing] shall distribute to the Tribes and the UIHO [Urban Indian Health Organization] a Programmatic Action Log Update. The Update shall contain a continuous list/log of Programmatic Actions being developed and/or initiated by each State Agency. The Update shall provide a short description of each Programmatic Action, any clearly foreseeable Tribal Implications, important dates or implementation timeframes, and if the Programmatic Action is considered an Actionable Item. The Update shall indicate a date by which additional consultation must be requested by a Tribe or the UIHO (thirty days from receipt of the Update). The Update shall also contain an area to track whether additional consultation was requested and by whom, and to update current status/resolution of Programmatic Actions.

Additional Consultation:
A Tribe or UIHO may request additional consultation on any Actionable Item on the Update or on any question, concern, policy, practice, or issue within the scope of the State Agencies' responsibilities relating to the health of American Indians/Alaska Natives living in Colorado. Actionable Items on the Update shall indicate a date by which a Tribe or the UIHO must request additional consultation (thirty days from receipt of the Update). Additional consultation shall be initiated by written notice (may be in the form of an email) from a designated Tribal or UIHO Liaison(s) and directed to a designated Indian Health Liaison(s). Consultation may include but shall not be limited to meetings (face-to-face or via teleconference), written correspondence including emails, presentations, and discussions at the Colorado Commission of Indian Affairs' Health and Wellness Committee meetings. When consultation is completed, a written response from one or both State Agencies to the Party that requested the consultation shall be sent describing the final determination or outcome regarding the topic of consultation. This information shall also be included on the Programmatic Action Log Update.

Meetings:
Face-to-Face and Remotely; The State Agencies, Tribes, and UIHO, all together or individually, shall meet face-to-face no less than once per fiscal year and as resources allow. As necessary, the

State Agencies, Tribes, and UIHO, all together or individually, shall meet remotely via teleconference or videoconference to discuss outstanding issues and/or hold consultations as described above.

The tribal consultation for this waiver process began on February 11, 2026 with log #634. The 30- day review period ended on March 13, 2026 and the State did not receive any comments as result of this consultation

Program Description:
Provide a brief description of the proposed selective contracting program or, if this is a request to amend an existing selective contracting waiver, the history of and changes requested to the existing program. Please include the estimated number of enrollees served throughout the waiver.

Amendment with requested effective date of July 1, 2026:
Colorado is terminating its 1915(c) CHCBS waiver on June 30, 2026 and transitioned its participants over a 1-year period to the CLLI waiver beginning on July 1, 2025. The CLLI waiver was also renamed to the Children with Complex Health Needs Waiver. This amendment effectuates the termination of the 1915(c) CHCBS waiver as of June 30, 2026, removes all related waiver language, and documents the 1-year transition period during which participants will be moved to the CLLI waiver.

Department response: Colorado has **nine(9)** 1915(c) Home and Community Based Services Waivers serving over 48,000 members and increasing annually. The waivers include: Persons with Brain Injury (BI), Children's Extensive Support (CES), Children's Habilitation Residential Program (CHRP), **Children with Complex Health Needs (CwCHN)**, Complementary and Integrative Health (CIH), Community Mental Health Supports (CMHS), Developmental Disabilities (DD), Elderly, Blind, and Disabled (EBD), and Supported Living Services (SLS).

Historically, Colorado offered case management under three different mechanisms for 1915(c) waiver participants. Under the BI, CLLI **(CwCHN as of 7/1/2025)**, CIH, CMHS, and EBD waiver programs, case management (initial screening, ongoing monitoring, assessment/support planning, and other pre- enrollment functions) has been conducted through contract agreements which are included in the State's approved Public Assistance Cost Allocation Plan (PACAP). For the CES, CHRP, DD and SLS waivers, case management has been conducted through contract agreements and through Targeted Case Management (TCM) under the State Plan. TCM has been billed for all ongoing case management duties such as quarterly monitoring and monthly contact for the per member per month payment. Pre-enrollment case management activities have been conducted through contract agreements which are included in the State's approved PACAP. In the remaining waiver, CHCBS, case management **was previously** a 1915(c) waiver service provided by private case management agencies, Single Entry Points (SEP), and Community Centered Boards (CCB).

The State is compliant with Conflict-Free Case Management requirements as outlined in 42 CFR § 441.301(c)(1)(vi) and in Colorado's House Bill 21-1187. HB 21-1187 required the State to create "defined service areas" where case management agencies will serve all HCBS waiver members in their respective defined service areas. The implementation date of HB 21-1187 was

July 1, 2024.

Through research and stakeholder engagement, the State determined it will be utilizing TCM for CM for all 10 waivers. Defined service areas were implemented July 1, 2023, with a final implementation date of June 30, 2024. The establishment of defined service areas provides individuals seeking long-term service and supports one place to obtain case management services for all 10 HCBS waivers. Members will have the option to choose their case manager at the agency in which they are assigned.

Prior to defining the defined service areas, the State hired a contractor to analyze data, caseloads, the number of assessments and support plans, and to look at geographical issues resulting in catchment area recommendations. Additionally, stakeholders provided feedback on the proposed maps and the contractor adjusted its recommendations to the State based on webinar feedback and survey responses.

Each defined service area has one case management agency that provides case management functions for all 1915(c) waivers.

The State selected Targeted Case Management (TCM) as the funding option for certain case management functions as it is simpler for case managers and the State to manage. If case management were funded under HCBS waivers, separate codes would have to be developed and used for each waiver and every time a change was made, the State would have to amend all the associated waivers rather than just a single State Plan Amendment for TCM. As Colorado has **nine (9)** 1915(c) waiver programs, changes would be not only administratively burdensome but cost prohibitive.

In addition, the State determined that it was beneficial to use TCM to fund case management as it would cover individuals who met the targeting criteria and were Medicaid-eligible but were not on a waiver yet. This ensures that when case management is done for Medicaid members who do not become enrolled on a waiver program, the agency is reimbursed for its work.

For the **nine (9)** Colorado HCBS waivers, the State will utilize the Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)) and the 1915(b)(4) to request waiver of Section 1902(a)(23) - Freedom of Choice to limit the qualified Medicaid providers of case management. For five (5) of the waivers (Children's Extensive Support (CES), Children's Habilitation Residential Program (CHRP), Community Mental Health Supports (CMHS), Developmental Disabilities (DD), and Supported Living Services (SLS)), the state will utilize Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)) to limit the qualified Medicaid providers of case management for the waivers with target groups of eligible individuals with developmental disabilities or chronic mental illness. For these five (5) waivers, no 1915(b)(4) is needed to waive choice.

For the remaining **four (4**) waivers, (Persons with Brain Injury (BI), **Children with Complex Health Needs (CwCHN),** Complementary and Integrative Health (CIH), and Elderly, Blind, and Disabled (EBD)), the state is utilizing the 1915(b)(4) to request waiver of Section 1902(a) (23) - Freedom of Choice to allow the state to contract with a single case management agency in a defined service area.

Colorado had a transition plan for these changes that was reviewed and approved by CMS in order to transition case management and come into compliance with the federal requirements for conflict free case management. This was the first step in that process. The dates of the agencies transitions do not impact the 1915(b)(4) authorities moving forward.

Waiver Services:
Please list all existing State Plan services the State will provide through this selective contracting waiver.

Department response: Colorado will be providing the State Plan service of Targeted Case Management through this selective contracting waiver.

A. Statutory Authority

1. **Waiver Authority.** The State is seeking authority under the following subsection of 1915(b):

   ✓ **1915(b) (4) - FFS Selective Contracting program**

2. **Sections Waived.** The State requests a waiver of these sections of 1902 of the Social Security Act:

   a.___ **Section 1902(a) (1) - Statewideness**
   b.___ **Section 1902(a) (10) (B) - Comparability of Services**

   c.✓ **Section 1902(a) (23) - Freedom of Choice**
   d.___ **Other Sections of 1902** – (please specify)

B. Delivery Systems

1. **Reimbursement.** Payment for the selective contracting program is:

   ✓ the same as stipulated in the State Plan
   ___ is different than stipulated in the State Plan (please describe)

2. **Procurement**. The State will select the contractor in the following manner:

   ✓ **Competitive** procurement
   ___ **Open** cooperative procurement
   ___ **Sole source** procurement
   ___ **Other** (please describe)

C. C. Restriction of Freedom of Choice

1. **Provider Limitations**.

   ✓ Beneficiaries will be limited to a single provider in their service area.
   ___ Beneficiaries will be given a choice of providers in their service area.

   (NOTE: Please indicate the area(s) of the State where the waiver program will be implemented)

Department response: Colorado will implement this service statewide.

2. **State Standards.**

   Detail any difference between the state standards that will be applied under this waiver and those detailed in the State Plan coverage or reimbursement documents.

Department response: There will be no change to the state standards detailed under this 1915(b)(4) waiver and those detailed in the State Plan. All providers must meet, accept and comply with the State's standards for reimbursement, quality, and utilization.

D. D. Populations Affected by Waiver

(May be modified as needed to fit the State's specific circumstances)

1. **Included Populations**. The following populations are included in the waiver:

   ___ Section 1931 Children and Related Populations
   ___ Section 1931 Adults and Related Populations
   ✓ Blind/Disabled Adults and Related Populations
   ✓ Blind/Disabled Children and Related Populations
   ✓ Aged and Related Populations
   ___ Foster Care Children
   ___ Title XXI CHIP Children

2. **Excluded Populations.** Indicate if any of the following populations are excluded from participating in the waiver:

   ___ Dual Eligibles
   ___ Poverty Level Pregnant Women
   ___ Individuals with other insurance
   ✓ Individuals residing in a nursing facility or ICF/MR
   ___ Individuals enrolled in a managed care program
   ___ Individuals participating in a HCBS Waiver program
   ___ American Indians/Alaskan Natives
   ___ Special Needs Children (State Defined). Please provide this definition.

___ Individuals receiving retroactive eligibility
___ Other (Please define):

Part II: Access, Provider Capacity and Utilization Standards

A. Timely Access Standards

Describe the standard that the State will adopt (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State has adopted) defining timely Medicaid beneficiary access to the contracted services, *i.e.,* what constitutes timely access to the service?

Department response: Case Management Agencies (CMAs) are contracted in Colorado to complete the Level of Care eligibility determination screen (LOC screen), assessment, and person- centered support plan (PCSP).

Case Management Agencies are required to complete the LOC screen upon verification of the applicant's financial eligibility or verification that an application has been submitted.
The CMA completes the assessment within the following time frames:

- For an individual who is not being discharged from a hospital or a nursing facility, the member's LOC screen is completed within ten (10) working days.
- For a member who is being transferred from a nursing facility to an HCBS program, the LOC screen is completed within five (5) working days.
- For a member who is being transferred from a hospital to an HCBS program, the LOC screen is completed within two (2) working days.

The CMA is required to complete the PCSP within fifteen working days after the determination of program eligibility.

The case manager reviews the LOC screen, assessment, and PCSP with the member every six months.

The case manager is required to complete a re-screening within twelve months of the initial or previous LOC screen and PCSP. A LOC Screen and PCSP shall be completed sooner if the member's condition changes or as needed by program requirements.

1. How does the State measure (or propose to measure) the timeliness of Medicaid beneficiary access to the services covered under the selective contracting program?

Department response: Case Management Agencies (CMAs) are required to maintain a tracking system to assure that re-evaluations are completed on a timely basis. The State monitors CMAs annually to ensure compliance through record reviews and reports electronically generated by the state's case management IT system. The state's case management IT system is utilized by every CMA and contains electronic member records and the timeframes for evaluation and re-

evaluation. The annual program evaluation includes a review of a random sample to ensure evaluations and re-evaluations are being completed correctly and timely.

The State then completes a programmatic evaluation that consists of a desk audit in conjunction with the state's case management IT system to audit member files and assure that CMA responsibilities have been performed according to necessary waiver requirements. The state's case management IT system is an electronic record used by each CMA to maintain member-specific data. Data includes member referrals, screening, LOC screen, person-centered support plan, case notes, evaluation and reevaluation documentation, and documentation on all other case management activities. The state's case management IT system is used to track and evaluate timelines for evaluations, reevaluations, and a notice of action requirements to assure that processes are completed according to state prescribed schedules. The State reviews a sample of member files to measure the accuracy of documentation and track appropriateness of services based upon the LOC determination. Additionally, the sample is used to evaluate compliance with the aforementioned case management functions. The contracted case management agency submits deliverables to the State on an annual and quarterly basis for review and approval. Case management agencies are evaluated through quality improvement strategy reviews annually

2. Describe the remedies the State has or will put in place in the event that Medicaid beneficiaries are unable to access the contracted service in a timely fashion.

Department response: Should the State find through the programmatic evaluations that a CMA is not in compliance with policy or regulations, the agency is required to take corrective action. Technical assistance is provided to the CMA. The State conducts follow-up monitoring to assure corrective action implementation, improvement, and ongoing compliance. In addition, the contract with the CMAs allows the State to withhold funding and/or terminate the contract due to noncompliance. If a compliance issue extends to multiple CMAs, the State provides clarification through formal policy memos, formal training, or both.

If complaints are raised by the member about the person-centered support planning process, the case manager, or other CMA functions, case managers are required to document the complaint on the CMA Complaint Log and assist the member to resolve the complaint. The case manager’s supervisor is also required to assist in the resolution of the complaint. The CMA will be required to have a Community Advisory Council consisting of members in services, family members of individuals in services, county commissioners, and other disability professionals in the community. This Council will review all complaints and grievances and provide an open forum to report case manager and CMA complaints to the CMA’s governing board and the State for remediation when/if complaints cannot be resolved satisfactorily for members and families.

The CMA Complaint Log is reviewed by the State on a quarterly basis. State staff are able to identify trends and discern whether a particular case manager or case management agency is receiving an unusual number of or an increase in complaints and can remediate accordingly.

Members may also contact the case manager's supervisor or the State if they do not feel comfortable contacting the case manager directly. The contact information for the case manager, case manager's supervisor, the CMA administrator, and the State is included in the copy of the PCSP that is provided to the member. The member also has the option of lodging an anonymous complaint to the case manager, CMA, or the State.

Family members, and/or advocates who have concerns or complaints may contact the case manager, case manager's supervisor, CMA administrator, or State directly. If the State receives a complaint, State staff investigate the complaint and remediate any issues.

B. Provider Capacity Standards

> Describe how the State will ensure (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State has ensured) that its selective contracting program provides a sufficient supply of contracted providers to meet Medicaid beneficiaries' needs.

Department response: The State hired a contractor to analyze data, caseloads, the numbers of assessments and support plans throughout the state, and geographical issues which resulted in catchment area recommendations.

Information was gathered from stakeholders to inform the final decision on how the future catchment areas should be defined. The following factors were used as key considerations in developing each catchment area:

- Geographic barriers: The State considered the presence of mountain ranges, travel route data, and the total size of the geographic region.
- Economy of scale: The State evaluated the minimum number of members within a catchment area to best ensure financial viability of the case management agency.
- Population density: The State evaluated the total concentration of members within a specific geographic area.

The contractor's analyses and stakeholder engagements resulted in 20 discrete catchment areas.

1. Provide a detailed capacity analysis of the number of providers (e.g., by type, or number of beds for facility-based programs), or vehicles (by type, per contractor for non-emergency transportation programs), needed per location or region to assure sufficient capacity under the selective contracting program.

Department response: The State contracted with a contractor from January 2021 through June 2021 to assist with planning for the changes to case management infrastructure necessary to implement the State's new vision of one case management agency (CMA) per defined service area. With this new vision, CMAs will serve all 1915(c) HCBS waivers and the new structure strengthens the case management quality performance process. A defined service area map was created. Stakeholder meetings were held for feedback during the contract, and several factors were taking into consideration when developing the catchment areas such as

data, geographic factors, and the current catchment areas. A minimum number of 400 participants per catchment area was established. The State will have standard case load sizes in the Code of Colorado Regulations and, it is expected that the CMAs will increase their case manager capacity to meet demand. Additionally, the State is requiring all CMAs to have a robust transition plan, including recruitment and retention of case management staff to ensure continuity of care and case management capacity as the system transitions.

2. Describe how the State will evaluate and ensure on an ongoing basis that providers are appropriately distributed throughout the geographic regions covered by the selective contracting program so that Medicaid beneficiaries have sufficient and timely access throughout the regions affected by the program.

Department response: The State will evaluate and ensure on an ongoing basis that providers are appropriately distributed throughout the geographic regions through the submission of CMS-372 reports and Evidentiary Reports for the concurrent 1915(c) waivers. The State will monitor the CMAs by ensuring assessments, reassessments, and Person-Centered Support Plans are completed timely.

Additionally, the State will be participating in the National Core Indicator-Aging and Disability Surveys that will begin in State Fiscal Year 2022-23. This survey will be completed biannually for the HCBS-EBD, HCBS-BI, HCBS-CMHS, and HCBS-CIH waivers. The state will be participating in the NCI-Individual with Developmental Disabilities (IDD) survey on alternate years that the NCI-AD survey does not occur. This survey will be completed biannually for the HCBS-DD and HCBS-SLS waivers. These surveys will be conducted by Case Management Agency Catchment Area in order to determine satisfaction with services, supports, case management entity, and quality of life. The State will also conduct a Children's Waiver Satisfaction Survey for the HCBS-**CwCHN,** HCBS-CES, HCBS-CHRP, and CHCBS waivers. This survey has been developed and will start in SFY 2024-25.

Should the State find that a CMA is not in compliance with policy or regulations, the agency is required to take corrective action. Technical assistance is provided to the CMA. The State conducts follow-up monitoring to assure corrective action implementation, improvement, and ongoing compliance. In addition, the contract with the CMAs allows the State to withhold funding and/or terminate the contract due to noncompliance. If a compliance issue extends to multiple CMAs, the State provides clarification through formal policy memos, formal training, or both.

Additionally, members have the ability to request a different Case Manager if they are dissatisfied with their current one.

CMAs will also be monitored through the competitive Request for Proposal (RFP) process. They will have to submit documentation of presence, access, and availability for members in each catchment area. RFPs will be completed at a minimum every 8 years.

C. Utilization Standards

Describe the State's utilization standards specific to the selective contracting program.

Department response: Member's utilization of case management services may vary depending upon the needs and requirements of the member. At a minimum, the member will be evaluated for Level of Care upon initial enrollment. A reevaluation is required within 12 months of the initial or previous assessment. A reevaluation may be completed sooner if there is a significant change in the member's condition or if required by program criteria. Members will have at least one Level of Care evaluation annually.

The person-centered support planning process will occur no less than annually or as warranted by the member's needs or a change in the member's condition. Additionally, members will be contacted by their case manager at least quarterly to review the Level of Care screen, assessment, and person-centered support plan.

1. How will the State (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State) regularly monitor(s) the selective contracting program to determine appropriate Medicaid beneficiary utilization, as defined by the utilization standard described above?

Department response: CMAs are required to maintain a tracking system to assure that re-evaluations are completed on a timely basis. The State monitors CMAs annually to ensure compliance through record reviews and reports electronically generated by the state's case management IT system. The state's case management IT system is utilized by every CMA and contains electronic member records and the timeframes for evaluation and re-evaluation. The annual CMA program evaluation includes a review of a random sample to ensure evaluations and re-evaluations are being completed correctly and timely. The State then completes a programmatic evaluation that consists of a desk audit in conjunction with the state's case management IT system to audit member files and assure CMA responsibilities have been performed according to waiver requirements. The state's case management IT system is an electronic record used by each CMA to maintain member-specific data. Data includes member referrals, screening, level of care eligibility screen (LOC screen), person-centered support plan, case notes, evaluation and reevaluation documentation, and all other case management activities. Additionally, the state's case management IT system is used to track and evaluate timelines for evaluations, reevaluations, and notice of action requirements to assure that processes are completed according to State prescribed schedules. The State reviews a sample of member files to measure the accuracy of documentation and track appropriateness of services based upon the LOC screen. Additionally, the sample is used to evaluate compliance with the aforementioned case management functions. Each CMA submits deliverables per contractual requirements to the State on an annual and quarterly basis for review and determination of approval.

2. Describe the remedies the State has or will put in place in the event that Medicaid beneficiary utilization falls below the utilization standards described above.

Department response: Should the State find that a CMA is not in compliance with policy or regulations, the agency is required to take corrective action. Technical assistance is provided to

the CMA. The State conducts follow-up monitoring to assure corrective action implementation, improvement, and ongoing compliance. In addition, the contract with the CMAs allows the State to withhold funding and/or terminate the contract due to noncompliance. If a compliance issue extends to multiple CMAs, the State provides clarification through formal policy memos, formal training, or both.

Part III: Quality

A. Quality Standards and Contract Monitoring

1. Describe the State's quality measurement standards specific to the selective contracting program.

    a. Describe how the State will (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State):

        i. Regularly monitor(s) the contracted providers to determine compliance with the State's quality standards for the selective contracting program.

Department response: The State will regularly monitor the contracted providers through the submission of CMS-372 reports and Evidentiary Reports for the concurrent 1915(c) waivers (CO.0006 HCBS-EBD, CO.0288 HCBS-BI, CO.0450 HCBS-**CwCHN**, **and** CO.0961 HCBS-CIH These reports detail the review and remediation of waiver performance measures, which include access, utilization and cost-effectiveness for the 1915(c) waivers. The State reviews the performance measures annually, developing quality improvement plans for any measure that falls below 86% compliance. CMS review and approval of the CMS-372 reports and the review and final report of the evidence package affirm that all performance measures are met or that a corrective action plan is required (further detail provided in 2.a.i and ii below).

The State **is** participating in the National Core Indicator-Aging and Disability Surveys that will begin in State Fiscal Year 2022-23. This survey will be completed biannually for the HCBS-EBD, HCBS-BI, HCBS-CMHS, and HCBS-CIH waivers. The **is** participating in the NCI-Individual with Developmental Disabilities (IDD) survey on alternate years that the NCI- AD survey does not occur. This survey will be completed biannually for the HCBS-DD and HCBS-SLS waivers. These surveys will be conducted by Case Management Agency Catchment Area in order to determine satisfaction with services, supports, case management entity, and quality of life. The State **is also conducting** a Children's Waiver Satisfaction Survey for the HCBS-**CwCHN**, HCBS-CES, **and** HCBS-CHRP. This survey has been developed and will run SFY 2024-25.

These surveys provide the State with member perspective into how the 1915(c) and 1915(b)(4) waiver programs are managed and implemented. Both surveys will cover a variety of topics including demographics, access and delivery of services and supports, freedom of choice, community integration, involvement and inclusion, employment, health, information and service

planning, medication, relationships, rights and respect, safety, service coordination, wellness, and satisfaction with services and supports. The State will utilize survey questions to evaluate if the CMAs are meeting their contractual requirements regarding to the development and implementation of the person-centered support plan and provision of the member's choice of a case manager.

ii. Take(s) corrective action if there is a failure to comply.

Department response: The State annually reviews performance measures for compliance with the submission of CMS-372 reports. In the development of the reports, the State reviews all the performance measures for compliance. For a measure that falls below 86% compliance, the State develops a quality improvement plan to come into compliance.

Should the State find that a CMA is not in compliance with policy or regulations, the agency is required to take corrective action. The State conducts follow-up monitoring to assure corrective action implementation and ongoing compliance. In addition, the contract with the CMAs allows the State to withhold funding and terminate the contract due to noncompliance. If a compliance issue extends to multiple CMAs, the State provides clarification through formal policy memos, formal training, or both. Technical assistance is provided to CMAs via phone, email, and/or meetings.

2. Describe the State's contract monitoring process specific to the selective contracting program.

    a. Describe how the State will (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State):

        i. Regularly monitor(s) the contracted providers to determine compliance with the contractual requirements of the selective contracting program.

Department response: The State's Quality Improvement Strategy (QIS) employs discovery, analysis, and remediation activities as the primary method for ensuring that Home- and Community-Based Services provided through the 1915 (c) waivers and State Plan are monitored and that necessary corrective action plans are in place when necessary. The discovery and analysis phase will occur annually for all HCB services authorized under Section 1915(b), (c) and 1915(k) authorities.

The State maintains oversight over the HCBS waivers in its case management agency contracts through tracking the contract deliverables on a monthly, quarterly, semi-annually, and yearly basis depending on the details of the agreement. The State has access to and reviews all required reports, documentation, and communications. Delegated responsibilities of case management agencies are monitored, corrected, and remediated by the Department's Office of Community Living (OCL).

The State performs quality performance reviews on Case Management Agencies annually and targeted programmatic reviews. The State utilizes data from the State's case management IT

system to complete program review tools to determine compliance with required case management activities.

The State audits the CMAs for administrative functions including qualifications of the individuals performing the assessment and person-centered support planning, the process involving the evaluation of need, participant (contact) monitoring, case reviews, complaint procedures, provision of participant choice, etc. Ongoing monitoring of CMAs is completed through the tracking of administrative contract deliverables based on required contractual frequency.

The State uses standardized tools for LOC eligibility determination (LOC screen), person-centered support planning, and critical incident reporting for the waiver populations. The data generated from LOC screen, person-centered support plans (PCSPs), and critical incident reports and their concomitant follow-ups are electronically available to CMAs and the State through the State's case management IT system, allowing effective access for clinical and administrative functions as well as for system improvement activities. This standardization and electronic availability provides comparability across CMAs, waiver programs, and allows ongoing analysis. In addition, the State is implementing a new case management system to streamline processes for identifying member needs and coordinating support. This new IT system eliminates the need for case managers to complete documentation in multiple systems which can reduce the chance for errors and/or missing information.

The information gathered from the Department's monitoring processes is used to determine areas that require additional training/technical assistance, system improvements, and quality improvement plans. The State uses performance results to establish baseline data and to trend and analyze these data over time. The Department's aggregation and root cause analysis of data are incorporated into annual reports that provide information to identify aspects of the case management system which require action or attention. The State relies on a variety of resources to prioritize changes in the State's case management system. In addition to using information from annual reviews, analysis of performance measure data, and feedback from case managers, the State factors in appropriation of funds, legislation, and federal mandates.

The State is assessing and improving processes and systems on an ongoing basis. The OCL's Waiver Administration and Compliance unit evaluates the QIS annually as part of the data collection and analysis for CMS-372 reporting. A formal review of the waiver programs occurs again after waiver year 3, when three years of data has been collected, trends have been analyzed, and any trend-contributing factors identified. This review informs the waiver renewal process. The results of the annual 372 reporting analysis and the formal review are shared with OCL and the Department's leadership.

Evaluation of the QIS is the responsibility of both the Waiver Administration and Compliance Unit and the Case Management and Quality Performance Division in OCL. This evaluation takes into account the following elements:

- Compliance with federal and state regulations and protocols,
- Effectiveness of the strategy in improving care processes and outcomes,
- Effectiveness of the performance measures used for discovery,

- Effectiveness of the projects undertaken for remediation,
- Relevance of the strategy with current practices, and
- Budgetary considerations.

Through its annual review of the QIS, the State can determine the effectiveness of the training and the State's case management system. The State also reviews performance measure outcomes to determine if specific CMA technical assistance is required, what changes need to be made to the training, or if specific targeted training needs to be developed and administered.

ii. Take(s) corrective action if there is a failure to comply.

Department response: If problems are identified during a CMA audit, the State communicates findings directly with the CMA administrator and documents findings in the CMA's annual report of audit findings, and if needed, requires corrective action plans to be developed and implemented. The State conducts follow-up monitoring to assure corrective action implementation and continued compliance. In addition, the contract with CMAs allows the State to withhold funding and terminate a contract due to noncompliance. If a compliance issue extends to multiple CMAs, the State provides clarification through formal policy memos, formal training, or both. Technical assistance is provided to CMAs via phone, e-mail, or meeting.

If issues arise at any other time, the State works with the responsible parties (case manager, case management supervisor, CMA administrator) to ensure appropriate remediation occurs.

B. Coordination and Continuity of Care Standards

Describe how the State assures that coordination and continuity of care is not negatively impacted by the selective contracting program.

Department response: The selective contracting program will have a positive impact on the coordination and continuity of care in Colorado. Redesigning the system is intended to simplify access and remove silos so members will be able to more easily navigate and find the right programs and services that work for them. The new system allows one case management agency to provide case management services for all waiver programs in each catchment area. The CMA designation was awarded by the State through a competitive procurement process. This creates consistency in the quality, accountability and stability of case management services members receive across the state. It allows the State to provide greater oversight and support to ensure a high performing case management system statewide. Further, these changes meet the federal Conflict-Free Case Management requirement and allow the State to ensure quality case management services for members across the state. The State had a robust and well-vetted transition process that considered work with both incoming and outgoing agencies to ensure a smooth transition for members. The State went through a phased process for these transitions in FY 23-24 where a small number of agencies transitioned in November 2023, another group

transitioned in March 2024, and the final group transitioned in July 2024. Members experienced outreach and communication regarding a change in their case management agency from both the State and the awarded case management agency after designation occurred and as transitions happened in their designated service area. Home and Community Based Services continued as approved in member service plans.

Part IV: Program Operations

A. Beneficiary Information

Describe how beneficiaries will get information about the selective contracting program.

Department response: Members will be informed at intake of case management agency. Initially and whenever there is a change in a catchment area's CMA, members will be informed of the change by direct mail.

B. Individuals with Special Needs.

✓ __ The State has special processes in place for persons with special needs (Please provide detail).

Department response: All members on this waiver program and enrolled on a HCBS 1915(c) waiver have special needs. The State has established special processes through the 1915(c) waivers to ensure members receive the services they need. This is established through the Level of Care eligibility determination screen, the reevaluation, and the person-centered support plan that is reviewed annually.

Section B – Waiver Cost-Effectiveness & Efficiency

Efficient and economic provision of covered care and services:

1. Provide a description of the State's efficient and economic provision of covered care and services.

Department response: Contracting with a single entity for case management services in a given region will result in the efficient and economic provision of case management services across the state. By having a single entity serve a given region (catchment area), duplication of case management services is reduced, communication with members and between case management staff is streamlined, and administrative costs are managed more efficiently. Any potential cost impact of changing case management structures will also be avoided by using the existing delivery structure. This meets the Department's legislative goals of federal compliance with conflict free case management, and improving the state case management system's quality, simplicity, stability, and accountability.

2. Project the waiver expenditures for the upcoming waiver period.

Department Response: The State determined the growth rate by using the most updated forecast for enrollment/utilization from FY 2021-22 actuals which were $26,898,534. For year 2, the growth rate is from FY 2021-22 actual expenditure to the FY 2024-25 estimate expenditure from the State's most recent forecast.

Year 1 from: 07/01/2023 to 06/30/2024

Trend rate from current expenditures (or historical figures): 11.86%

Projected pre-waiver cost	$30,089,151
Projected Waiver cost	$30,089,151
Difference:	$0

Year 2 from: 07/01/2024 to 06/30/2025

Trend rate from current expenditures (or historical figures): 12.99%

Projected pre-waiver cost	$30,394,264
Projected Waiver cost	$30,394,264
Difference:	$0

Year 3 (if applicable) from: 07/01/2025 to 06/30/2026
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)

Projected pre-waiver cost	$30,704,652
Projected Waiver cost	$30,704,652
Difference:	$0

Year 4 (if applicable) from: 07/01/2026 to 06/30/2027
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)

Projected pre-waiver cost	$31,020,486
Projected Waiver cost	$31,020,486
Difference:	$0

Year 5 (if applicable) from: 07/01/2027 to 06/30/2028
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)

Projected pre-waiver cost	$31,341,947
Projected Waiver cost	$31,341,947
Difference:	$0