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State/Territory Name: Colorado

State Plan Amendment (SPA) #: 23-0001

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

May 24, 2023

Kim Bimestefer, Executive Director
Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

Re: Colorado State Plan Amendment (SPA) 23-0001

Dear Ms. Bimestefer:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 23-0001. This amendment proposes add the populations served by the following 1915(c) HCBS waivers as target groups for Targeted Case Management: Brain Injury (BI), Children's Home and Community Based Services (CHCBS), Children with Life Limiting Illness (CLLI) Complementary and Integrative Health (CIH), Community Mental Health Supports (CMHS), and Elderly, Blind, and Disabled (EBD).

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing 42 CFR 441.18. This letter is to inform you that Colorado Medicaid SPA 23-0001 was approved on May 24, 2023, with an effective date of July 1, 2023.

If you have any questions, please contact Michala Walker at 816-426-6503 or via email at Michala.Walker@cms.hhs.gov.

Sincerely,

[redacted]

James G. Scott, Director
Division of Program Operations

Enclosures

cc: Erica Schaler
Julie Masters
Sarah Hoerle
Jami Gazerro

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 23 — 0001

2. STATE: CO

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2023

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 441.18

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2023 $ 0
b. FFY 2024 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Supp to Att. 3.1-A - Limitations to Care and Services - Item 19 - TCM (Pages 1-~~6 of 6~~); Att. 4.19-B – Methods and Standards for Establishing Payment Rates – Introduction to Att. 4.19b – (Page 2 of 3); Att. 4.19B – Methods and Standards for Establishing Payment Rate (Pages 1-~~2 of 2~~) 3 of 3

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Supp to Att. 3.1-A - Item 19 - TCM (Pg 1 of 4; 4 of 4) (TN CO-19-0005); (Pg 2 of 4) (TN CO-12-003); (Pg 3 of 4) (TN CO-21-0042); Att.4.19-B - Intro to Att 4.19-B (Pg 2 of 3) (TN CO-22-0018); Att 4.19-B - Item 19 TCM - (Pg 1 of 1) (TN CO-20-0021)

9. SUBJECT OF AMENDMENT
This State Plan Amendment seeks to add ~~the following 1915(c) HCBS waivers to Targeted Case Management:~~ the populations served by the following HCBS waivers as target groups for Targeted Case Management: Brain Injury (BI), Children's Home and Community Based Services (CHCBS), Children with Life Limiting Illness (CLLI) Complementary and Integrative Health (CIH), Community Mental Health Supports (CMHS), and Elderly, Blind, and Disabled (EBD)

10. GOVERNOR'S REVIEW *(Check One)*
( ) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
(●) OTHER, AS SPECIFIED: Governor's letter dated 24 September 2022

11. SIGNATURE OF S[redacted]

12. TYPED NAME
Adela Flores Brennan

13. TITLE
Medicaid Director

14. DATE SUBMITTED
2/27/23

15. RETURN TO
Colorado Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203-1818

Attn: Alex Lyons

FOR CMS USE ONLY

16. DATE RECEIVED
February 27, 2023

17. DATE APPROVED
May 24, 2023

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2023

[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
James G. Scott

21. TITLE OF APPROVING OFFICIAL
Director, Division of Program Operations

22. REMARKS

Boxes 7 and 9: State authorized pen and ink changes on 5/19/23 and 5/24/23

FORM CMS-179 (09/24)

Instructions on Back

State Plan under Title XIX of the Social Security Act
State/Territory: Colorado

TARGETED CASE MANAGEMENT SERVICES
Persons Utilizing Long Term Services and Supports Programs

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):
Medicaid recipients who are actively enrolled in a 1915(c) Home and Community-Based Services (HCBS) waiver.

Excluded are persons residing in Class I nursing facilities or Intermediate Care Facilities- for Individuals with Intellectual and Developmental Disabilities (ICF-IID).

___ Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to_____consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):
X Entire State
___ Only in the following geographic areas:

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))
___ Services are provided in accordance with §1902(a)(10)(B) of the Act.
X Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

- Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include
  - taking client history;
  - identifying the individual's needs and completing related documentation; and
  - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;

Comprehensive assessment shall be completed at the time of enrollment. Assessment information shall be reviewed at least annually. Reassessment shall occur when the client experiences significant change in need or level of support.

- Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:
  - specifies the goals and actions to address the medical, social, educational, and

State Plan under Title XIX of the Social Security Act
State/Territory: Colorado

TARGETED CASE MANAGEMENT SERVICES
Persons Utilizing Long Term Services and Supports Programs

- other services needed by the individual;
- includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
- identifies a course of action to respond to the assessed needs of the eligible individual;

- Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
  - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

- Monitoring and follow-up activities:
  - activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
    - services are being furnished in accordance with the individual's care plan;
    - services in the care plan are adequate; and
    - changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

Monitoring shall be completed as necessary to ensure implementation of the person-centered support plan and to evaluate health, safety, and welfare of the client. Follow up actions shall be performed when necessary to address health and safety concerns or services in the person-centered support plan. The Case Management Agency will conduct quarterly monitoring contacts with the member, as defined by the member's certification period start and end dates. An in-person monitoring contact is required at least one (1) time during the Person-Centered Support Plan certification period. The Case Manager will ensure the one (1) required in-person monitoring contact occurs, with the member physically present, in the member's place of residence or location of services. While a total of four monitoring contacts per year are eligible for a monitoring contact payment, Case Management Agencies will perform as many monitoring contacts as needed to support the member with their programs and services. Services are delivered as follows:

- 1915(c) HCBS waivers – at minimum – one per year

State Plan under Title XIX of the Social Security Act
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TARGETED CASE MANAGEMENT SERVICES
Persons Utilizing Long Term Services and Supports Programs

X Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.
(42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

Targeted Case Management services for HCBS waivers will be provided by Case Management Agencies (CMA). CMA means a public or private not-for-profit or for-profit agency that meets all applicable state and federal requirements and is certified by the state department to provide case management services for Home and Community Based Services waivers pursuant to section CRS 25.5- 10-209.5. Providers must meet established program requirements and attend all required trainings.

All Home and Community Based Services (HCBS) case managers must be employed by an approved CMA.

The minimum required for Targeted Case Management case managers for HCBS waivers is:

1. A bachelor's degree; or
2. Five (5) years of experience in the field of LTSS which includes Developmental Disabilities; or
3. Some combination of education and relevant experience appropriate to the requirements of the position.

Relevant experience is defined as:

a. Experience in one of the following areas: long-term care services and supports, gerontology, physical rehabilitation, disability services, children with special health care needs, behavioral science, special education, public health or non-profit administration, or health/medical services, including working directly with persons with physical, intellectual, or developmental disabilities, mental illness, or other vulnerable populations as appropriate to the position being filled; and
b. Completed coursework and/or experience related to the type of administrative duties performed by case managers may qualify for up to two (2) years of required relevant experience

HCBS Case manager supervisor educational experience: That agency's supervisor(s) shall meet minimum standards for education and/or experience and shall be able to demonstrate competency in pertinent case management knowledge and skills

State Plan under Title XIX of the Social Security Act
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TARGETED CASE MANAGEMENT SERVICES
Persons Utilizing Long Term Services and Supports Programs

Freedom of choice (42 CFR 441.18(a)(1)):
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):
X Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):
The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose**.**

Case Records (42 CFR 441.18(a)(7)):Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:
Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

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TARGETED CASE MANAGEMENT SERVICES
Persons Utilizing Long Term Services and Supports Programs

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

. Case Management Agencies will perform as many monitoring contacts as needed to support the member with their programs and services.

A separate component of TCM encompasses monitoring the quality of services to ensure the member is receiving services in accordance with the service plan. The total number of units for Targeted Case Management – Monitoring Visit is limited to up to four units per service plan year per client

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-
OTHER TYPES OF CARE

Effective Dates for Reimbursement Rates for Specified Services

Service	Attachment	Effective Date
9. Clinic Services	Attachment4.19-B, Page 1-3 of 4	July 1, 2022
10. Dental Services	Attachment 4.19-B, Page 1of 3	July 1, 2022
11. Physical Therapy, Occupational Therapy, Speech Therapy, and Audiology Services	Attachment 4.19-B	July 1, 2022
12.b. Dentures	Attachment 4.19-B	July 1, 2022
12.c. Prosthetics	Attachment 4.19-B	July 1, 2022
12.d. Eyeglasses and Contact Lenses	Attachment 4.19-B	July 1, 2022
13.c. Preventive Services - Screening, Brief Intervention, and Referral to Treatment (SBIRT)	Attachment 4.19-B	July 1, 2022
13.d. Rehabilitative Services: Substance Use Disorder Treatment	Attachment 4.19-B	July 1, 2022
13.d. Rehabilitative Services: Behavioral Health Services	Attachment 4.19-B	July 1, 2022
13.d. Rehabilitative Services: Mental Health and Substance Abuse Rehabilitation Services for Children	Attachment 4.19-B, Page 1-2 of 2	July 1, 2022
19. Targeted Case Management: Persons Utilizing Long Term Services and Supports	Attachment 4.19-B, Page 1-3 of 3	July 1, 2023
19.1. Targeted Case Management: Early Intervention	Attachment 4.19-B, Page 1-3 of 3	July 1, 2023
19.a. Targeted Case Management: Outpatient Substance Use Disorder Treatment	Attachment 4.19-B, Page 1 of 2	July 1, 2022

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES –
OTHER TYPES OF CARE

19. Targeted Case Management Services: Persons Utilizing Long Term Services and Supports Program

Payment for targeted case management (TCM) services under the State Plan do not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

The reimbursement methodology for TCM Long Term Services and Supports Program is based upon a market-based rate with a monthly payment per member according to the State's approved fee schedule regardless of the number of contacts with a member each month.

For the Colorado Department of Health Care and Financing's fee schedule, please visit https://www.colorado.gov/hcpf/provider-rates-fee-schedule.

TCM services for Persons Utilizing Long Term Services and Supports Program is reimbursed at the lower of the following:

1. Submitted charges; or
2. Fee schedule as determined by the Department of Health Care Policy and Financing.

Except as otherwise noted in the State Plan, state-developed fee schedule rates are the same for both governmental and private providers of TCM services for Persons Utilizing Longer Term Services and Supports Program. The rates are effective for services on or after the date listed on the Attachment 4.19-B Introduction Page.

The TCM fee-for-services rate is based on the time a case manager will spend on a case each month based on agency surveys determining average time spent on associated activities based on the current needs of the population. There are three fee-for-services rates in TCM: Ongoing Case Management, Monitoring, and Rural Travel Add-On.

Ongoing Case Management includes all of the day to day meetings, communications, activities and support that a case manager provides to members for program eligibility, engagement, and health and safety.

TCM Monitoring encompasses reviewing the quality of services and to ensure the member is receiving services in accordance with the service plan. The total number of units for Targeted Case Management Monitoring Visit is limited to up to four units per service plan year per client.

Targeted Case Management Monitor Visit, Rural Travel Add on is limited to four units per service plan year per client. Rural travel add-ons may only be billed with one of the required, quarterly face-to-face visits. Rural travel add-ons may be billed for members residing in counties designated as rural or frontier.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES –
OTHER TYPES OF CARE

The base for the rate is estimated personnel related costs for these hours and included consideration for direct cost allocations. The proposed rate is based on the following assumptions:

- Direct Personnel Costs: There are two sets of wages, case manager and supervisor, in the TCM model. Both wages were derived from the May 2021 BLS statewide wage data. These wages were adjusted for inflation by using the average SSI inflation rates for the past three years, which adjusted the salary by 9.7 percent.
- Caseload: This drives the average number of hours assumed for a given case in a month, based on a 40-hour work week. The proposed rate assumes a caseload of 40 cases per case manager, which translates to an average of 3.67 hours devoted to each client each month.
- Supervisor Span of Control: The supervisor span of control is the number of employees providing direct service supervised by a supervisor. This component of the rate model captures the costs associated with direct supervision; other levels of management are contained in the non-direct cost allocation
- Program Support: Payroll Related. The TCM model allows for one supervisor for every ten case managers.
- Benefits Factor: The benefits factor represents taxes and benefits for the direct care employee and the direct care supervisor. The benefits factor is calculated using reported costs from the spring 2022 and the wage survey data. The same benefit factor of 24 percent was used for all of the proposed rates.
- Program Support, Payroll Related: This category of non-direct cost allocations captures salaries and benefits not captured in the direct care or supervisor of direct care components of the rate. As with all non-direct cost allocations, we calculate these costs as a percentage of the direct care salaries and benefits. The source of all of the non-direct cost allocations is the spring 2022 targeted cost survey. The percentage add-on for this category of costs is 13.2 percent. The salaries and benefits included are those of program managers, associate program managers, program directors and program secretaries.
- Program Support, Non-Payroll Related: This category of non-direct cost allocations includes program expenses, medical professional services, staff development, staff travel, and vehicles. The percentage add-on is 12.5 percent and is based on data reported in the spring 2022 targeted cost survey.
- Other Non-Direct Program Related Expenses: This category of non-direct cost allocations captures general program management costs. These costs include program administration expenses, other professional services, telephone, dues and subscriptions, insurance and other general management expenses. The percentage add-on is 18.4 percent and is based on data reported in the spring 2007 targeted cost survey.
- Facility Related Costs: This category of non-direct cost allocations captures costs associated with the office space for the case manager. The 2022 cost survey asked providers to report on costs by service – Day Habilitation, Residential Habilitation and Supported Employment. The business model for Supported Employment is the closest in nature to TCM, so we used the survey data associated with Supported Employment to develop this allocation percentage. The

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES –
OTHER TYPES OF CARE

- percentage is 4.0 percent and includes rent/leases, maintenance and utilities.
- Management and General: The spring 2022 cost survey may not have captured all administrative costs associated with providing Comprehensive Waiver services. To reflect costs like those of the Chief Executive Officer (CEO), Chief Financial Officer (CFO), and other non-program general administration, we included an additional overhead percentage of 5 percent.