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State/Territory Name: Colorado

State Plan Amendment (SPA) #: 24-0035

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS Form 179
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Service
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

December 23, 2024

Adela Flores-Brennan
Medicaid Director
Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

RE: CO 24-0035 Colorado 1915(k) Community First Choice State Plan Amendment (SPA) and CO-0007.R00.00 1915(b)(4) Fee-for Service Selective Contracting Waiver

Dear Director Flores-Brennan:

The Centers for Medicare & Medicaid Services (CMS) is approving Colorado's request to amend its state plan to add a new 1915(k) Community First Choice (CFC) benefit, transmittal number CO 24-0035. CMS conducted the review of the state's submittal according to statutory requirements in Title XIX of the Social Security Act and relevant federal regulations.

The SPA is approved with an effective date of July 1, 2025. Enclosed are the following pages to be incorporated into your approved state plan:

- Attachment 3.1-K, pages 1-71
- Attachment 4.19-B, pages 1-4 and Introduction, pages 1-3

It is important to note that CMS' approval of the 1915(k) action solely addresses the state's compliance with the applicable Medicaid authorities. CMS' approval does not address the state's independent and separate obligations under federal laws including, but not limited to, the Americans with Disabilities Act, §504 of the Rehabilitation Act, or the Supreme Court's Olmstead decision. Guidance from the Department of Justice concerning compliance with the Americans with Disabilities Act and the Olmstead decision is available at http://www.ada.gov/olmstead/q&a_olmstead.htm.

Concurrently, CMS is approving Colorado's request for an initial 1915(b)(4) Fee-for-Service (FFS) Selective Contracting Waiver, CMS control number, CO-0007.R00.00 titled "Community First Choice". This waiver allows Colorado to selectively contract with Financial Management Services vendors to provide administrative and financial services for members who utilize Consumer Directed Attendant Support Services under the 1915(k) state plan option. This 1915(b) waiver is authorized under section 1915(b)(4) of the Social Security Act and provides a waiver of the following section of Title XIX: Section 1902(a)(23) Freedom of Choice.

Our decision is based on the evidence submitted to CMS demonstrating that the state's proposal is consistent with the purposes of the Medicaid program, will meet all the statutory and regulatory requirements for assuring beneficiaries' access to and quality of services, and will be a cost-effective means of providing services to enrollees under this waiver.

The Community First Choice 1915(b)(4) Fee-for Service Selective Contracting Waiver, CO-0007.R00.00, is effective for 5 years beginning July 1, 2025 through June 30, 2030 and operates concurrently with the Community First Choice SPA. The state may request renewal of this waiver authority by providing evidence and documentation of satisfactory performance and oversight. Colorado's request that this waiver authority be renewed should be submitted to the CMS no later than April 1, 2030.

We appreciate the cooperation and effort provided by you and your staff during the review of these concurrent actions. If you have any questions concerning this information, please contact Shawn Zimmerman at (410) 786-82991 or via email at Shawn.Zimmerman@cms.hhs.gov for the 1915(k) waiver or Nicole Gillette-Payne at (212) 616-2465 or via email at Nicole.Gillette4@cms.hhs.gov for the 1915(b)(4) waiver.

Sincerely,

George P. Failla, Jr., Director
Division of HCBS Operations and Oversight

John Giles, Director
Managed Care Group

Cc:
Bonnie Silva, HCPF
Colin Laughlin, HCPF
Amanda Lofgren, HCPF
Angela Goodell, HCPF
Lana Eggers, HCPF
Sarah Hoerle, HCPF
Julie Masters, HCPF
Eileen Saunders, HCPF
Jessica Coral, HCPF
Michele Weller, CMS
Shawn Zimmerman, CMS
Cynthia Nanes, CMS
Wendy Hill Petras, CMS
Nicole Gillette-Payne, CMS
Cynthia Garraway, CMS
Nikki Lemmon, CMS
Matthew Klein, CMS
Frank Schneider, CMS

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: 24 — 0035

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, 2025

5. FEDERAL STATUTE/REGULATION CITATION
2401 of ACA/42 CFR 441 subpart K 42 CFR Part 430 Subpart B

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2025 $ 114,942,247
b. FFY 2026 $ 466,351,027

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-K, pages 1-71
Attachment 4.19-B, pages 1-4
Attachment 4.19-B Introduction Page, pages 1-3

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
N/A

9. SUBJECT OF AMENDMENT
Amending Colorado's State Plan to include Community First Choice (CFC) 1915 (k) (NEW)

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 5 April 2023

11. SIGNATURE OF STATE AGENCY OFFICIAL

12. TYPED NAME
Adela Flores-Brennan

13. TITLE
State Medicaid Director

14. DATE SUBMITTED
October 22, 2024

15. RETURN TO
Colorado Department of Health Care Policy and Financing
303 E. 17th Avenue, Suite 1100
Denver, CO 80203

Attn: Julie Masters

FOR CMS USE ONLY

16. DATE RECEIVED

17. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL

21. TITLE OF APPROVING OFFICIAL

22. REMARKS

Community First Choice (CFC) State Plan Amendment (SPA) Submission

October 2024

Benefit Summary:

Please provide a brief general overview of the state's proposed Community First Choice (CFC) benefit, including but not limited to an overview of services, delivery method, impact on other long-term services and supports (LTSS) programs, and how services will be coordinated between the CFC program and other state services provided:

Services and delivery method: Colorado's Community First Choice (CFC) benefit offers Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) support and assistance through a Self-Directed with Service Budget Model, Consumer Directed Attendant Support Services (CDASS), and through an Agency-Provider Model where members can choose the level of consumer control they wish to have in their services. The CDASS model is a Self-Directed Model with Service Budget that utilizes a Financial Management Services (FMS) vendor to support the CFC member with administrative tasks, such as payroll and tax withholdings, and allows for waiving the Nurse Practice Act. The CFC benefit includes services to assist individuals in acquiring, enhancing, and/or maintaining skills necessary to accomplish activities of daily living, instrumental activities of daily living, and health-related tasks, backup systems, and voluntary training on selecting, managing, and dismissing attendants. In addition, Colorado is choosing to incorporate three optional services in the CFC benefit: Transition Setup, Remote Supports, and Home Delivered Meals.

Impact on other LTSS programs: The Department of Health Care Policy and Financing (HCPF or the Department), has made the following alterations to current LTSS programs to prevent duplication of services:

1. Services offered in CFC will be accessed through the 1915(k) authority and will no longer be available through a 1915(c) waiver after the member transitions to CFC. 1915(c) per diem residential services will be left unamended.
2. The current 1915(c) waivers will be amended to remove Personal Care,

Homemaker, Health Maintenance Activities, In-Home Support Services (IHSS), Consumer Directed Attendant Support Services (CDASS), Electronic Monitoring (including Personal Emergency Response System (PERS) and Medication Reminders), Remote Supports, Transition Setup, and Home Delivered Meals. These services, while leaving the 1915(c) waivers, will remain accessible to all waiver members under the CFC benefit. Members who become eligible for Health First Colorado (Colorado's Medicaid program) via enrollment in a 1915(c) waiver and who select to utilize services under CFC will need to continue utilizing at least one waiver service every month to maintain eligibility for the 1915(c) waiver and the CFC benefit. Additionally, the Department added the Wellness Education Benefit service to all 1915(c) waivers to, at their option, help members maintain waiver eligibility. The Wellness Education Benefit service consists of individualized educational materials designed to provide members and their families with actionable tools that can be used to increase community engagement, manage health-related issues, achieve goals identified in their Person-Centered Support Plan, and improve awareness of Health First Colorado services.

3. For the first year that CFC is implemented, Colorado will maintain or exceed the current level of expenditures for services provided under the 1915(c) waivers. This will ensure that members will have access to services under either a 1915(c) waiver or CFC, depending on the timing of their transition between authorities. Additional details are located in Attachment 4.19-B.
4. Colorado's Medicaid Management Information System (MMIS) will have safeguards to ensure duplication of services does not occur. Members will have access to services that are medically necessary which may include consumer-controlled service delivery models and/or agency-based delivery models.

Coordination between CFC and other State Services: The Department coordinates CFC with other services by using:

1. An assessment process that allows all individuals potentially eligible for CFC to experience one assessment for eligibility determination and have an informed choice about CFC, 1915(c) waiver(s), and other state plan services.

2. A Person-Centered Support Plan and Needs Assessment that includes all LTSS services.

Community First Choice Development and Implementation Council

Date of 1st Council meeting: May 4, 2022

☒ **The state has consulted with its Development and Implementation Council before submitting its CFC State Plan amendment.**

☒ **The state has consulted with its Development and Implementation Council on its assessment of compliance with home and community-based settings requirements, including on the settings the state believes overcome the presumption of having institutional qualities.**

☒ **The state has sought public input on home and community-based settings compliance beyond the Development and Implementation Council. If yes, please describe:**

Beginning in May of 2022, The Department coordinated monthly meetings with the Community First Choice Council (CFCC) to gather input and guidance on each component of Colorado's CFC benefit. The majority of CFCC members are individuals with disabilities, elderly individuals, and their representatives. Additionally, the Department created a CFC workgroup to specifically address policy for one of Colorado's participant-directed service delivery options, Consumer-Directed Attendant Support Services (CDASS). This workgroup was created to review, prioritize, and investigate key CDASS policy areas as the Department worked to integrate CDASS into the CFC benefit. The workgroup met for four months with key stakeholders, many of whom also regularly attend the CFC Council Meetings.

In addition to meeting with the CFCC on the development of Colorado's CFC benefit, the Department has consulted the CFCC regarding compliance with home- and community-based setting requirements. The August 2022 CFCC meeting focused entirely on home- and community-based settings, and CFC's compliance with the HCBS Settings Final Rule.

The Department has also sought broader public input on home- and community-based settings compliance beyond that provided by the CFCC. The Department has gathered input from HCBS participants and advocates, providers, support planning agencies (also known as case management agencies in Colorado), and other members of the public on home- and community-based settings compliance. This stakeholder engagement consisted of the following:

- Presented to and spoke with numerous groups, including those representing people with disabilities, providers, support planning agencies (case management agencies), Long-Term Care Ombudsmen, and adult protective services (2016-2022);
- Held public question-and-answer sessions (2018, 2021);
- Convened Rights Modification Stakeholder Workgroup to develop Colorado's codification of federal rule, informed consent template, and other materials (2019-2020);
- Continued this work via Open Meeting Series (2020-2021);
- Held town halls to discuss heightened scrutiny determinations (2021 and 2023);
- Conducted formal stakeholder engagement as part of finalizing the state's codification of the federal rule (2021); and
- Developed separate stakeholder communications plan reflecting these and other approaches (2022).

The Department's first batch of heightened scrutiny determinations was open for public comment from June 10, 2021, through July 10, 2021. The Department hosted three public town halls in connection with these determinations. The Department's second batch of heightened scrutiny determinations was open for public comment from April 25, 2023, through May 25, 2023. The Department hosted one public town hall in connection with this smaller batch of determinations. The Department reviewed and addressed the comments received during and after each public comment period, as set out in the updated summary sheets for each setting.

Community First Choice Eligibility

☒ Individuals are eligible for medical assistance under an eligibility group identified in the state plan.

☒ Categorically Needy Individuals

☒ Medically Needy Individuals

☒ Medically Needy individuals receive the same services that are provided to Categorically Needy individuals

☐ Different services than those provided to Categorically Needy individuals are provided to Medically Needy individuals. (If this box is checked, a separate template must be submitted to describe the CFC benefits provided to Medically Needy individuals)

The state assures the following:

☒ Individuals are in eligibility groups in which they are entitled to nursing facility services, or

☐ If individuals are in an eligibility group under the state plan that does not include nursing facility services, and to which the state has elected to make CFC services available (if not otherwise required), such individuals have an income that is at or below 150 percent of the Federal poverty level (FPL)

Level of Care

☒ The state assures that absent the provision of home and community-based attendant services and supports provided under CFC, individuals would require the level of care furnished in a long- term care hospital, a nursing facility, an intermediate care facility for individuals with intellectual disabilities, an institution providing inpatient psychiatric services for individuals under age 21, or an institution for mental diseases for individuals age 65 or over.

Recertification

☐ The state has chosen to permanently waive the annual recertification of level of

care requirement for individuals in accordance with 441.510(c)(1) & (2).

Please indicate the levels of care that are being waived:

☐ **Long-term care hospital**

☐ **Nursing facility**

☐ **Intermediate care facility for individuals with intellectual disabilities**

☐ **Institution providing psychiatric services for individuals under age 21**

☐ **Institution for mental diseases for individuals age 65 or over**

Describe the state process for determining an individual's level of care:

Members will be assessed for institutional level of care using a Level of Care Eligibility Determination Screening Instrument (Level of Care Screen). The Level of Care Screen includes the Level of Care Eligibility Determination outcome that is based on an individual's performance level as documented in the screen, in areas including, but not limited to, completing Activities of Daily Living, memory and cognition, sensory and communication, and behavior, as well as other criteria specific to applicable program and specific to age appropriateness. The Level of Care Eligibility Determination assesses for:

- Nursing Facility Level of Care Eligibility Criteria.
- Hospital Level of Care Eligibility Criteria
- Intermediate Care Facility Level of Care Eligibility Criteria.
- Inpatient Psychiatric Level of Care Eligibility Criteria.

For initial level of care eligibility determinations, the Professional Medical Information Page (PMIP) must be completed by a treating medical professional who verifies the individual's need for institutional level of care. The Department oversees eligibility determinations completed by support planning agencies (case management agencies). Colorado does not have Institutions for Mental Diseases for Individuals over 65, however, this population is captured in Colorado's Nursing Facility Level of Care Eligibility Criteria.

Informing Individuals Potentially Eligible for the Community First Choice Option

Indicate how the state ensures that individuals potentially eligible for CFC services and supports are informed of the program's availability and services:

☒ **Letter**

☒ **Email**

☒ **Other - Describe:**

Agencies serving as access points for publicly funded LTSS.

Please describe the process used for informing beneficiaries:

The Department will work with contracted support planning agencies (case management agencies) to inform current 1915(c) waiver members, and current members receiving state plan services, about CFC. The Department will send information to Medicaid providers, nursing facility administrators, social workers and discharge planners, hospital transition coordinators, and options counseling agencies to ensure providers are equipped to inform potential members of CFC services. Medicaid providers will be given CFC information and resources to share with beneficiaries to ensure that all individuals seeking LTSS can make an informed decision about CFC regardless of where the member enters the Health First Colorado Medicaid system. The Department will provide briefings and presentations about CFC to other state departments, agencies, and stakeholder groups.

The Department will work with the CFC Council to identify additional advocacy groups and populations in need of targeted outreach. Additionally, the Department will conduct specific outreach to inform Colorado's Native Tribes of the availability of CFC services. In the first year of CFC, each 1915(c) waiver member shall be informed by their support planner (also known as case manager in Colorado), in a manner prescribed by the Department, about CFC and will be supported to transition to CFC during the member's regularly scheduled Continued Stay Review (CSR).

Assurances (All assurances must be checked).

☒ **Services are provided on a statewide basis.**

☒ **Individuals make an affirmative choice to receive services through the CFC option.**

☒ **Services are provided without regard to the individual's age, type or nature of disability, severity of disability, or the form of home and community-based**

attendant services and supports that the individual needs to lead an independent life.

☒ Individuals receiving services through CFC will not be precluded from receiving other home and community-based long-term care services and supports through other Medicaid state plan, waiver, grant or demonstration authorities.

☒ For the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law), spousal impoverishment rules are used to determine the eligibility of individuals with a community spouse who seek eligibility for home and community-based services provided under 1915 (k).

CFC Service Models

Indicate which service models are used in the state's CFC program to provide consumer-directed home and community-based attendant services and supports (Select all that apply):

☒ Agency-Provider Model

☒ Self-Directed Model with Service Budget

☐ Other Service Model. Describe:

The Department elects to utilize two service delivery options for Colorado's Community First Choice (CFC) benefit: the Agency-Provider model and the Self-Directed Model with Service Budget.

Agency-Provider Model - In this model, the employer of record is the agency. Attendants are employed by an agency that determines the rate of pay and training needs. This service delivery model allows members to determine the level of consumer control they desire. Members not interested in directing their own Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) support can choose to utilize CFC personal care providers and CFC homemaker providers to receive support and services for their needs. The member has a choice in the agency they select to provide their services, with the agency responsible for staffing, training, and oversight of service delivery. Members who wish to choose an attendant and waive the Nurse Practice Act can utilize an In-Home Support Service (IHSS) Agency to access their ADL/IADL services. Using an IHSS Agency, the member and/or authorized representatives have the right to:

- Present a person(s) of his/her/their choosing to the provider agency as a potential attendant.
- Train and schedule attendant(s) to meet his/her/their needs.
- Dismiss attendants who are not meeting his/her/their needs.

Self-Direction with Service Budget Model - In this model, the member, or their Authorized Representative (AR), is the employer of record. Attendants are employed by the member/AR. The member determines the rate of pay and training needs. This service delivery model, called Consumer Directed Attendant Support Services (CDASS), allows members to completely self-direct all aspects of their service delivery by becoming the legal employer of attendants with the assistance of a Financial Management Service (FMS) vendor. Budgets are approved determined by support planner (case manager) and member/authorized representative. Support planner (case manager) inform members of

their approved budget. With CDASS, members have budget and employer authority and accept more responsibility and control over the services and supports. The member recruits, hires, trains, and supervises their CDASS Attendant. Members who need additional support to direct and manage their care can appoint an AR to help with CDASS administration.

Under this model, members must choose an FMS vendor to work with who will assist them with fulfilling their responsibilities as an employer of their attendants.

Financial Management Services

- **The state must make available financial management services to all individuals with a service budget.**

The state will claim costs associated with financial management services as:

☒ A Medicaid Service

☐ An Administrative Activity

☒ The state assures that financial management service activities will be provided in accordance with 42 CFR 441.545(B)(1). (Must check)

If applicable, please describe the types of activities that the financial management service entity will be providing, in addition to the regulatory requirements at 42 CFR 441.545(B)(1).
The FMS provides administrative and financial services to CDASS members and their authorized representatives to complete employment-related functions for the members' attendants and to record, monitor, and report on CDASS member allocations and utilization, including providing members with periodic reports of expenditures and a status of approved service budget.

FMS vendors provide the following assistance:

- Completes attendant enrollment with required background checks, collects and processes attendant timesheets, and services customer complaints and questions.
- Fulfills requirements to comply with Electronic Visit Verification (EVV) regulations, implements Americans with Disabilities Act accommodations, and produces reports demonstrating fulfillment of contractual performance standards.
- Administer necessary systems and services in response to newly mandated local and state laws impacting CDASS.
- Collect and process timesheets submitted by attendants within agreed-upon timeframes as identified in FMS vendor materials and websites.
- Conduct payroll functions, including withholding employment-related taxes such as

workers' compensation insurance, and unemployment benefits, withholding all federal and state taxes, and compliance with federal and state laws regarding overtime pay and minimum wage.

- Distribute paychecks in accordance with agreements made with the member or authorized representative and timelines established by the Colorado Department of Labor and Employment.
- Submit authorized claims for CDASS provided to an eligible member.
- Track and report the utilization of a member's allocations to the member or the members authorized representative through periodic reports of expenditures.

Specify the type of entity that provides financial management services:

☐ **A Medicaid Agency**

☐ **Another State Agency - Specify:**

Click or tap here to enter text.

☒ **Vendor Organization**

Describe:

The Department contracts with multiple FMS vendors that are selected through a competitive Request for Proposal process every five years. An FMS is selected by the member, or authorized representative, to complete employment-related functions for CDASS attendants and to track and report individual member CDASS allocations. The FMS acts as the fiscal/employer agent (F/EA) by performing payroll and administrative functions for members receiving CDASS benefits. The F/EA pays attendants for CDASS services and maintains workers' compensation policies on the member-employer's behalf. The F/EA withholds, calculates, deposits, and files withheld Federal Income Tax and member-employer and attendant-employee Social Security and Medicare taxes.

Other Payment Methods

The state also provides for the payment of CFC services through the following methods:

☐ **Use of Direct Cash Payments - The state elects to disburse cash prospectively to CFC participants. The state assures that all Internal Revenue Service (IRS) requirements regarding payroll/tax filing functions will be followed, including when participants perform the payroll/tax filing functions themselves. Describe:**

Click or tap here to enter text.

☐ **Vouchers- Describe:**

Click or tap here to enter text.

Service Budget Methodology

Describe the budget methodology the state uses to determine the individual's service budget amount. Also describe how the state assures that the individual's budget allocation is objective and evidence- based utilizing valid, reliable cost data and can be applied consistently to individuals:

The methodology support planners (case managers) use for determining service hours is based on both evidence-based and objective research and guidelines for assessing member service needs while maintaining person-centered practices, accounting for the unique needs

of each member. The support planner (case manager) and the member and/or the member's authorized representative discuss the member's individual service needs and goals during the Person-Centered Support Planning process. The support planner (case manager) reviews the member's service needs for appropriateness based on the member's level of functioning and condition. The state employs standardized and evidence-based norms for each task and trains support planners (case managers) on appropriate service authorization. These guidelines are person centered and age-appropriate, utilizing well-known national standards such as Ages and Stages.

The support planner (case manager) uses the information collected in the Person-Centered Support Plan to fill out a standardized task worksheet services calculator. This worksheet is used to calculate the frequency and duration of support needs to determine the appropriate number of weekly service hours. For example, if the member and support planner (case manager) discuss that the member requires support with bathing, the support planner (case manager) determines how many times per week the member bathes, then uses the established norms to determine how long the task should take per occurrence. That time is entered into the task worksheet to establish the necessary amount of time each week for the bathing task. The support planner (case manager) follows this process for each task where the member requires assistance. The weekly service hours are then multiplied by the State's published rates for each service to calculate an annual budget.

The worksheets and methodology for determining the appropriate number of service hours are established from evidence-based norms and are objectively applied by support planners (case managers) consistently to all members receiving LTSS. The annual budget allocation is then approved by the support planner (case manager) via a Prior Authorization Request (PAR).

Describe how the state informs the individual of the specific dollar amount they may use for CFC services and supports before the person-centered service plan is finalized:

The support planner (case manager) provides the member with a written notice of services authorized prior to finalization of the Person-Centered Support Plan.

Describe how the individual may adjust the budget, including how he or she may freely change the budget and the circumstances, if any, which may require prior approval of the budget change from the state:

Members have the autonomy to spend their approved allocation to accommodate temporary fluctuations in their service needs. The Department sets thresholds to limit overspending an annual allocation early in the certification period. Annual allocations are managed by the FMS to ensure member spending does not exceed the approved amount. Members may not exceed the annual allocation. If a member believes their annual allocation is no longer sufficient for their ongoing care needs, they can contact their support planner (case manager) to request a revision or discuss the changes during their quarterly communication. If the member requires an allocation change, the support planner (case manager) will complete a reassessment and complete a new task worksheet. If the member requests further training to assist with budget management, the support planner (case manager) will refer the member and/or the authorized representative to the Information and Assistance Services for additional training.

Describe the circumstances that may require a change in the person-centered service plan:

The Person-Centered Support Plan development and revision occurs no less than annually or as warranted by the member's needs or change in condition. The support planner (case manager) shall continually identify individual strengths, needs, and preferences for services and supports as they change or as indicated by the occurrence of critical incidents. Members may request an unscheduled reassessment at any time.

Describe how the individual requests a fair hearing if his or her request for a budget adjustment is denied or the amount of the budget is reduced:

Members who dispute their assessed service needs may initiate an appeal before an Administrative Law Judge. The support planner (case manager) shall provide the member with a Long-Term Care Waiver Program Notice of Action (LTC 803) to inform the member of their appeal rights. A member has the right to request a review of their assessed service needs identified in the task worksheet and allocation at any time through their support planning agency (case management agency).

Describe the procedures used to safeguard individuals when the budgeted service

amount is insufficient to meet the individual's needs:

Ongoing, the support plan will be reviewed every 6 months with the support planner (case manager). The support plan shall be modified by the support planner (case manager) when there is a change in the member's needs. In the event the support planner (case manager) or member has identified concerns related to the member's service needs being met through their support plan, the support planner (case manager) will review with the member the other service delivery options available to meet their needs. If the member is not in agreement with their needs being met, they may request a reassessment from the support planner (case manager) or may file an appeal at any time.

Describe how the state notifies individuals of the amount of any limit to the individual's CFC services and supports:

The state uses the FMS vendor to notify members of their annual and monthly allocations, how much the member has spent to-date, and what is remaining. The available tasks in CDASS and corresponding definitions are provided to the member in the CDASS Program Manual and in CDASS Orientation. Support planners (case managers) are required to communicate any limitations in place.

Describe the process for making adjustments to the individual's budget when a reassessment indicates there has been a change in his or her medical condition, functional status, or living situation:

If there is a change in member condition or service needs, the member and/or authorized representative may request the support planner (case manager) to perform a reassessment. Should the reassessment indicate that a change in need for attendant support is justified, the support planner (case manager) will complete the standardized task worksheet to determine the appropriate amount of service hours. The support planner (case manager) must also complete a Prior Authorization Request (PAR) revision indicating the change and submit it to the Department's fiscal agent and to the FMS.

In approving an increase in the allocation, the support planner (case manager) will consider the following: any deterioration in the member's functioning or change in the natural support condition, the appropriateness of attendant wages as determined by Department's established rate for equivalent services, and the appropriate use and application of funds to CDASS services.

In approving a decrease in the allocation, the support planner (case manager) will consider the following: any improvement of functional condition or changes in the available natural supports, inaccuracies or misrepresentation in previously reported condition or need for service, and the appropriate use and application of funds to CDASS services.

Mandatory Services and Supports

1. **Assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health-related tasks through hand-on assistance, supervision, and/or cueing.**

Identify the activities to be provided by applicable provider type and describe any service limitations related to such activities.

☒ **Personal Attendant Services. Describe:**

Personal Attendant Services means services that are furnished to an eligible member to meet the member's physical, maintenance, and supportive needs through hands-on assistance, supervision and/or cueing. These services do not require a nurse's supervision or physician orders. Personal Attendant Services also include the option for Acquisition, Maintenance, and Enhancement of Skills when the support is related to functional skills training and is desired by the member to accomplish ADL/IADLs and health related tasks to increase their independence and reduce supports needed in the home and community.

Provider Type: Personal Care Agency Provider, IHSS Agency, CDASS Attendant. There is no service limit on Personal Care. However, no individual provider will be reimbursed for over sixteen (16) hours of care per day except in an emergency situation. Members can utilize additional service hours of Personal Care, based on their assessed needs, with a different provider(s).

☒ **License Required**

Personal Care Agency Providers and IHSS Agency Providers must have a Class A or B Home Care Agency license in good standing with the Colorado Department of Health and Environment (CDPHE).

CDASS Attendants do not require a license for Personal Care.

☒ **Certification Required. Describe:**

IHSS Agency providers must have the additional certification as an IHSS Agency through CDPHE.

Personal Care Agency Providers and CDASS Attendants do not require additional certification for Personal Care.

☐ **Education-Based Standard. Describe:**

Click or tap here to enter text.

☒ **Other Qualifications Required for this Provider Type. Describe:**

CDASS Attendant Providers must meet individual member-defined requirements. All provider types must accommodate for additional training identified through the Person-Centered Support Planning process by the member.

All providers of Personal Care must be approved by the Department at time of initial application as a Medicaid Provider and sign the Department Provider Agreement.

☐ **Companion Services. Describe:**

Click or tap here to enter text.

Provider Type: Click or tap here to enter text.

☐ **License Required**
Click or tap here to enter text.

☐ **Certification Required. Describe:**
Click or tap here to enter text.

☐ **Education-Based Standard. Describe:**
Click or tap here to enter text.

☐ **Other Qualifications Required for this Provider Type. Describe:**

Click or tap here to enter text.

1
2

☒ **Homemaker/Chore. Describe:**

General household activities provided by a provider in a member's home to maintain a healthy and safe environment for the member through hands-on assistance, supervision and/or cueing. Homemaker shall be provided when there is an assessed need and may only be provided in the primary living space of the member. Homemaker services also include the option for Acquisition, Maintenance, and Enhancement of Skills when the support is related to functional skills training and is desired by the member to accomplish ADL/IADLs and health related tasks to increase their independence and reduce supports needed in the home and community.

Provider Type:

Homemaker Provider, IHSS Agency, CDASS Attendant. There is no service limit on Homemaker. However, Legally Responsible Persons of Homemaker have a 10-hour per week limit. Members can utilize additional service hours of Homemaker, based on their assessed needs, with a different provider(s) or another Legally Responsible Persons.

☒ **License Required**

IHSS Agencies must have a Class A or B Home Care Agency license in good standing with CDPHE.

Homemaker Providers may have a Class A or Class B Home Care Agency license in good standing with CDPHE or a certification as listed below.

CDASS Attendants do not require a license for Homemaker.

☒ **Certification Required. Describe:**

If Homemaker Providers do not have a Class A or Class B Home Care Agency license, they must have a certification from CDPHE as an HCBS Provider Agency.

IHSS Agency providers must have the additional certification as an IHSS agency through CDPHE.

CDASS Attendants do not require a certification for Homemaker.

☐ **Education-Based Standard. Describe:**

Click or tap here to enter text.

☒ **Other Qualifications Required for this Provider Type. Describe:**

CDASS Attendant providers must meet individual member-defined requirements. All provider types must accommodate for additional training identified through the Person-Centered Support Planning process by the member.

All providers of Homemaker must be approved by the Department at time of initial application as a Medicaid Provider and sign the Department Provider Agreement.

☒ **Other Services. Describe:**

Health Maintenance Activities (HMA):
Activities include routine and repetitive health-related tasks furnished to an eligible member in the community or in the member's home, which is necessary for health and normal bodily functioning that a person with a disability is physically unable to carry out. These activities include skilled tasks typically performed by a Certified Nursing Assistant (CNA) or licensed nurse that do not require the clinical assessment and judgment of a licensed nurse.

Provider Type: IHSS Agency, CDASS Attendant. There is no service limit on HMA. However, no individual provider will be reimbursed for over sixteen (16) hours of care per day except in an emergency situation. Members can utilize additional service hours of HMA, based on their assessed needs, with a different provider(s).

☒ **License Required**

IHSS Agency providers must have a Class A or B Home Care Agency license in good standing with CDPHE.

CDASS Attendants do not require a license for HMA.

☒ **Certification Required. Describe:**

IHSS Agency providers must have the additional certification as an IHSS Agency through CDPHE.

CDASS Attendants do not require a certification for HMA.

☐ **Education-Based Standard. Describe:**

Click or tap here to enter text.

☒ **Other Qualifications Required for this Provider Type. Describe:**

CDASS Attendant providers must meet individual member-defined requirements. All provider types must accommodate for additional training identified through the Person-Centered Support Planning process by the member.

All providers of HMA must be approved by the Department at time of initial application as a Medicaid Provider and sign the Department Provider Agreement.

2. The acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs, IADLs, and health-related tasks.

Identify the activities to be provided by applicable provider type, and any describe any service limitations related to such activities:

Homemaker and Personal Care Services include the option for Acquisition, Maintenance, and Enhancement of Skills when the support is related to functional skills training and is desired by the member to accomplish ADL/IADLs and health related tasks to increase their independence and reduce supports needed in the home and community. Detailed, task-related goals shall be documented by the support planner (case manager) in the Person-Centered Support Plan, including documentation monitoring progress and any decreased human assistance previously authorized.

Provider Type: CFC Personal Care Provider, CFC Homemaker Provider, IHSS Agency, CDASS Attendant

☒ **License Required**

Personal Care Agency Providers and Personal Care IHSS Agency Providers must have a Class A or B Home Care Agency license in good standing with CDPHE.

IHSS Homemaker Agencies must have a Class A or B Home Care Agency license in good standing with CDPHE.

Homemaker Providers may have a Class A or Class B Home Care Agency license in good standing with CDPHE or a certification as listed below.

CDASS Attendants do not require a license for Personal Care or Homemaker.

☒ **Certification Required. Describe:**

If Homemaker Providers do not have a Class A or Class B Home Care Agency license, they must have a certification from CDPHE as an HCBS Provider Agency.

IHSS Agency Personal Care providers must have the additional certification as an IHSS agency through CDPHE.

IHSS Agency Homemaker providers must have the additional certification as an IHSS agency through CDPHE.

CDASS Attendants do not require a certification for Personal Care or Homemaker.

☐ **Education-Based Standard. Describe:**

Click or tap here to enter text.

☒ **Other Qualifications Required for this Provider Type. Describe:**

All provider types must accommodate for additional training identified through the Person-Centered Support Planning process by the member. All providers of Homemaker and Personal Care must be approved by the Department at time of initial application as a Medicaid Provider and sign the Department Provider Agreement.

3. Individual back-up systems or mechanisms to ensure continuity of services and supports.

Identify the systems or mechanisms to be provided and limitations for:

☒ **Personal Emergency Response Systems**

☐ **Pagers**

☒ **Other Mobile Electronic Devices Other. Describe:**

Back-up systems and supports consists of Electronic Monitoring services which shall include personal emergency response systems (PERS), medication reminder systems, or other devices which ensure continuity of services and supports.

- Medication Reminders means devices, controls, or appliances that remind or signal the member to take actions related to medications.
- Personal Emergency Response System (PERS) means ongoing remote monitoring through a device designed to signal trained alarm monitoring personnel in an emergency situation.

This excludes items that would otherwise be covered by the Durable Medical Equipment Benefit.

Describe any limitations for the systems or mechanisms provided:

The following are not benefits of electronic monitoring services:

- Augmentative communication devices and communication boards
- Hearing aids and accessories
- Phonic ears
- Environmental control units, unless required for the medical safety of a member living alone unattended
- Computers/Phones and computer software
- Wheelchair lifts for automobiles or vans
- Exercise equipment, such as exercise cycles
- Hot tubs, Jacuzzis, or similar items.

For individuals who do not have an assessed need for Electronic Monitoring, the case manager, during the Person-Centered Planning Process, will discuss additional supports available for continuity of care needs.

Provider Type: Electronic Monitoring Provider

☐ **License Required**
Click or tap here to enter text.

☐ **Certification Required. Describe:**
Click or tap here to enter text.

☐ **Education-Based Standard. Describe:**
Click or tap here to enter text.

☒ **Other Qualifications Required for this Provider Type. Describe:**

Electronic Monitoring providers must be approved by the Department at time of initial application as a Medicaid Provider and sign the Department Provider Agreement. All provider types must accommodate for additional training identified through the Person-Centered Support Planning process by the member.

4. Voluntary training on how to select, manage and dismiss attendants.

The state will claim costs associated with voluntary training as (check one)

☐ **Medicaid Service**

☒ **An Administrative Activity**

Describe the voluntary training program the state will provide to individuals on selecting, managing and dismissing attendants:

Members and/or authorized representatives will access supportive training based on the philosophy and responsibilities of participant-directed care. At a minimum, this training includes: an overview of the program, member and/or authorized representative rights and responsibilities, planning and organizing attendant services, managing personnel issues, communication skills, recognizing and recruiting quality attendant support, managing health, allocation budgeting, accessing resources, safety, and prevention strategies, managing emergencies, and working with the Financial Management Services (FMS) vendor. Members can access this training program through a referral from the FMS, their support planning agency (case management agency), and/or obtain the training access information and request to participate themselves.

Provider Type: Training and Support Contractor

☐ **License Required**
Click or tap here to enter text.

☐ **Certification Required. Describe:**
Click or tap here to enter text.

☐ **Education-Based Standard. Describe:**
Click or tap here to enter text.

☒ **Other Qualifications Required for this Provider Type. Describe:**

The provider must have an executed contract with Department. All provider types must accommodate for additional training identified through the Person-Centered Support Planning process by the member.

Optional Services and Supports:

Indicate which of the following optional services and supports the state provides and provide a detailed description of these benefits and any applicable limitations.

☒ **Transition Costs (Provided to individuals transitioning from a nursing facility, Institution for Mental Disease, Intermediate care facility for Individuals with Intellectual Disabilities to a community-based home setting) - Check all of the following costs that apply:**

☒ **Rental and Security Deposits**

Description and Limitations:

Transition Setup covers the purchase of one-time, non-recurring expenses up to 30 days post-transition necessary for a member to establish a basic household as they transition from an institutional setting to a community setting, including security deposits required to obtain a lease on an apartment or home. Transition Setup may be authorized past 30 days on a case-by-case basis if there is a demonstrated need. Transition Setup expenses must not exceed $2,000 per eligible member. The $2,000 limit is a combined limitation for all Transition Setup expenses listed. The Department may authorize additional funds above the $2,000 limit, not exceeding a total value of $2,500, when it is demonstrated as necessary to ensure the member's health, safety, and welfare. Transition Setup is not available when the person is moving to a provider-owned or - controlled setting. Not available for a transition to a living arrangement that does not match or exceed U.S. Department of Housing and Urban Development (HUD) certification criteria.

☒ **Utility Security Deposits**

Description and Limitations:

Transition Setup covers the purchase of one-time, non-recurring expenses up to 30 days post-transition necessary for a member to establish a basic household as they transition from an institutional setting to a community setting, including utility security deposits and setup fees to access essential utilities or services (telephone, electricity, heat, and water). Transition Setup expenses must not exceed $2,000 per eligible member. The Department may authorize additional funds above the $2,000 limit, not to exceed a total value of $2,500, when it is demonstrated as a necessary expense to ensure member's health, safety, and welfare. Transition Setup is not available when the person is moving to a provider-owned or - controlled setting, and does not include ongoing regular utility charges.

☐ **First Month's Rent**

Description and Limitations:

Click or tap here to enter text.

☐ **First Month's Utilities**

Description and Limitations:

Click or tap here to enter text.

☒ **Basic Kitchen Supplies**

Description and Limitations:

Transition Setup covers the purchase of one-time, non-recurring expenses up to 30 days post-transition necessary for a member to establish a basic household as they transition from an institutional setting to a community setting, including basic kitchen supplies. Transition Setup expenses must not exceed $2,000 per eligible member. The Department may authorize additional funds above the $2,000 limit, not exceeding a total value of $2,500, when it is demonstrated as necessary to ensure the member's health, safety, and welfare. Transition Setup is not available when the person is moving to a provider-owned or - controlled setting.

☒ **Bedding and Furniture**

Description and Limitations:

Transition Setup covers the purchase of one-time, non-recurring expenses up to 30 days post-transition necessary for a member to establish a basic household as they transition from an institutional setting to a community setting, including bedding and furniture. Transition Setup expenses must not exceed $2,000 per eligible member. The Department may authorize additional funds above the $2,000 limit, not to exceed a total value of $2,500, when it is demonstrated as a necessary expense to ensure the health, safety, and welfare of the member. Transition Setup is not available when the person is moving to a provider-owned or - controlled setting.

☒ **Other Household Items**

Description and Limitations:

Transition Setup covers the purchase of one-time, non-recurring expenses up to 30 days post-transition necessary for a member to establish a basic household as they transition from an institutional setting to a community setting including other essential household furnishings required to occupy and use a community domicile, including window coverings, food preparation items, or bath linens. Transition Setup expenses must not exceed $2,000 per eligible member. The Department may authorize additional funds above the $2,000 limit, not to exceed a total value of $2,500, when it is demonstrated as a necessary expense to ensure the health, safety, and welfare of the member. Transition Setup is not available when the person is moving to a provider-owned or - controlled setting.

☒ **Other coverable necessities linked to an assessed need to enable transition from an institution to the community**

Description and Limitations:

Transition Setup covers the purchase of one-time, non-recurring expenses up to 30 days post-transition necessary for a member to establish a basic household as they transition from

an institutional setting to a community setting including expenses incurred directly from the moving, transport, provision, or assembly of household furnishings to the residence, as well as housing application fees and fees associated with obtaining legal and/or identification documents necessary for a housing application such as a birth certificate, state ID, or criminal background check. Transition Setup expenses must not exceed $2,000 per eligible member. The Department may authorize additional funds above the $2,000 limit, not to exceed a total value of $2,500, when it is demonstrated as a necessary expense to ensure the health, safety, and welfare of the member. Transition Setup is not available when the person is moving to a provider-owned or - controlled setting. Transition Setup may be authorized past 30 days on a case-by-case basis if there is a demonstrated need.

☒ **Goods and Services - Services or supports for a need identified in the individual's person-centered plan of services that increase an individual's independence or substitute for human assistance, to the extent that expenditures would otherwise be made for the human assistance. Include a service description including provider type and any limitations for each service provided.**

Home Delivered Meals

The Home Delivered Meals service includes:

- Meals and Nutritional Meal Plans
  - Meals and Nutritional Meal Plans may be tailored to the member's individual needs (including nutritional counseling, if desired by the member), selected meal types, and instructions for meal preparation and delivery.

Limitation/Exclusions

- Home Delivered Meals cannot be rendered when the member resides in or is moving to a provider-owned or controlled setting.
- Delivery must not constitute a full nutritional regimen and includes no more than two meals per day or 14 meals per week.
- Items or services through which the member's need for Home Delivered Meal services can otherwise be met, including any item or service available under the state plan, applicable HCBS waiver, or other resources are excluded.
- Meals not identified in the Nutritional Meal Plan or any item outside of the meals not identified in the meal plan, such as additional food items or cooking appliances are excluded.
- Meal plans and meals provided are reimbursable only when they benefit the member. Services provided to someone other than the member are not reimbursable.
- Home Delivered Meals may be authorized up to 365 days. Home Delivered Meals may be authorized past 365 days on a case-by-case basis if there is a demonstrated need.

Provider Type: Home-Delivered Meal Provider

☒ **License Required**
Providers must have a current license to operate a retail food establishment.

☐ **Certification Required. Describe:**
Click or tap here to enter text.

☐ **Education-Based Standard. Describe:**

Click or tap here to enter text.

☒ Other Qualifications Required for this Provider Type. Describe:

Providers must have an on-staff or contracted Registered Dietitian (RD) or Registered Dietitian Nutritionist (RDN). All provider types must accommodate for additional training identified through the Person-Centered Support Planning process by the member. All providers of Home Delivered Meals must be approved by the Department at time of initial application as a Medicaid Provider and sign the Department Provider Agreement.

Remote Supports

Remote Supports includes live two-way support from a remote location that increases the member's independence and substitutes for human assistance. Remote Supports is available to the member if they desire remote coaching, prompts, supervision, or consultation to perform certain tasks they identify during the Person-Centered Support Planning process. The goal of Remote Supports is to increase autonomy by providing the member an opportunity to build life skills through independent learning via cueing, coaching, and on-call support.

This service includes purchasing and maintaining technology equipment and training the member on using the equipment. The member must be able to initiate the service when needed and turn off the equipment when no longer needed.

Remote Supports does not replace informal or formal support but reduces the need for in-person human assistance at the member's discretion. Only the member may initiate live two-way interactions unless otherwise documented in the member's Person-Centered Support Plan. Video may only be used during live two-way support communications when the member chooses.

Provider Type: Remote Supports Provider

☐ License Required

Click or tap here to enter text.

☒ Certification Required. Describe:

The provider must meet the standards for a Certified Remote Supports Medicaid provider according to Department regulations and must receive the Department Remote Support Provider Training Completion Certificate.

☐ Education-Based Standard. Describe:

Click or tap here to enter text.

☒ **Other Qualifications Required for this Provider Type. Describe:**

All providers of Remote Supports must be approved by the Department at time of initial application as a Medicaid Provider and sign the Department Provider Agreement. All provider types must accommodate for additional training identified through the Person-Centered Support Planning process by the member.

Home and Community Based Settings

☒ **Each individual receiving CFC services and supports must reside in a home or community-based setting and receive CFC services in community settings that meet the requirements of 42 CFR 441.530**

Setting Types (check all that apply):

☐ **CFC services are only provided in private residences and are not provided in provider- owned or controlled settings.**
☒ **CFC services may be provided in private residences and in provider owned or controlled settings.**
☒ **The CFC benefit includes settings that have been determined home and community-based through the heightened scrutiny process.**

Provider-owned or controlled settings:

1. **Please identify all residential setting types in which an individual may receive services under the CFC benefit.**

Individuals may receive CFC in the following residential settings:

- Residential settings owned or leased by individuals receiving HCBS or their families (personal homes).
- Certified Foster Care Homes.

2. **Please identify all non-residential setting types in which a person may receive services under the CFC benefit.**

Individuals may receive CFC in the following non-residential settings:

- Physical locations that are nonresidential and not owned, leased, operated, or managed by an HCBS provider or by an independent contractor providing non-residential services. (Locations in the community where HCBS can be provided—examples include grocery stores, parks, and events).
- Day Habilitation settings for individuals with intellectual and developmental disabilities (IDD).
- Adult Day Services and Day Treatment settings for individuals with disabilities.

Setting Assurances- The state assures the following:

☒ **CFC services will be furnished to individuals who reside in a home or community setting, which does not include a nursing facility, institution for mental diseases, an intermediate care facility for individuals with intellectual disabilities, or a hospital providing long-term care services.**

☒ **Any permissible modifications of rights within a provider owned and controlled setting is incorporated into an individual's person-centered service plan and meets the requirements of 42 CFR 441.530(a)(vi)(F).**

Additional state assurances:

Click or tap here to enter text.

Community First Choice Support System, Assessment and Service Plan

Support System

☒ **The support system is provided in accordance with the requirements of §441.555. Provide a description of how the support system is implemented and identify the entity or entities responsible for performing support activities:**

Prior to enrolling in CFC, the support planner (case manager) provides information about CFC services and supports through the Person-Centered Support Planning process. This process includes providing information to the member regarding HCBS settings requirements and any assistance needed to make an informed choice about the program. The support planner (case manager) assists the member in establishing assessment and support plan scheduling and provides information about their rights and responsibilities regarding the assessment and support plan process, including steps to request changes in their Person-Centered Support Plan and explaining the grievance process.

Upon meeting Level of Care for CFC, the Needs Assessment is conducted,

and the Person-Centered Support Plan is developed in collaboration with the member, the member's authorized representative, or others who are important to the member. The support plan is a collaborative effort where the member leads the process and identifies personal goals and supports to help achieve those goals. The support planner (case manager) writes the support plan in a manner that reflects the member's own words wherever possible and allows the member to see documents and computer screens.

The Person-Centered Support Plan is used to address the member's needs, personal goals, preferences, unique strengths, abilities, desires, health and safety, and risk factors and strategies to mitigate identified risks. The plan establishes a personal safety and backup plan, including information on the responsibilities for reporting critical incidents and the method by which critical incidents are reported. The plan must also document decisions made through the service planning process including, but not limited to, rights modifications, the existence of appropriate services and supports and the actions necessary for the plan to be achieved. The plan requires documentation that the member has been offered a choice of services in the Home and Community-Based Services or institutional care, including service delivery options, and of qualified providers.

Members who are eligible and interested in participant directed service delivery models are informed of their options by the support planner (case manager) during the Person-Centered Support Planning phase. Additionally, the Department contracts with a Training and Support Contractor to further guide individuals through the various aspects of Colorado's participant directed service delivery models, including the attendant support management plan development process. The Training and Support Contractor works collaboratively with the Financial Management Services (FMS) vendors, support planning agencies (case management agencies), and the Department to ensure individuals are successful in their enrollment process.

Specify any tools or instruments used as part of the risk management system to identify and mitigate potential risks to the individual receiving CFC services:

Risks are assessed as part of the Person-Centered Support Planning with the member and are documented in the member's electronic record. Support planners (case managers) are required to provide members with all the choices available to the member for Long Term Care. The support planner

(case manager) discusses the possible risks associated with the member's choice of living arrangement with the member and/or guardian. The support planner (case manager) and the member then develop strategies for reducing these risks. Strategies for reducing these risks include developing backup plans. Back-up plans are designed to be person-centered and often include relying on the member's choice of family, friends, or neighbors to care for the member if a provider is unable to do so. Members may choose Personal Emergency Response System (PERS) for backup supports. For life or limb emergencies, members are instructed to call their emergency number (i.e. 911).

While HCPF does not require the use of a specified tool or instrument as part of the risk management system, HCPF requires Provider Agencies and support planning agencies (case management agencies) to develop written policies and procedures for the timely reporting, recording, and reviewing of incidents.

Critical incident categories that must be reported include but are not limited to: Injury/illness; mistreatment/abuse/neglect/exploitation; damage/theft of property; medication mismanagement; lost or missing person; criminal activity; unsafe housing/displacement; or death. Critical incidents are required to be reported by all providers. Oversight is provided by HCPF and/or the Departments of Public Health and Environment (CDPHE) and Human Services (DHS).

Critical incidents regarding allegations of abuse, neglect, and exploitation are to be reported immediately by support planners (case managers) to the protective services unit of the county department of social services in the individual's county of residence and/or local law enforcement agency as required by C.R.S. 26-3.1-102. Support planners (case managers) report critical incidents to Department staff using the Critical Incident Reporting System (CIRS) accessible through the State's case management IT system. The Department and the contract Quality Improvement Organization (QIO) review and track critical incident reports to ensure that a resolution is met, and the member's health and safety have been maintained. The QIO is responsible for managing the Critical Incident Reporting system for the 1915(k) benefit

The county departments of social services are also required to use the Colorado Adult Protective Services automated system to enter information on referrals, information and referral phone calls, and ongoing cases. DHS is responsible for the administration and oversight of the Adult Protection Program.

The Department's interagency agreement with CDPHE requires that the agency responds to and remediates quality of care complaints about services provided by Medicaid-certified home health agencies. Support planners (case managers) are

responsible for following up with appropriate individuals and/or agencies in the event any issues or complaints have been presented.

Depending on the type of risk at issue, a rights modification may be an appropriate way to mitigate the risk. HCPF codified rights modification requirements in state rules and regulations and published an informed consent template to ensure all criteria are documented. Under this codification, modifications to individual rights must be based on an individualized assessed need and comply with the federal requirements for documentation and due process, including obtaining the individual's informed consent.

Providers must ensure staff are trained on person-centeredness, person-centered practices, and dignity of risk. Compliance with this requirement is a requirement under current rules and regulations. In addition, support planning agencies (case management agencies) must ensure support planners (case managers) are trained on person-centered planning.

Provide a description of the conflict of interest standards that apply to all individuals and entities, public or private to ensure that a single entity doesn't provide the assessments of functional need and/or the person-centered service plan development process along with direct CFC service provision to the same individual:

Support planners (case managers) conduct the Needs Assessment and the Person-Centered Support Plan. The state assures that the individual conducting the Needs Assessment and Person-Centered Support Plan is not:

1. Related by blood or marriage to the participant, or to any paid caregiver of the individual,
2. Financially responsible for the individual,
3. Empowered to make financial or health-related decisions on behalf of the participant,
4. Individuals who would benefit financially from the provision of assessed needs and services,
5. Providers of state plan HCBS for the individual, or those who have an interest in or are employed by a provider of state plan HCBS for the individual, except when the State demonstrates that the only willing and qualified entity/entities to perform assessments of functional need and develop Person-Centered Support Plans in a geographic area also provides HCBS, and the State devises conflict of interest protections including separation of assessment/planning and HCBS provider functions within provider entities, which are described in the state plan, and individuals are provided with a clear and accessible

alternative dispute resolution process.

The state has created defined service areas where support planning agencies (case management agencies) provide service to all CFC members in their respective defined service areas. The establishment of defined service areas provide individuals seeking LTSS one place to obtain support planning (case management) services. Members have the option to request a change to their support planner (case manager) at the agency in which they are assigned. Members may also request an exception to be served by a support planning agency (case management agency) outside of their defined service area. When a member in a support planning agency's (case management agency's) defined service area requests to transfer to a support planning agency (case management agency) outside the member's defined service area, if approved, the support planning agencies (case management agencies) shall coordinate the transfer in accordance with state rules and regulations..

☒ **Conflict of Interest Exception: The only willing and qualified entity performing assessments of functional need and or developing the person-centered service plan also provide home and community-based services.**

Provide a description, including firewalls, to be implemented within the entity to protect against conflict of interest, such as separation of assessment and/or planning functions from direct service provision functions, and a description of the alternative dispute resolution process:

A support planning agency (case management agency) may be granted a conflict of interest waiver, known in Colorado as the Conflict-Free Case Management Waiver, by the Department to provide specific direct services within their defined service area to maintain eligible service providers in rural and frontier areas across Colorado. This waiver may only be granted if the state demonstrates that the only willing and qualified entity/entities to perform assessments of functional need and develop Person-Centered Support Plans in the geographic area also provides home and community-based services. The support planning agency (case management agency) shall submit a formal application for a Conflict-Free Case Management Waiver and shall receive formal notification from the Department via email of the receipt of the application within 10 business days. If the Conflict-Free Case Management Waiver application is approved, the Department will coordinate with the support planning agency (case management agency) for next steps in implementation and execution, if necessary. If the Conflict-Free Case Management Waiver application is denied, the Department will coordinate

with the support planning agency (case management agency) for a transition period within their contract period, if necessary.

When a support planning agency (case management agency) submits a waiver request to the Department, the support planning agency (case management agency) must provide the Department with the following information:

1. Specific service that is lacking in the support planning agency (case management agency) Defined Service Area.
2. Number of other providers available in the support planning agency (case management agency) Defined Service Area for this service.
3. Number of Medicaid members served by the support planning agency (case management agency) for this service.
4. If the lack of service is in a particular area, indicate the area and the number of members being served in that area.
5. Efforts the support planning agency (case management agency) has made to develop the service that is lacking.
6. Procedure the support planning agency (case management agency) follows to ensure the member has been offered a choice of providers.
7. Procedure the support planning agency (case management agency) uses to avoid any possible bias of using only the support planning agency (case management agency) when the service may be available from another provider agency.
8. Written documentation indicating Direct Service Provider functions and support planning agency (case management agency) functions are being administered separately.
9. Any other information the support planning agency (case management agency) may feel is pertinent to obtain a waiver.

When granted a waiver the support planning agency (case management agency) must provide the following:

1. Support planning agencies (case management agencies) that are granted a waiver to provide services must provide written notification to the member and/or guardian about the potential influence the support planning agency (case management agency) has on the support planning process (such as exercising free choice of providers, controlling the content of the Person-Centered Support Plan, including assessment of risk, services, frequency and duration, and informing the member of their rights).

2. The support planning agency (case management agency) must also provide the member and/or guardian written information about how to file a provider agency complaint as well as how to make a complaint against the support planning agency (case management agency).
3. Upon member and/or guardian request the support planning agency (case management agency) must provide an option for the member and/or guardian to choose a different entity or individual to develop the Person-Centered Support Plan. The support planning agency (case management agency) must also provide an option for the Person-Centered Support Plan to be monitored by a different support planning (case management) entity or individual.

The direct service provider functions and support planning agency (case management agency) functions must be administratively separated (including staff) with safeguards in place to ensure a distinction exists between direct services and support planning (case management). If a new service provider(s) becomes available in the area, the support planning agency (case management agency) may continue to provide direct services while the Department and the support planning agency (case management agency) support the alternate provider(s) in stabilizing and expanding to accommodate all needs in that service area. If other service providers are available in the area, the support planner (case manager) must document the offer of choice of provider in the Care and Case Management IT system. To ensure conflict of interest is being mitigated by the support planning agency (case management agency), the Department will conduct annual quality reviews that will include, but not be limited to, reviews of documentation of provider choice and informed consent for services.

Assessment of Need

Describe the assessment process or processes the state will use to obtain information concerning the individual's needs, strengths, preferences, and goals.

Following the Level of Care Screen, which collects information on Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) functioning, behavior needs, medical concerns, and other needs, support planners (case managers) conduct a Needs Assessment. The assessment supports a comprehensive, person-centered approach to the identification of a member's needs, preferences, and goals. The assessment also includes covering a set of life domains that critically affect independence and quality of life. The assessment informs the development of an individualized Person-Centered Support Plan by gathering specific information on personal goals, support needs, preferences for service delivery, and personal strengths. The assessment process also informs the assignment of individual budgets, and provides information critical to the provision of services, including accommodations needed, service intensity, staff competency, and member preferences.

☒ **The state will allow the use of telemedicine or other information technology medium in lieu of a face-to-face assessment in accordance with §441.535. The individual is provided with the opportunity for an in-person assessment in lieu of one performed via telemedicine. Include a description about how an individual receives appropriate support including access to on-site support staff during the assessment:**

Support planning agencies (case management agencies) may use phone or telehealth to complete the Level of Care Screen and Needs Assessment when there is a documented safety risk to the support planner (case manager) or member including public health emergencies as determined by state and federal government. To facilitate person-centered practices, support planning agencies (case management agencies) may use phone or telehealth to engage in the development and monitoring of the Person-Centered Support Plan based on the member's preference of engagement. The support planning agency (case management agency) and the support planner (case manager) must meet the same minimum qualifications required for all support planners (case managers). Members may utilize natural supports during the Level of Care Screen and Needs Assessment. Regardless of where the assessment takes place, the member is allowed to bring their own natural supports including, but not limited to, a translator or an advocate. The support planning agency (case management agency) must provide reasonable accommodations to meet the member's needs.

The state will claim costs associated with CFC assessment activities as:

☐ **A Medicaid Service**

☒ **An Administrative Activity**

Indicate who is responsible for completing the assessment prior to developing the CFC person-centered service plan. Also specify their qualifications:

☐ **Social Worker (specify qualifications)**
Click or tap here to enter text.

☐ **Registered Nurse, licensed to practice in the state, acting within scope of practice under state law.**

☐ **Licensed Practical Nurse or Vocational Nurse, acting within scope of practice under state law.**

☐ **Licensed Physician (M.D. or O.D.), acting within scope of practice under state law.**

☒**Case Manager (specify qualifications)**

The minimum qualifications for HCBS support planners (case managers) are:

1. A bachelor's degree; or
2. Five (5) years of experience in the field of Long-Term Support Services, 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 experience in one of the following areas:
    a. Long-Term 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/or
    b. Completed coursework and/or experience related to the type of administrative duties performed by support planners (case managers) may qualify for up to two (2) years of required relevant experience.

☐ **Other (specify what type of individual and their qualifications)**

Click or tap here to enter text.

The reassessment process is conducted every:

☒12 months

☐Other (must be in increments of time less than 12 months)
Click or tap here to enter text.

Describe the reassessment process the state will use when there is a significant change in the individual's needs or the individual requests a reassessment. Indicate if this process is conducted in the same manner and by the same entity as the initial assessment process or if different procedures are followed:

Support planners (case managers) are required to complete a reassessment of the Level of Care Screen for members within 12 months of the initial or previous assessment. A reassessment may be completed sooner if there is a significant change in the member's condition. The support planner (case manager) reviews the previous Level of Care Screen and Needs Assessments, with the member, and makes updates and/or changes as needed at reassessment. At both assessment and reassessment, a support planner (case manager) performs the following tasks:

1. Review Person-Centered Support Plan, service agreements, and provider contracts or agreements.
2. Evaluate effectiveness, appropriateness, and quality of services and supports.
3. Verify continuing Medicaid eligibility, and other financial and program eligibility.
4. Inform the individual's medical provider of any changes in the individual's needs.
5. Maintain appropriate documentation, including type and frequency of LTSS the individual is receiving for approval of continued program eligibility, if required by the program.
6. Refer the individual to community resources as needed and assist with the development of resources for the individual (within reason) if the resource is not available within the individual's community.
7. Submit appropriate documentation for authorization of services, in accordance with program requirements.

There is an attestation at the end of both the Level of Care Screen and the Needs Assessments to confirm that the support planner (case manager) reviewed and updated both in entirety, at reassessment and initial assessment.

Person-Centered Service Plan

The CFC service plan must be developed using a person-centered and person-directed planning process. This process is driven by the individual and includes people chosen by the individual to participate.

The state will claim costs associated with CFC person-centered planning process as:

☐ **A Medicaid Service**

☒ **An Administrative Activity**

Indicate who is responsible for completing the Community First Choice person-centered service plan.

☒ **Case Manager. Specify qualifications:**

The minimum qualifications for HCBS support planners (case managers) are:

1. A bachelor's degree; or
2. Five (5) years of experience in the field of Long-Term Services and Supports, which includes Developmental Disabilities; or
3. Some combination of education and relevant experience appropriate to the requirements of the position.
4. Relevant experience is defined as:
    a. Experience in one of the following areas: Long-Term 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 support planners (case managers) may qualify for up to two (2) years of required relevant experience.

☐ **Social Worker. Specify qualifications:**

Click or tap here to enter text.

☐ **Registered Nurse, licensed to practice in the state, acting within scope of practice under state law.**

☐ **Licensed Practical Nurse or Vocational Nurse, acting within scope of practice under state law. Licensed Physician (M.D. or O.D.), acting within scope of practice under state law.**

☐ **Other. Specify provider type and qualifications:**
Click or tap here to enter text.

Person-Centered Service Plan Development Process:

Use the section below to describe the process that is used to develop the person-centered service plan.

Specify the supports and information that are made available to the individual (and/or family or authorized representative, as appropriate) to direct and be actively engaged in the person-centered service plan development process and the individual's authority to determine who is included in the process:

The support planner (case manager) is required to develop the Person-Centered Support Plan at a time and location convenient for the member with the member and others chosen by the member. Members and legal representatives are informed they have the authority to select and invite individuals of their choice in the Person-Centered Support Planning process. The support planner (case manager) will complete the Person-Centered Support Plan, which utilizes person-centered philosophies and items, such as the optional Personal Story module, to allow the participant to direct the assessment and support planning processes to the extent possible and desired. The support planning process requires support planners (case managers) to provide the member with information about their rights and responsibilities regarding the assessment and support plan process. This includes information for the individual to request updates to the plan as needed, explanation of complaint procedures, critical incident procedures, and appeal processes.

The support planner (case manager) provides necessary information and support to ensure that the member directs the process to the maximum extent possible and is enabled to make informed choices and decisions. The support planner (case manager) writes the support plan in a manner that reflects the participant's own words wherever possible and allows the participant to see documents and computer screens so they can better understand what is being entered. The member may request updates to the plan as needed.

Indicate who develops the person-centered service plan. Identify what individuals, other than the individual receiving services or their authorized representative, are expected to participate in the person-centered service plan development process. Please explain how the state assures that the individual has the opportunity to include participants of their choice:

The support planner (case manager) develops the Person-Centered Support Plan with the member. The support planner (case manager) is required to develop the plan at a time and location convenient for the member, with the member, and others chosen by the member. The Person-Centered Support Plan must have a listing of the plan meeting participants and their relationship to the member. Members and legal representatives are informed they have the authority to select and invite individuals of their choice in the Person-Centered Support Planning process, however members are not required to invite any other individual if they choose.

Describe the timing of the person-centered service plan development to assure the individual has access to services as quickly as possible; describe how and when it is updated, including mechanisms to address changing circumstances and needs or at the request of the individual:

The Person-Centered Support Plan development and revision occurs no less than annually or as warranted by the member's needs or change in condition. The member may also request updates to the service plan as needed. The support planner (case manager) shall continually identify member's strengths, needs and preferences for services and supports as they change or as indicated by the occurrence of critical incidents. The Person-Centered Support Planning process immediately follows the eligibility determination process, using the Level of Care Screen, and the Needs Assessment. The support planning agency (case management agency) shall complete the Level of Care Screen within the following time frame: For an individual who is not being discharged from a hospital or a nursing facility, the individual assessment shall be completed and documented in the Department prescribed technology system within ten (10) working days after receiving confirmation that the Medicaid application has been received by the county department of social services.

Describe the state's expectations regarding the scheduling and location of meetings to accommodate individuals receiving services and how cultural considerations of the individual are reflected in the development of the person-centered service plan:

Support planners (case managers) are required to develop the service plan at times and locations chosen by the member. Support planners (case managers) are expected to reflect the cultural considerations of the individual and provide information in plain language and in a manner that is accessible to individuals with disabilities and individuals who have limited English proficiency. Support planning agencies (case management agencies) are required to take trainings on Disability and Cultural Competency and Equity, Diversity, Inclusion, and Accessibility (EDIA).

Training must ensure staff are culturally competent and provide culturally responsive services and business practices at all levels of the agency. HCPF's EDIA Officer and/or their designee will offer free EDIA-related professional development training to support planning agencies (case management agencies) upon request.

Describe how the service plan development process ensures that the person-centered service plan addresses the individual's goals, needs (including health care needs), and preferences and offers choices regarding the services and supports they receive and from whom. Please include a description of how the state records in the person-centered service plan the alternative home and community-based settings that were considered by the individual:

The Person-Centered Support Plan is required to address the individual's needs, personal goals, preferences, unique strengths, abilities, desires, health and safety, and risk factors. The process offers informed choices to the member regarding the services and supports they receive and from whom, as well as the documentation of services needed, including type of service, specific functions to be performed, duration and frequency of service, and type of provider. Through standard monitoring responsibilities, the support planner (case manager) shall assure the quality of services and supports in accordance with the Person-Centered Support Plan and make necessary adjustments to the plan as needed to meet member's goals, needs, and preferences. The plan must also document decisions made through the service planning process including, but not limited to, rights modifications, the existence of appropriate services and supports and the actions necessary for the plan to be achieved. The plan requires documentation that the member has been offered a choice of services in the Home and Community-Based Services or institutional care, including service delivery options, and of qualified providers.

Describe the strategies used for resolving conflict or disagreements within the process:

Support planning agencies (case management agencies) shall have procedures setting forth a process for the timely resolution of grievances or complaints. Use of the grievance procedure shall not prejudice the future provision of appropriate services or supports. The grievance procedure shall be provided, orally and in writing, to all members receiving services, the parents of a minor, guardian and/or authorized representative, as applicable, at the time of submission and at any time that changes to the procedure occur. The grievance procedure shall, at a minimum, include the following:

1. Contact information for a person within the support planning agency (case management agency) who will receive grievances.
2. Identification of support person(s) who can assist the member in submitting a grievance.
3. An opportunity to find a mutually acceptable solution. This could include the use of mediation if both parties voluntarily agree.
4. Timelines for resolving the grievance.
5. Consideration by the agency director or designee if the grievance cannot be resolved at a lower level.
6. Assurances that no member shall be coerced, intimidated, threatened, or retaliated against because the member has exercised his or her right to file a grievance or has participated in the grievance process.

Please describe how the person-centered service plan development process provides for the assignment of responsibilities for the development of the plan and to implement and monitor the plan.

support planners (case managers) are responsible for the Person-Centered Support Plan development and monitoring. The support planner (case manager) is required to explain the minimum monitoring requirements to the member during plan development, and all support planner (case manager) responsibilities are outlined in support planning agency (case management agency) contracts and state rules and regulations. The support planners (case managers) shall ensure that individuals obtain authorized services in accordance with their Person-Centered Support Plan and monitor the quality of the services and supports. The support planner (case manager) shall make necessary adjustments to the plan as needed to meet member's goals, needs, and preferences. Support planners (case managers) are required to conduct quarterly monitoring contacts with members regarding ongoing service needs and satisfaction with services. The member must be seen at the time of the initial evaluation and reevaluation to ensure that the member is in the home. The support planner (case manager) shall perform 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 support planner (case manager) shall

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. The support planner (case manager) shall perform three additional monitoring contacts each certification period either in-person, on the phone, or through other technological modalities based on the member's preference of engagement. Support planners (case managers) are also required to contact the member when significant changes occur in the member's physical or mental condition. The support planner (case manager) shall assure the health and welfare of the individual, and individual safety, satisfaction, and quality of life by monitoring service providers to ensure the appropriateness, timeliness, and number of services provided.

☒The state assures that assessment and service planning will be conducted according to 441.540(B) 1-12.

The person-centered service plan is reviewed and updated every:

☐ 3 months

☐ 6 months

☒ 12 months

☐ Other (must less than 12 months) Click or tap here to enter text.

AND

☒ When an individual's circumstances or needs change significantly or at the individuals request.

Describe the person-centered service plan review process the state will use. In the description please indicate if this process is conducted in the same manner and by the same entity as the initial service plan review process or if different procedures are followed:

The support planner (case manager) reviews the Level of Care and Person-Centered Support Plan with the member no less than annually at the time of their Continued Stay Review (CSR). The member may also request updates to the Person-Centered Support Plan as needed throughout the member's certification period. The support planner (case manager) shall continually identify member's strengths, needs and preferences for services and supports as they change or as indicated by the occurrence of critical incidents. If a new assessment is warranted, the support planner (case manager) follows the same procedure for the Level of Care and Person-Centered Support Plan as during the initial review. Upon Department approval, the CSR Level of Care screen may be completed by the support planner (case manager) at an alternate location from the member's place of residence or via the telephone for

situations where there is a documented safety risk to the support planner (case manager) or member. For the Person-Centered Support Plan process, members are given a choice of meeting locations or meeting via telephone or virtually.

Community First Choice Service Delivery Systems

Identify the service delivery system(s) that will be used for individuals receiving CFC services:

☒ **Traditional State-Managed Fee-for-Service (4.19(b) page is required**

☐ **Managed Care Organization**

☐ **Other Describe:**

Click or tap here to enter text.

Quality Assurance System

Please describe the state's quality improvement strategy:
The Department Quality Strategy outlined below encompasses all services provided in the 1915 (k) benefit.

System Improvements:
The Department draws from multiple sources when determining the need for and methods to accomplish system design changes. Data is collected on an ongoing and continuous basis from Colorado Department of Public Health and Environment (CDPHE), Critical Incident Reporting System (CIRS), annual programmatic and administrative evaluations, and stakeholder input. The Benefits and Services Management (BSM) Division in the Office of Community Living (OCL), in partnership with the Case Management Quality and Performance (CMQP) Division and Office of Information Technology (OIT), uses an interdisciplinary approach to review and monitor the system to determine the need for design changes including those to the State's case management IT system. Work groups form as necessary to discuss prioritization and selection of system design changes.

Discovery and Remediation Information:
The Department maintains oversight over the 1915 (k) benefit in its contracts or interagency agreements through tracking of contract deliverables on a monthly, quarterly, semi-annually, and yearly basis, depending on the details of each agreement. The Department has access to and reviews all required reports, documentation, and communications. Delegated responsibilities of these agencies and vendors are monitored, corrected, and remediated by the Department.

Colorado selects a random sample (unless otherwise noted in the application) of participants for annual review. The results obtained reflect the performance of the multi-layered system, ensuring systemic responsiveness for CFC and to the needs of all individuals served. The Department trends, prioritizes and implements system improvements (i.e. system design changes) warranted from the analysis of the discovery and remediation information gathered.

The support planning agencies (case management agencies) are required to use Department prescribed tools for Level of Care eligibility determinations, Person-Centered Support Planning, and critical incident reporting for the CFC population. Through use of the state's Care and Case Management IT System, the data generated from Level of Care eligibility determinations, Person-Centered Support Plans, and critical incident reports and their concomitant follow-up are electronically available to support planning agency (case management agency) and the Department allowing effective access and use for clinical and administrative functions as well as for system improvement activities. This standardization

and electronic availability provide comparability across support planning agencies (case management agencies) and facilitates ongoing analysis. The Department implemented a new case management system in July 2023 with the goal of streamlining processes for identifying member needs and coordinating support. This new system eliminates the need for support planners (case managers) to complete documentation in multiple systems which effectively reduces the chance for errors and/or missing information.

Service providers that are required by Medical Assistance Program regulations to be surveyed by the CDPHE, must complete the survey prior to certification ensuring compliance with licensing, qualification standards, and training requirements. The Department is provided with monthly and annual reports detailing the number and types of provider agencies that have been surveyed, the number of agencies that have deficiencies and types of deficiencies cited, the date deficiencies were corrected, as well as the number of provider complaints received, number investigated, number substantiated, and number resolved. Providers who are not in compliance with CDPHE and other state standards receive deficient practice citations. Department staff review all provider surveys to verify that deficiencies have been remediated and to identify patterns and/or problems on a statewide basis by service area. The results of these reviews assist the Department in determining providers' need for technical assistance, training resources, and other needed interventions.

The Department initiates termination of the provider agreement for any provider who is in violation of any applicable certification standard, licensure requirements, or provision of the provider agreement and who does not adequately respond to a plan of correction within the prescribed period of time. Following Medicaid provider certification, the fiscal agent enrolls all providers in accordance with program regulations and maintains provider enrollment information in Colorado's Medicaid Management Information System (MMIS), the interChange. All provider qualifications are verified by the fiscal agent upon initial enrollment and in a revalidation cycle; at least every five years.

The interChange is designed to meet federal certification requirements for claims processing and submitted claims are adjudicated against interChange edits prior to payment. Claims are submitted through the Department's fiscal agent for reimbursement. The Department also engages in a post-payment review of claims to ensure the integrity of provider billings. The information gathered from the Department's monitoring processes is used to determine areas that need additional training/technical assistance, system improvements, and quality improvement plans.

Trending:
The Department uses performance results to establish baseline data that undergoes trending and analysis over time. The Department's data aggregation and root cause analysis are incorporated into annual reports that provide information to identify aspects of the

system which require action or attention.

Prioritization:
The Department relies on a variety of resources to prioritize changes in the State's case management IT system. In addition to using information from annual reviews, analysis of performance measure data, and feedback from support planners (case managers), the Department factors in appropriation of funds, legislation, and federal mandates. For changes to the interChange, the Department has developed a Priority and Change Board that convenes monthly to review and prioritize system modifications and enhancements. Change requests are presented to the Board, which discusses the merits and risks of each proposal, then ranks it according to several factors including implementation dates, level of effort, required resources, code contention, contracting requirements, and risk. Change requests are tabled, sent to the fiscal agent for an order of magnitude, or cancelled. If an order of magnitude is requested, it is reviewed at the next scheduled Board meeting. If selected for continuance, the Board decides where in the priority list the project is ranked.

The Department continually works to enhance coordination with its sister agency, CDPHE. The Department engages in quarterly meetings with CDPHE to maintain oversight of delegated responsibilities - report findings and analysis, provider licensure/certification and surveys, provider investigations, corrective actions and follow-up. Documentation of inter-agency meeting minutes, decisions and agreements are maintained in accordance with state record maintenance protocol. Quality improvement activities and results are reviewed and analyzed amongst benefit administrators, support planning (case management) specialists, and critical incidents administrators.

Implementation:
Prior to implementation of a system-level improvement, the Department ensures the following are in place:

- Process to address the identified need for the system-level improvement,
- Policy and instructions to support the newly created process,
- Method to measure progress and monitor compliance with the system-level improvement activities including identifying the responsible parties,
- Communication plan,
- Evaluation plan to measure the success of the system-level improvement activities post- implementation, and
- Implementation strategy.

Describe the methods the state will use to continuously monitor the health and welfare of each individual who receives home and community-based attendant services and supports, including a process for the mandatory reporting,

investigation, and resolution of allegations of neglect, abuse, or exploitation in connection with the provision of such services and supports:

Support planners (case managers) are required to conduct quarterly monitoring with participants. The quarterly monitoring with participants can be conducted in-person or virtually. Support planners (case managers) verify with individuals and provider agencies to ensure services are delivered in accordance with the Person-Centered Support Plan. The quarterly monitoring requires that support planners (case managers) monitor the access to services, if services are meeting the individual's needs, the use of the contingency plan, health and safety, and follow-up to any critical incident reports. Critical incidents are those incidents that create the risk of serious harm to the health or welfare of an individual receiving services and may endanger or negatively impact the mental and/or physical well-being of an individual. Critical incident categories that must be reported include but are not limited to: Injury/illness; mistreatment/abuse/neglect/exploitation; damage/theft of property; medication mismanagement; lost or missing person; criminal activity; unsafe housing/displacement; or death.

Critical incidents are required to be reported by all providers. Oversight is provided by the Department, CDPHE, and the Department of Human Services (DHS).

Critical incidents regarding allegations of abuse, neglect, and exploitation, are to be reported immediately by support planners (case managers) to the protective services unit of the county department of social services in the individual's county of residence and/or local law enforcement agency as required by C.R.S. 26-3.1-102. In addition, critical incidents are required to be reported to the Department within 24 hours by the support planner (case manager). Support planners (case managers) report critical incidents to Department staff using the Critical Incident Reporting System (CIRS) accessible through the state's case management IT system.

The county departments of social services are also required to use the Colorado Adult Protective Services automated system to enter information on referrals, information and referral phone calls, and ongoing cases. DHS is responsible for the administration and oversight of the Adult Protection Program.

The Department requires that provider agencies respond to and remediates quality of care complaints about services provided. Support planners (case managers) are responsible for following up with appropriate individuals and/or agencies in the event any issues or complaints have been presented. Each member and/or legal guardian is informed at the time of initial assessment and reassessment to notify the support planner (case manager) if there are changes in the care needs and/or problems with services.

The Department and the contract Quality Improvement Organization (QIO) review and track critical incident reports to ensure that a resolution is met, and the member's health

and safety have been maintained. The QIO is responsible for managing the Critical Incident Reporting system for the 1915(k) benefit. The QIO assesses the appropriateness of both the provider and support planning agencies (case management agencies) response to critical incidents, gathers, aggregates, and analyzes the critical incident report (CIR) data, and ensures that appropriate follow-up for each incident is completed. The QIO also supports Office of Community Living (OCL) in the analysis of CIR data, understanding the root cause of identified issues, and providing recommendations for changes in the reporting system and other protocols aimed at reducing/preventing the occurrence of future critical incidents. The QIO conducts desk reviews of case files from support planning agencies (case management agencies).

Describe how the state measures individual outcomes associated with the receipt of home and community-based attendant services and supports as set forth in the person-centered service plan, particularly for the health and welfare of individuals receiving such services and supports. (These measures must be reported to CMS upon request.)

support planners (case managers) are required to conduct quarterly monitoring with participants. The monitoring includes verifying that services are furnished in accordance with the service plan. The case management system for Prior Authorization (PAR) development and submission allows support planners (case managers) to see the unit decrement on the PAR. Additionally, support planners (case managers) verify with individuals and provider agencies to ensure services are delivered in accordance with the Person-Centered Support Plan. The quarterly monitoring requires that support planners (case managers) monitor the access to services, if services are meeting the individual's needs, the use of the contingency plan, health and safety, and follow-up to any critical incident reports. The Department collects performance measures, including health and welfare performance indicators, utilizing data collected directly from members after the support planning process. These measures help the Department monitor the member's experience and outcomes with services and the support planning process. Colorado is a Money Follows the Person (MFP) grantee state and as such, the Department will be required to report on the HCBS Quality Measure set for CFC starting in 2025. The HCBS Quality Measure set includes measures derived from experience of care surveys. Colorado will use the National Core Indicator-Aging and Disabilities (NCI-AD) and the National Core Indicators-Intellectual and Developmental Disabilities (NCI-IDD) surveys to assess the experience of care of the groups included in CFC.

Describe the standards for all service delivery models for training, procedures appeals for denials and reconsideration for an individual's person-centered service plan:

Training:
Members are first informed that they have a choice of how they receive services, either through an agency-based model or through a participant-directed model. If a member chooses a participant directed model, members and/or authorized representatives will access supportive training based on the philosophy and responsibilities of participant-directed care. Members who choose an agency-based delivery model will be offered training via different methods such as one-on-one, group, and self-paced through virtual and in-person formats. The same type of content is covered in this training as is covered in the Fiscal Employer Agent model training with relevant changes for addressing the differences within agency-based delivery model rules, regulations, and procedures. At a minimum, this training includes: members or their authorized representative are informed of the ability to choose a provider, an overview of the program, member and/or authorized representative rights and responsibilities, planning and organizing attendant services, managing personnel issues, communication skills, recognizing and recruiting quality attendant support, managing health, accessing resources, safety and prevention strategies, and managing emergencies. If the member utilizes the self-direction with service budget model, they will also be trained on allocation budgeting and working with the Financial Management Services vendor.

Denials and Reconsiderations Procedures:
Members who have a dispute regarding their assessed service needs have the ability to initiate an appeal before an Administrative Law Judge. The support planning agency (case management agency) shall provide the member with a Long-Term Care Waiver Program Notice of Action (LTC 803) to inform the member of their appeal rights in accordance with state rules and regulations.

A member has the right to request a review of their assessed service needs identified in their assessment at any time through their support planner (case manager). If the member and/or authorized representative report a change which requires a modification to the member's Person-Centered Support Plan, the support planner (case manager) performs a reassessment.

Describe the methods used to monitor provider qualifications:
Providers interested in providing services that require licensing or certification to Colorado Medicaid members must obtain certification from the Department. Licensing and certification are obtained by a provider after undergoing a survey by CDPHE. CDPHE will recommend a provider for Medicaid certification after the provider has successfully completed a survey. The Department will review the recommendation by CDPHE and either certify the provider or ask that the provider improve the conformance to rules and/or regulations before certifying the provider. Service types that do not require licensure are not required to complete a CDPHE survey and obtain certification directly from the

Department. All provider qualifications, including those types not requiring CDPHE license or recommendation, are verified by the fiscal agent upon initial enrollment and in a revalidation cycle; at least every five years. Data reports verifying non-surveyed providers continually meet CFC requirements are maintained by the Department's provider enrollment compliance staff.

The Department currently reviews provider qualifications for desired HCBS services to furnish at the time of initial application to become a Medicaid-enrolled provider and then every five years through provider re-validation. Review includes confirmation of any and all licenses, certificates, or other standards required to furnish desired service at time of initial Medicaid provider enrollment and any service specific provider requirements.

The CDPHE interagency agreement (IA) is to manage aspects of provider qualifications, surveys, complaints and critical incidents for provider types that require CDPHE licensing or certification. The IA requires monthly and annual reports detailing number and types of agencies surveyed, the number of agencies with deficiencies, types of deficiencies cited, date deficiencies were corrected, number of complaints received, investigated, and substantiated. Oversight is through monthly meetings and reports. Issues that impact the agreement, problems discovered at specific agencies or widespread issues and solutions are discussed. Oversight is provided by the Department, CDPHE, and/or DHS. The response to a critical incident is unique to the type of incident and the parties involved. However, the Department and/or the contract Quality Improvement Organization (QIO) vendor reviews all critical incidents. Critical Incidents involving providers surveyed by CDPHE which meet occurrence reporting criteria must be reported to the Department and CDPHE and are responded to by CDPHE.

Providers of HCBS services that require CDPHE survey are surveyed at a minimum every 36.9 months. Risk-based surveys may occur more often if a credible complaint is received by CDPHE. Credible complaints are ones that are validated; when investigated they have not been found to be fabricated allegations or misinterpreted impressions of something that did not occur. If during the investigation of a complaint by CDPHE, the findings are severe (i.e., a systemic failure, patient harm, etc.) it may trigger the investigation to be converted to a full survey at the time the investigation is underway. The findings of the investigation may be grounds for CDPHE to initiate a full recertification survey of the provider agency regardless of the date of the last survey.

Describe the methods for assuring that individuals are given a choice between institutional and community-based services:

Support planning agency (case management agency) responsibilities include informing the participant or their legally authorized representative (e.g., parents of a minor, guardian if within the scope of the guardianship order)

during intake and the annual Person-Centered Support Planning process of the freedom of choice between institutional and Home and Community-Based Service and service options to inform that choice. A signature from the participant or their legally authorized representative is required on the state's designated form confirming this informed choice.

Describe the methods for assuring that individuals are given a choice of services, supports and providers:

Each support planning agency (case management agency) is required to provide members with a free choice of willing and qualified providers. Support planning agencies (case management agencies) have developed individual methods for providing choice to their members in regards to services and service-delivery models. An example of these methods includes providing each member list of providers for all services they are eligible to receive. The list includes provider type, location, etc. To ensure that members continue to exercise free choice of providers, the Department has added a signature section to the Person-Centered Support Plan that allows members to indicate whether they have been provided with free choice of providers.

Describe the methods for monitoring that the services and supports provided to each individual are appropriate:

Upon initial enrollment and annually thereafter, a Long-Term Care Level of Care Eligibility Determination Screen (an assessment required to be conducted in-person) is completed, the Needs Assessment is conducted, and Person-Centered Support Plan is developed. Thereafter, support planners (case managers) conduct quarterly monitoring contacts during the member's annual certification period. These contacts include monitoring the delivery and quality of services and supports identified in the Person-Centered Support Plan including ensuring that services are delivered in accordance with the scope, frequency, and duration documented. These monitoring contacts do not include the initial Level of Care Screen, Needs Assessment, and Person-Centered Support Planning contacts, or the subsequent annual reassessment and Person-Centered Support Planning contacts for upcoming certification periods. The monitoring contacts are intended to monitor service delivery, health, and welfare. An in-person monitoring contact is required at least one (1) time during the Long-Term Care certification period. The support planner (case manager) shall 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 service provision. Upon Department approval in advance, this contact may be completed by the support planner (case manager) at an alternate location, via the telephone, or using a virtual technology method. Such approval may be granted for situations in which in-person face-to-face meetings would pose a documented safety risk to the support planner (case manager) or member (e.g. natural disaster, pandemic, etc.). The support planner (case manager) shall perform three additional monitoring contacts each certification period either in-person, on the phone, or through other technological modalities based on the member's preference of engagement.

The monitoring contacts include:

- The evaluation and assessment strategies for meeting the needs, preferences, and goals of the member.
- Evaluating and obtaining information concerning the member's satisfaction with the services, the effectiveness of services being provided, an informal assessment of changes in the member's function, service appropriateness, and service cost-effectiveness.
- Monitoring the health, safety, and welfare of members, including the provider agencies' procedures to address the member's needs.
- Evaluating the member's satisfaction with services and choice in providers.
- Ensuring that services are delivered in a way that promotes a member's ability to engage in self-determination, self-representation, and self-advocacy.
- Support planners (case managers) shall contact the provider agency to

coordinate, arrange, or adjust services to address and resolve quality issues or concerns.

- Support planners (case managers) shall monitor the effectiveness of services. If a member isn't getting the help they need, then the support planner (case manager) will work with the member to find solutions.

The Person-Centered Support Plan is required to address the individual's needs, personal goals, preferences, unique strengths, abilities, desires, health and safety, and risk factors. The plan must also document decisions made through the service planning process including, but not limited to, rights modifications, the existence of appropriate services and supports and the actions necessary for the plan to be achieved. The plan requires documentation that the member has been offered a choice of HCBS services or institutional care, including service delivery options, and of qualified providers.

Describe the state process for ongoing monitoring of compliance with the home and community-based setting requirements, including systemic oversight and individual outcomes:

The ongoing monitoring process includes the following initiatives:

- Including HCBS Settings Final Rule-related performance measures regarding rights modifications within the quality improvement system (QIS).
- Developing process(es) for support planners (case managers) to confirm with individuals that the settings at which they receive services are compliant.
- Ensuring that settings are monitored by state agencies for compliance with HCBS Settings Final Rule criteria. Specifically, the Colorado Department of Public Health & Environment (CDPHE) cross-trained its survey staff on HCBS Settings Final Rule criteria so that they could address these criteria as part of new provider enrollment as well as routine quality assurance surveys. Regarding such surveys:
    - Under an Interagency Agreement (IA) between the Department and CDPHE, CDPHE surveys prospective HCBS providers before it recommends them to HCPF for certification as Medicaid HCBS providers. As relevant to CFC, provider types subject to certification include adult day programs, program approved service agencies (PASAs), and home care agencies (HCAs) (providing Personal Care, Homemaker, etc.). These initial certification surveys, along with routine quality assurance surveys, address initial and ongoing compliance with the HCBS Settings Final Rule (for Medicaid-certified settings). Settings such as Adult Day Service centers that operate exclusively on a private-pay basis are not covered by this process.)

- Similarly, under an IA between the Department and CDHS, CDHS surveys Certified Foster Care Homes for children, to confirm their compliance with the applicable regulations. CDHS is responsible for monitoring compliance of Certified Foster Care Homes with HCBS Settings requirements. CDHS's regulations for providers cross-reference HCPF's, which in turn now include the HCBS Settings Final Rule. (If included in the first bullet point above, certain providers may instead be surveyed by CDPHE.)

- Identifying and publicizing process(es) for CFC participants, support planners (case managers), and others to report potential violations of HCBS Settings Final Rule criteria. The Department has added a dedicated "Ask a Question/Report a Concern" section to its HCBS Settings Final Rule website and explained how individuals can report concerns as part of videos and resource sheets for participants on their rights and the rights modification process.

- Monitoring data from member experience surveys related to outcomes relevant under the HCBS Settings Final Rule.

ii. Frequency of monitoring efforts

- Performance measures are assessed annually.

- To support compliance with the HCBS Settings Final Rule, support planners (case managers)assess the adequacy of information supporting a proposed rights modification before they discuss the proposal with the individual, obtain informed consent, and enter that information into the case management system. This happens for all new rights modifications as they are implemented and for all continuing modifications as they come up for review/renewal. By rule, when a right has been modified, the continuing need for such modification is reviewed by the individual's Member Identified Team, as led by the individual or their guardian or other legally authorized representative, at a frequency decided by the team, but at least every six months. This review includes the original reason for modification, current circumstances, success or failure of programmatic intervention, and the need for continued modification. If the six-month review indicates that changes are needed to the Rights Modification, the support planner (case manager) obtains a new signature on an updated Informed Consent form. If the six-month review indicates that no changes are needed, then the original signature is still valid for the remaining period (up to six months).

  An additional tool to support support planners (case managers) in identifying broader compliance issues at HCBS settings (beyond just rights modification concerns), the Ongoing Monitoring Guide, has been developed and is being finalized. Support planners (case managers) will be asked to use this tool during quarterly case

management monitoring contacts. The guide will help support planners (case managers) spot potential issues of concern and reinforce the process for escalating issues as needed. HCPF paused the release of this guide to prevent support planners (case managers) from becoming overwhelmed in the context of the PHE unwind and related eligibility determination difficulties, case management redesign, and the rollout of the new Care and Case Management IT System. HCPF currently plans to release the guide early in the current state fiscal year, which began on July 1, 2024.

- State agency monitoring: in addition to initial surveys as described above, CDPHE routinely surveys provider types subject to (re)certification (see list above) on a three-year cycle. Recertification surveys include visiting private homes where individuals receive Individual Residential Services and Supports (IRSS). Recertification surveys address compliance with the HCBS Settings Final Rule. Additionally, CDHS annually resurveys CHRP residential habilitation providers, including Certified Foster Care Homes, to confirm their compliance with the applicable regulations.

- Stakeholder reporting of potential violations occurs on an as-needed basis.

- Member experience surveys occur at different times, depending on the survey. The Individual/Family/Advocate (IFA) Survey, which was specific to the HCBS Settings Final Rule, was just closed in early September 2024. When the survey was still open, it could be completed as often as desired.

iii. Summary of findings

- Performance measures are collected and shared with support planning agencies (case management agencies) through annual quality improvement strategies. This includes findings related to compliance with the performance measures regarding rights modifications under the HCBS Settings Final Rule. If a support planning agency (case management agency) is below 86%, it is put on a CAP.

- The Ongoing Monitoring Guide is not yet rolled out, so there are no findings to summarize. Once available to support planners (case managers) for use during quarterly monitoring contacts, it is expected to help ensure that even settings excluded from the CDPHE/IA survey processes still experience ongoing monitoring and oversight.

- Providers are required to submit a Plan of Correction to CDPHE for deficiencies.

- The Department hears from advocates, support planning agencies (case management agencies), and/or providers with questions or concerns that are addressed when raised.

- Reporting on member experience surveys depends on the survey. Reports on and analysis of IFA Survey responses were previously available on the Department's website, and are available upon request. Updated reporting on that particular survey was disrupted by the pandemic, and the survey had little in the way of ongoing uptake/responses before it was closed in September 2024.

iv. Activities to address findings—(e.g. quality improvement plans and/or corrective action plans including temporary or provisional licensure or certification).

- Deficiencies in performance on QIS measures are addressed as negotiated with CMS. Approaches to remediation may include a continuous quality improvement plan to correct identified issues.

- The Department may implement corrective action plans with support planning agencies (case management agencies) if needed.

- When CDPHE identifies deficiencies in the course of surveys, it ordinarily offers the provider an opportunity to remedy the deficiencies pursuant to a Plan of Correction. If that process proves unsuccessful, CDPHE recommends decertification to HCPF. The process that CDHS follows as to foster care homes is similar.

- The Department's response to stakeholder concerns depends on the nature of the concern. Department staff may directly contact the provider or support planning agency (case management agency) to correct the noncompliance, and/or file a complaint with CDPHE to initiate an investigation and possible enforcement action. If on review, the concern does not involve noncompliance with the HCBS Settings Final Rule, the Department may refer the concern elsewhere and/or seek to educate the stakeholder on what the rule does and does not require. Finally, for recurring concerns, statewide training of providers and/or c support planning agencies (case management agencies), as well as development of additional resources for members, may be warranted.

- Survey responses identifiable to specific providers/settings or support planning agencies (case management agencies) have been addressed through CDPHE investigation work and technical assistance, outreach to support planning agencies (case management agencies), and other measures, depending on the type of concern.

Choice and Control

Describe the quality assurance system's methods to (1) maximize consumer independence and control,

(2) provide information about the provisions of quality improvement to each individual receiving CFC services and supports:

Each support planning agency (case management agency) is required to provide members with a free choice of willing and qualified providers. support planning agencies (case management agencies) have developed individual methods for providing choice to their members in regards to services and service-delivery models. In order to ensure that members continue to exercise free choice of providers, the Department has added a signature section to the Person-Centered Support Plan that allows members to indicate whether they have been provided with free choice of providers. As part of the state's Quality Assurance strategy, the Department reviews data collected on members in a representative sample whose Person-Centered Support Plan documents a choice between and among HCBS services and qualified service providers. Regulatory and contractual requirements of support planning agencies (case management agencies) identify that members seeking and receiving services have autonomy and self-direction throughout the support planning processes. Development of the state's case management system was designed to have several areas that document that these practices are applied. Those specific documented areas in the case management system will be used to monitor compliance.

After the development of the Needs Assessment and Person-Centered Support Plan, the support planners (case managers) conduct quarterly monitoring contacts during the member's certification period. These contacts include monitoring the delivery and quality of services and supports identified in the Person-Centered Support Plan including ensuring that services are delivered in accordance with the scope, frequency, and duration documented. These monitoring contacts are separate from the initial Level of Care function assessment, Needs Assessment, and Person-Centered Support Planning meeting(s), as well as the Continued Stay Review meeting (required annually or once during the certification period) where the support planner (case manager) reviews these assessments more formally with the member to determine any changes necessary for the upcoming certification period.

The support planner (case manager) may meet the member at the residence, monitoring service delivery, health, and welfare. An in-person monitoring contact is required at least one (1) time during the Person-Centered Support Plan certification period. The support planner (case manager) shall 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. Upon Department approval in advance, this contact may be completed by the support planner (case manager) at an alternate location, via the telephone, or using a virtual technology method. Such approval may be granted for situations in which in-person face-to-face meetings would pose a documented safety risk to the support planner (case manager) or member (e.g.

natural disaster, pandemic, etc.). The support planner (case manager)shall perform three additional monitoring contacts each certification period either in-person, on the phone, or through other technological modalities based on the member's preference of engagement.

The monitoring contacts also include:

- The evaluation and assessment strategies for meeting the needs, preferences, and goals of the member.
- Evaluating and obtaining information concerning the member's satisfaction with the services, the effectiveness of services being provided, an informal assessment of changes in the member's function, service appropriateness, and service cost-effectiveness.
- Monitoring the health, safety, and welfare of members, including the provider agencies' procedures to address the member's needs.
- Evaluating the member's satisfaction with services and choice in providers.
- Ensuring that services are delivered in a way that promotes a member's ability to engage in self-determination, self-representation, and self-advocacy.
- Support Planner (Case Manager) shall contact the provider agency to coordinate, arrange, or adjust services to address and resolve quality issues or concerns.

The Person-Centered Support Plan is required to address the individual's needs, personal goals, preferences, unique strengths, abilities, desires, health and safety, and risk factors. The plan must also document decisions made through the service planning process including, but not limited to, rights modifications, the existence of appropriate services and supports, and the actions necessary for the plan to be achieved. The plan requires documentation that the member has been offered a choice of services in the home and community-based settings or institutional care, including service delivery options, and of qualified providers.

The Department performs monitoring of the support planning agency (case management agency) and the Department's support planning agency (case management agency) reviewers survey a random sample of members records. Included in the record review is an examination of the LTC 803 Form(s) to ensure that each support planning agency (case management agency) is using the approved form to convey information to the member on fair hearing rights. The Department monitors also have access to the state's case management IT system which allows them to review LTC 803 forms as reviewers receive individual complaints.

Stakeholder Feedback

Describe how the state will elicit feedback from key stakeholders to improve the quality of the community-based attendant services and supports benefit:

The Department elicits and incorporates stakeholder feedback into its quality improvement strategy in the following ways:

1. The Department will hold Community First Choice Council (CFCC) meetings regularly to elicit feedback from individuals with disabilities, older adults, and their advocates on the quality of the CFC community-based services and supports. The CFCC also serves as a way for the Department to present to members information about CFC, its services, and any improvements that are underway.
2. The Department will continue to regularly outreach specific communities and populations historically underrepresented in stakeholder engagement in Colorado. The Department will elicit feedback from these communities as well as present information and updates about CFC.
3. The Department will continue to attend meetings held by associations, advocacy groups, and other stakeholder groups, such as the Participant Directed Programs Policy Collaborative, to elicit feedback and present information.
4. The Department will continue to update information about CFC on the program website and will ensure the CFC email address and phone line for members to provide feedback are easily accessible on the website.
5. The Department will continue to hold webinars and community forums when major changes are under consideration or are in the process of implementation.

Identify the stakeholders from whom the state will elicit feedback:

☒ **The state will elicit feedback from the following stakeholders: (1) Individuals receiving CFC services and if applicable, their representatives, (2) disability organizations, (3) providers, (4) families of elderly individuals or individuals with disabilities, (5) and members of the community**

☐ **Other Describe:**

Click or tap here to enter text.

State Assurances

☒ The state assures there are necessary safeguards in place to protect the health and welfare of individuals provided services under this state plan option, and to assure financial accountability for funds expended for CFC services.

☒ With respect to expenditures during the first full year in which the state plan amendment is implemented, the state will maintain or exceed the level of state expenditures for home and community-based attendant services and supports provided under section 1905(a), section 1915, section 1115, or otherwise to individuals with disabilities or elderly individuals attributable to the preceding year.

☒ The state assures the collection and reporting of information, including data regarding how the state provides home and community-based attendant services and supports and other home and community-based services, the cost of such services and supports, and how the state provides individuals with disabilities who otherwise qualify for institutional care under the state plan or under a waiver the choice to instead receive home and community-based services in lieu of institutional care, and the impact of CFC on the physical and emotional health of individuals.

☒ The state shall provide the Secretary with the following information regarding the provision of home and community-based attendant services and supports under this subsection for each fiscal year such services and supports are provided:

(i) The number of individuals who are estimated to receive home and community-based attendant services and supports under this option during the fiscal year.

(ii) The number of individuals that received such services and supports during the preceding fiscal year.

(iii) The specific number of individuals served by type of disability, age, gender, education level, and employment status.

(iv) Whether the specific individuals have been previously served under any other home and community based services program under the state plan or under a waiver.

☒ **The state assures that home and community-based attendant services and supports are provided in accordance with the requirements of the Fair Labor Standards Act of 1938 and applicable Federal and state laws.**

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

29. Community First Choice (CFC)

Payment for Colorado's Community First Choice (CFC) services is based on state developed fee schedule rates, which are the same for both governmental and private providers of services. The fee schedule and any annual/periodic adjustments to the fee schedule and its effective dates are included in the fee schedule. Fee for Service (FFS) rates and fee schedules can be accessed here:
https://hcpf.colorado.gov/provider-rates-fee-schedule

The Department utilizes three different rate methodologies for select services included in Colorado's CFC Benefit. These three methodologies include: a Cost-Based Rate Methodology, a Market Price Rate Methodology and a Contracted Services Rate Methodology.

1. Cost-Based Rate Methodology:

The Cost-Based Rate methodology is calculated from the following factors:

- Salary expenses account for direct and indirect care workers' time for service delivery based on the Colorado mean wage for each position as established by the Bureau of Labor Statistics.
- Facility expenses incorporate costs associated with the facility type via property records listing square footage and actual costs and include estimated repair and maintenance costs, utility expenses, phone, and internet expenses.
- Administrative expenses incorporate computer, software, office supply costs, and the total number of employees to determine administrative and operating costs per employee.
- Capital expenses account for additional capital expenses such as medical equipment, supplies, and IT equipment directly related to service provision.
- The state accounts for variances in minimum wage requirements as directed by the State Legislation or local ordinances to acknowledge unique geographical considerations impacting access to care.
- The state accounts for variances in provider qualifications, administrative requirements such as payroll, and recertification requirements to acknowledge unique financial considerations impacting access to control over care.
- Effective for services provided on or after July 1, 2025, after the implementation of the rate, only legislative increases or decreases are

applied. These legislative rate changes are often annual and reflect inflationary increases or decreases.

- The Department hosts stakeholder feedback meetings in which the rates and rate determination factors are presented to external stakeholders such as providers, members, and member advocacy groups.

Each of the following CFC Services utilize Cost-Based Rate Methodology to develop individual rates unique to the service:

- Personal Attendant Services
  - Services provided to an eligible member to meet the member's physical, maintenance, and supportive needs through hands-on assistance, supervision and/or cueing.
- Homemaker
  - General household activities provided by a provider in a member's home to maintain a healthy and safe environment for the member through hands-on assistance, supervision and/or cueing.
- Health Maintenance
  - Activities include routine and repetitive health related tasks furnished to an eligible member in the community or in the member's home, which is necessary for health and normal bodily functioning that a person with a disability is physically unable to carry out.
- Home Delivered Meals
  - Nutritional Meal Plan which is tailored to the member's individual needs (including nutritional counseling, if desired by the member), selected meal types, and instructions for meal preparation and delivery.
- Transition Setup
  - Covers the purchase of one-time, non-recurring expenses up to 30 days post-transition necessary for a member to establish a basic household as they transition from an institutional setting to a community setting, including security deposits required to obtain a lease on an apartment or home.

Fee schedules can be accessed here: https://hcpf.colorado.gov/provider-rates-fee-schedule

2. Market Price Rate Methodology:

The Market Price Rate Methodology is calculated from the following factors:

- Case managers coordinate with providers and determine a market price that incorporates the member's needs, the products required, and frequency of use. The Department reviews and approves the market price determined and authorized by the case manager.

The following CFC Services utilize a Market Price Methodology:

- Personal Emergency Response Systems (PERS)
  - Ongoing remote monitoring through a device designed to signal trained alarm monitoring personnel in an emergency situation.
- Medication Reminder
  - Devices, controls, or appliances that remind or signal the member to take actions related to medications.
- Remote Supports Technology
  - Live two-way support from a remote location that increases the member's independence and substitutes for human assistance.

3. Contracted Services Rate Methodology

The Contracted Rate methodology is calculated from the following factors:

- Salary expenses account for direct and indirect staff time for performance of contract obligations based on the Occupational and Wage Statistics for each position as established by the Bureau of Labor Statistics.
- Facility expenses incorporate costs associated with the facility type via property records listing square footage and actual costs and include estimated repair and maintenance costs, utility expenses, phone, and internet expenses.
- Administrative expenses incorporate computer, software, office supply costs, and the total number of employees to determine administrative and operating costs per employee.
- Capital expenses account for additional capital expenses such as secure file transfer protocol and customer management/relationship systems, supplies, and IT equipment directly related to service provision.
- The state accounts for variances in provider qualifications, administrative requirements such as payroll, and certification requirements to acknowledge unique financial considerations impacting provision of services.

- For Financial Management Services (FMS), vendors are paid a per-member-per-month (PMPM) rate for their fiscal and administrative services provided to Consumer-Directed Attendant Support Services (CDASS) members.
- The Department uses a request for proposal solicitation process to procure FMS.
- The PMPM rate is based on the costs associated with the scope of work and national averages for FMS using a Fiscal/Employer Agent (F/EA) model.

The following CFC Services utilize a Contracted Services Rate Methodology:

- Financial Management Services
    - Administrative and financial services including but not limited to recording, monitoring, and reporting budget allocations and utilization; calculating employer and employee taxes and filing applicable returns; processing attendant timesheets; paying attendants; running attendant background checks; and providing compliant EVV systems for member and/or attendant use.

Rates Community First Choice (CFC) services do not include payment for room and board.

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

Effective Dates for Reimbursement Rates for Specified Services

Reimbursement rates for the services listed below on this Attachment 4.19-B introduction page are effective for services provided on or after the corresponding effective date. All payment rates can be found on the official website of the Department of Health Care Policy and Financing at https://www.colorado.gov/hcpf/provider-rates-fee-schedule

Service	Attachment	Effective Date
3. Laboratory and Radiology Services	Attachment 4.19-B	July 1, 2024
4.b. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services	Attachment 4.19-B, Page 1 of 1	July 1, 2024
4.c. Family Planning	Attachment 4.19-B	July 1, 2024
4.d. Tobacco Cessation Counseling for Pregnant Women	Attachment 4.19-B	July 1, 2024
5.a.2.a. Physician Services – Comprehensive fee schedule	Attachment 4.19-B	July 1, 2024
5.a.2.b. Physician Services – Alternative Payment Model Code Set	Attachment 4.19-B	July 1, 2024
5.b. Medical and Surgical Services Furnished by a Dentist	Attachment 4.19-B, Page 1 of 1	July 1, 2024
6.d. Services Provided by Non-Physician Practitioners	Attachment 4.19-B	July 1, 2024
7.A.-B. Home Health Care Services	Attachment 4.19-B, Page 1 of 7	July 1, 2024
7.C. Durable Medical Equipment	Attachment 4.19-B, Pages 2a and 2b of 7	July 1, 2024
8. Private Duty Nursing Services	Attachment 4.19-B	July 1, 2024

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, 2024
10. Dental Services	Attachment 4.19-B, Page 1of 3	July 1, 2024
11. Physical Therapy, Occupational Therapy, Speech Therapy, and Audiology Services	Attachment 4.19-B	July 1, 2024
12.b. Dentures	Attachment 4.19-B	July 1, 2024
12.c. Prosthetics	Attachment 4.19-B	July 1, 2024
12.d. Eyeglasses and Contact Lenses	Attachment 4.19-B	July 1, 2024
13.c. Preventive Services - Screening, Brief Intervention, and Referral to Treatment (SBIRT)	Attachment 4.19-B	July 1, 2024
13.d. Rehabilitative Services: Substance Use Disorder Treatment	Attachment 4.19-B	July 1, 2024
13.d. Rehabilitative Services: Behavioral Health Services	Attachment 4.19-B	July 1, 2024
13.d. Rehabilitative Services: Mental Health and Substance Abuse Rehabilitation Services for Children	Attachment 4.19-B, Page 1-2 of 2	July 1, 2024
19. Targeted Case Management: Persons with a Developmental Disability	Attachment 4.19-B, Page 1-2 of 2	July 1, 2024
19.a. Targeted Case Management: Outpatient Substance Use Disorder Treatment	Attachment 4.19-B, Page 1 of 2	July 1, 2024
19.b. Targeted Case Management: Transition Services	Attachment 4.19-B, Page 1 of 1	July 1, 2024

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

Effective Dates for Reimbursement Rates for Specified Services

Service	Attachment	Effective Date
20. Extended Services for Pregnant Women (Prenatal Plus Program)	Attachment 4.19-B	July 1, 2024
24.a. Transportation	Attachment 4.19-B	July 1, 2024
28. Freestanding Birth Center Services	Attachment 4.19-B	July 1, 2024
29. Community First Choice (CFC)	Attachment 4.19-B	July 1, 2025