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State/Territory Name: Colorado

State Plan Amendment (SPA) #: CO 25-0040

This file contains the following documents in the order listed:

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



Medicaid and CHIP Operations Group

March 3, 2026

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

Re: CO 25-0040 §1915(k) Community First Choice State Plan Amendment

Dear Adela Flores- Brennan:

The Centers for Medicare and Medicaid Services (CMS) is approving your request to amend the Community First Choice (CFC) state plan benefit submitted under transmittal number CO 25-0040. This amendment updates State Plan language regarding the Community First Choice program to add service utilization limitations as well a provider limitations on the amount of services they are allowed to provide. 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 a April 1, 2026 effective date. Enclosed are the following pages to be incorporated into your approved state plan:

- Attachment 3.1-k, pages 2, 9, 15-21, 26, 34, 49-50, and 57-58

It is important to note that CMS' approval of this change to the state's 1915(k) CFC state plan benefit 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.

If you have any questions concerning this information, please contact me at (410) 786-7561. You may also contact Shawn Zimmerman at Shawn.Zimmerman@cms.hhs.gov or (410) 786-8291.

Sincerely,

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

cc: Michele Wellder, CMS
Matt Klien, CMS
Ronna Bach, CMS
Cynthia Nanes, CMS
Susie Cummins, CMS
George Failla, CMS
Shante Shaw, CMS
Julie Masters, CO HCPF
Lana Eggers, CO HCPF
Adela Flores-Brennan, CO HCPF

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER <u>2 5</u> — <u>0 0 4 0</u>	2. STATE <u>CO</u>
3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT <input checked="" type="radio"/> XIX <input type="radio"/> XXI	

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

4. PROPOSED EFFECTIVE DATE
04/01/2026

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

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2026 \$ (3,440,999)
b. FFY 2027 \$ (8,301,266)

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-K - Pages 2, 9, 15, 16, 17, 18, 19, 20, 21, 26, 34, 49, 50, 57, 58

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)
Attachment 3.1-K - Pages 2, 9, 15, 16, 17, 18, 19, 20, 21, 26, 34, 49, 50, 57, 58

9. SUBJECT OF AMENDMENT
State Plan amendment to to make modifications to CFC service and provider limitations - Personal Care, Homemaker, Health Maintenance Activities (HMA).

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
Colin Laughlin

13. TITLE
Deputy Office Director

14. DATE SUBMITTED
12/29/2025

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

Attn: Jessica Farmen

FOR CMS USE ONLY

16. DATE RECEIVED <u>December 18, 2025</u>	17. DATE APPROVED <u>Mach 3, 2026</u>
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PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL <u>April 1, 2026</u>	19. SIGNATURE OF APPROVING OFFICIAL
20. TYPED NAME OF APPROVING OFFICIAL <u>George P. Failla, Jr.</u>	21. TITLE OF APPROVING OFFICIAL <u>Director, HCBS Operations and Oversight</u>

22. REMARKS

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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Community First Choice (CFC) State Plan Option

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 necessary services 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.

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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 and determined by support planners (case managers) and member/authorized representatives. Support planner (case manager) inform members of

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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, as well as the process to request an exception beyond those limitations if needed

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.

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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.

Personal Care may be authorized up to an annual limit of 10,000 fifteen-minute units/2,500 hours. Personal Care may be extended based on assessed need above the annual limit of 10,000 units/2,500 hours on a case-by-case basis if there is a demonstrated need documented by the member's support planner (case manager). Authorization above 10,000 annual units/2,500 hours will go through an exception process managed by the Department. For members who do not demonstrate an assessed and documented need for over 10,000 units/2,500 hours per year, the support planner (case manager), during the Person-Centered Planning Process, will discuss additional and/or alternative supports available for continuity of care needs.

Provider Type: Personal Care Agency Provider, IHSS Agency, CDASS Attendant.. 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:

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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.

Homemaker service may be authorized up to an annual limit of 4,500 fifteen-minute units/1,125 hours. Homemaker service may be extended based on assessed need above the annual limit of 4,500 units/1,125 hours on a case-by-case basis if there is a demonstrated need documented by the member's support planner (case manager). Authorization above 4,500 annual units/1,125 hours will go through an exception process managed by the Department. For members who do not demonstrate an assessed and documented need for over 4,500 units/1,125 hours per year, the support planner (case manager), during the Person-Centered Planning Process, will discuss additional and/or alternative supports available for continuity of care needs.

Provider Type:

Homemaker Provider, IHSS Agency, CDASS Attendant. Legally Responsible Persons providing Homemaker service have a limit of 5-hours per week per member. 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 Homemaker service, 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

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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.

Health Maintenance Activities may be authorized up to an annual limit of 19,000 fifteen-minute units/4,750 hours. Health Maintenance Activities may be extended based on assessed need above the annual limit of 19,000 units/4,750 hours on a case-by-case basis if there is a demonstrated need documented by the member's support planner (case manager). Authorization above 19,000 annual units/4,750 hours will go through an exception process managed by the Department. For members who do not demonstrate an assessed and documented need for over 19,000 units/4,750 hours per year, the support planner (case manager), during the Person-Centered Planning Process, will discuss additional and/or alternative supports available for continuity of care needs.

Provider Type: IHSS Agency, CDASS Attendant. No individual provider will be reimbursed for over sixteen (16) hours of care per day except in an emergency

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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.

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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.

Personal Care, which includes AME, may be authorized up to an annual limit of 10,000 fifteen-minute units/2,500 hours. Personal Care may be extended based on assessed need above the annual limit of 10,000 units/2,500 hours on a case-by-case basis if there is a demonstrated need documented by the member's support planner (case manager). Authorization above 10,000 annual units/2,500 hours will go through an exception process managed by the Department. For members who do not demonstrate an assessed and documented need for over 10,000 units/2,500 hours per year, the support planner (case manager), during the Person-Centered Planning Process, will discuss additional and/or alternative supports available for continuity of care needs.

Homemaker service, which includes AME, may be authorized up to an annual limit of 4,500 fifteen-minute units/1,125 hours. Homemaker service may be extended based on assessed need above the annual limit of 4,500 units/1,125 hours on a case-by-case basis if there is a demonstrated need documented by the member's support planner (case manager). Authorization above 4,500 annual units/1,125 hours will go through an exception process managed by the Department. For members who do not demonstrate an assessed and documented need for over 4,500 units/1,125 hours per year, the support planner (case manager), during the Person-Centered Planning Process, will discuss additional and/or alternative supports available for continuity of care needs.

Provider Type: CFC Personal Care Provider, CFC Homemaker Provider, IHSS Agency, CDASS Attendant. No individual provider will be reimbursed for over sixteen (16) hours of care per day except in an emergency situation.. Legally Responsible Persons

TN No.: 25-0040

Approval Date: March 3, 2026

Supersedes TN No.: 24-0035

Effective Date: April 1, 2026

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providing Homemaker service have a limit of 5 hours per week, per member. Members can utilize additional service hours, based on their assessed needs, with a different provider(s) or another Legally Responsible Persons if receiving Homemaker service.

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.

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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 are provisioned via a Transition Setup Coordinator, and 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.

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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

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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

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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

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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:

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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.

A member may request that units/hours for Personal Care, Homemaker service, Health Maintenance Activities, and/or Acquisition, Maintenance, and Enhancement of Skills be authorized above the limits stated in the mandatory services and supports section of this SPA by requesting that their case manager submit justification of need to the Department for review.

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