APPENDIX K: Emergency Preparedness and Response

Background:

This standalone appendix may be utilized by the state during emergency situations to request amendment to its approved waiver. It includes actions that states can take under the existing Section 1915(c) home and community-based waiver authority in order to respond to an emergency. Other activities may require the use of various other authorities such as the Section 1115 demonstrations or the Section 1135 authorities.[i] This appendix may be completed retroactively as needed by the state.

Appendix K-1: General Information

General Information:

A. State: Colorado

B. Waiver Title:

Elderly, Blind and Disabled (HCBS-EBD)
Community Mental Health Supports (HCBS-CMHS)
Supported Living Services (HCBS-SLS)
Brain Injury (HCBS-BI)
Spinal Cord Injury (HCBS-SCI)
Developmental Disabilities (HCBS-DD)
Children's Home and Community Based Services (CHCBS)
Children with Life Limiting Illness (HCBS-CLLI)
Children's Extensive Supports (HCBS-CES)
Children's Habilitation Residential Program (HCBS-CHRP

C. Control Number:

HCBS-EBD: CO.0006.R08.05
HCBS-CMHS: CO.0268.R05.06
HCBS-SLS: CO.0293.R05.02
HCBS-BI: CO.0288.R05.05
HCBS-SCI: CO.0961.R01.08
HCBS-DD: C0.0007.R08.02
CHCBS: CO.4157.R06.04
HCBS-CLLI: CO.0450.R02.07
HCBS-CES: CO.4180.R05.02
HCBS-CHRP: CO.0305.R05.02

D. Type of Emergency (The state may check more than one box):

●	**Pandemic or Epidemic**
○	**Natural Disaster**
○	**National Security Emergency**
○	**Environmental**
○	**Other (specify):**

E. Brief Description of Emergency. *In no more than one paragraph each*, briefly describe the: 1) nature of emergency; 2) number of individuals affected and the state's mechanism to identify individuals at risk; 3) roles of state, local and other entities involved in approved waiver operations; and 4) expected changes needed to service delivery methods, if applicable. The state should provide this information for each emergency checked if those emergencies affect different geographic areas and require different changes to the waiver.

The Department of Health Care Policy & Financing Office of Community Living (OCL) has prepared an Appendix K: Emergency Preparedness and Response for the Home and Community-Based Services (HCBS) waiver applications that include the Elderly, Blind, and Disabled (EBD), Community Mental Health Supports (CMHS), Supported Living Services (SLS), Brain Injury (BI), Spinal Cord Injury (SCI), Developmental Disabilities (DD), Children's Home and Community Based Services (CHCBS), Children with Life Limiting Illness (CLLI), Children's Extensive Supports (CES), Children's Habilitation Residential Program (CHRP) in order to ensure the health, welfare, and safety of our waiver participants by making additional resources available and accessible, changing waiver administrations and operations, and formalizing emergency actions to curtail or diminish the COVID-19 virus' impact on the state of Colorado. By preparing this amendment to the waiver in advance of the spread of the COVID-19 virus, early communication and protocols regarding necessary changes during this emergency can be delivered swiftly, comprehensively, and with required back-ups in place to all HCBS waiver clients, providers, advocacy groups, state agencies, and non-state or non-governmental contracted entities. The Department continues to collaborate and respond to federal, state, and local public and private partners, providers and facilities to ensure a minimal disruption of services for the 48,643 HCBS waiver clients.

As of end of day March 24, 2020, there were nine hundred and twelve (912) presumptive positive cases of COVID-19 in Colorado. https://www.colorado.gov/pacific/cdphe/2019-novel-coronavirus

Currently, state and local public health are working together, following federal guidance, to assess and test suspected cases, identify people who may have been exposed to cases, and determine the need for monitoring, isolation, quarantine, or other restriction of movement and activities. Colorado is taking an aggressive approach in testing suspected cases who may have milder illness and are not hospitalized. We will continue with this approach as long as we have the resources and capacity to do so. Also, a network of clinical laboratories throughout Colorado are participating in an additional testing program.

The state is requesting immediate implementation of the waiver amendment to ensure optimal maintenance of HCBS waiver clients' level of health, welfare and safety. For the HCBS waiver participants in the state of Colorado, the Department desires to initiate the necessary changes to the service delivery methods as detailed in section K-2 and K-3 to include the following:

- Temporarily exceed service limitations or requirements for amount, duration, and prior authorization to address health and welfare issues presented by the emergency;
- Temporarily expand setting(s) where services may be provided;
- Temporarily permit payment for services rendered by family caregivers or legally responsible individuals;
- Temporarily modify licensure or other requirements for settings where waiver services are furnished;
- Temporarily modify processes for level of care evaluations or re-evaluations;
- Temporarily allow all CMA required activities to be completed via phone or other technology-based method with HCBS members in accordance with HIPAA requirements; and
- Temporarily exclude Professional Medical Information Page (PMIP) from the initial LOC process for the length of the State Disaster Plan to prevent a portion of the LOC process from occurring after services are rendered.

F. Proposed Effective Date: Start Date: _3/10/2020_Anticipated End Date: __9/10/2020____

G. Description of Transition Plan.

Individuals will transition to their pre-emergency service plan as soon as they are able. Needs will be reassessed by Case Management Agency staff. Additional supports as required transitioning from Appendix K flexibility into ongoing service plans will be considered as needed.

H. Geographic Areas Affected:

All

I. Description of State Disaster Plan (if available) ***Reference to external documents is acceptable*****:**

Refer to Health Care Policy and Financing Continuity of Operations Plan (COOP) and Disaster Plan Attached

Appendix K-2: Temporary or Emergency-Specific Amendment to Approved Waiver

Temporary or Emergency-Specific Amendment to Approved Waiver:

These are changes that, while directly related to the state's response to an emergency situation, require amendment to the approved waiver document. These changes are time limited and tied specifically to individuals impacted by the emergency. Permanent or long-ranging changes will need to be incorporated into the main appendices of the waiver, via an amendment request in the waiver management system (WMS) upon advice from CMS.

a.___ Access and Eligibility:

i._X__ Temporarily increase the cost limits for entry into the waiver.
[Provide explanation of changes and specify the temporary cost limit.]

Temporarily waive the current cost limit of $40,552.29 for the CES waiver for individuals who are impacted by COVID-19 (CES). Temporarily waive the current cost limit of $52,938.31 for the SLS waiver for individuals who are impacted by COVID-19 (SLS).

ii.__X_ Temporarily modify additional targeting criteria.
[Explanation of changes]

The modification of targeting criteria would include the expansion to those children/youth who have a history of a Life Limiting Illness or history of enrollment onto the CLLI waiver, with a physician's attestation of also being immunocompromised for the duration of the State Disaster Plan (CLLI).

b._X__ Services

i.__X_ Temporarily modify service scope or coverage.

Individuals who demonstrate a need for Home Delivered meals, outside of a change in life circumstance, will be able to utilize this service up to the maximum of two (2) meals per day. (SCI), (EBD), (CMHS), (BI), (SLS), (DD)

Expand the medication reminder benefit to a Specialized Medical Equipment and Supplies (SMES) benefit. The definition is to allow the coverage of items necessary for life support, ancillary supplies, and equipment. This will allow SCI clients to obtain necessary personal protective equipment (PPE) when needed. (SCI)

Temporarily allow members on the CMHS waiver to access the In-Home Respite service. (CMHS)

ii._X__ Temporarily exceed service limitations (including limits on sets of services as described in Appendix C-4) or requirements for amount, duration, and prior authorization to address health and welfare issues presented by the emergency.
[Explanation of changes]

The 365-day transition period cap for Home Delivered Meal services will be extended for individuals who are currently utilizing the service. (SCI), (EBD), (CMHS), (BI), (SLS), (DD)

Relatives employed by an IHSS agency may provide over the forty (40) hours of personal care (up to forty-eight (48)) in a seven (7) day period. A family member who is an individual's authorized representative may be reimbursed for the provision of IHSS if the individual's personal care worker is unable to meet their personal care needs. (SCI), (EBD), (BI)

The four (4) one-way trip services per week for Non-Medical Transportation may be exceeded depending on need. (SCI), (EBD), (CMHS), (BI)

The number of units available for Transportation Services may exceed 508 units per Service Plan year. A unit is a per-trip charge for to and from Day Habilitation and Supported Employment programs. (SLS), (DD)

Behavioral Services – Counseling Services may exceed the current 208-unit limitation, as needed and identified by the behavioral consultant. (SLS), (DD)

Behavioral Services – Line Staff Services may exceed the current 960 units per service plan year based on need (SLS), (DD)

Expressive Therapy's, (Art and Play Therapy, and Music Therapy) maximum unit limitation may be exceeded when there is a demonstrated need. (CLLI)

Therapeutic Service's (Bereavement Counseling, Therapeutic Life Limiting Illness Support for Individual, Group or Family) maximum unit limitation may be exceeded when there is a demonstrated need. (CLLI)

Respite Care maximum of thirty (30) days or unit limitations may be exceeded when there is a demonstrated need. (CES), (SCI), (EBD), (CMHS), (BI), (SLS), (CHRP), (CLLI)

Special Medical Equipment and Supplies (SMES) unit maximums may be exceeded when there is a demonstrated need due to COVID-19. All medically necessary items that are covered under the Durable Medical Equipment or EPSDT benefit within the state plan shall be accessed first. (CES), (SCI), (EBD), (CMHS), (BI), (SLS), (DD)

Youth Day's ten (10) hour maximum limitation may be exceeded when there is a demonstrated need. (CES)

CDASS: Relative CDASS attendants may provide over the forty (40) hours of personal care in a seven (7) day period up to forty-eight (48) at this time. Requirements will be waived for a client to switch to agency-based care if a CDASS attendant cannot be in found. The Department may permit a client to receive both CDASS services and agency-based services or State Plan Long-Term Home Health (LTHH) if a CDASS attendant cannot be found. The Department will ensure that there is no duplication of consumer directed and agency-based services by reviewing the CDASS members timesheets. CDASS members will maintain time sheets to ensure no duplication of services. In addition, the Department will audit claims submitted for both services to ensure that duplication has not occurred. The Department will conduct training with CDASS attendants and agency-based providers to ensure that duplication of services does not occur. The Department will allow clients to exceed monthly budget caps and allocation caps, as necessary during the COVID-19 emergency period. (SCI), (EBD), (CMHS), (BI), (SLS)

Support Plan Authorization Limits (SPAL): Individuals will be permitted to exceed the SPALs and overall spending limit as defined in Appendix C-4: Additional Limits on Amount of Waiver Services, when there is a demonstrated need documented in the case management system (SLS).

Supported Community Connector unit limitations may be exceeded when there is a demonstrated need (CHRP).

Day Habilitation: Maximum of 7,112 combined units of Specialized Habilitation, Supported Community Connections, Prevocational Services, and Supported Employment per Service Plan year may be exceed when there is a demonstrated need (DD, SLS).

iii. __X_Temporarily add services to the waiver to address the emergency situation (for example, emergency counseling; heightened case management to address emergency needs; emergency medical supplies and equipment; individually directed goods and services; ancillary services to establish temporary residences for dislocated waiver enrollees; necessary technology; emergency evacuation transportation outside of the scope of non-emergency transportation or transportation already provided through the waiver).

Service Definition (Scope): ALL Waivers

A. Remote Support Services provide oversight and monitoring within the participant's home through an off-site electronic support system in order to reduce or replace the amount of staffing a participant needs in accordance with HIPAA requirements.

B. The purpose of Remote Support Services is to support the participant to exercise greater independence over their lives. It is integrated into the participant's overall support system and reduces the amount of staff support a person uses in their home while ensuring health and welfare.

C. Remote Support Service includes: 1. Electronic support system installation, repair, maintenance, and back-up system; 2. Training and technical assistance for the participant and his or her support network; 3. Off-site system monitoring staff; and 4. Stand-by intervention staff for notifying emergency personnel such as police, fire, and back-up support staff.

iv. _X__Temporarily expand setting(s) where services may be provided (e.g. hotels, shelters, schools, churches) Note for respite services only, the state should indicate any facility-based settings and indicate whether room and board is included:
[Explanation of modification, and advisement if room and board is included in the respite rate]:

ACF (EBD, CMHS)
Adaptive Therapeutic Recreational Equipment and Fees (CES)
Adult Day (SCI), (EBD), (CMHS), (BI)
Assistive Technology (CES), (SLS)
Behavioral Services (CHRP), (DD)
Behavioral Management and Education (BI)
Bereavement Counseling (CLLI)
Expressive Therapy (CLLI)
Community Connector (CES)
Complementary and Integrative Health Services (SCI)
Day Treatment (BI)
Day Habilitation (SLS), (DD)
Hippotherapy (CES)
Home Delivered Meals (EBD), (CMHS), (SCI), (BI), (SLS), (DD)
Home Modifications (SCI), (CES), (EBD), (CMHS), (BI), (SLS)
Homemaker (CES), (SCI), (EBD), CMHS), (BI)
Life Skills Training (SCI), (EBD), (CMHS), (BI), (SLS)IHSS (CHCBS), (SCI), (EBD)
Independent Living Skills Training (BI)
Intensive Supports (CHRP)
PERS (SCI), (EBD), (CMHS), (SLS)
Medication Reminder (SCI), (EBD), (CMHS)
Massage (CES), (CHRP), (CLLI)
Mental Health Therapy (BI)
Mentorship (SLS)
Movement Therapy (CES), (CHRP)
Palliative/Supportive Care (CLLI)
Peer Mentorship (SCI), (EBD), (CMHS), (BI), (SLS), (DD)
Prevocational (SLS), (DD)
Professional Services (SLS)
Respite (SCI), (CES), (EBD), (CMHS), (BI), (SLS), (CHRP), (CLLI), (DD)
Residential Services (CHRP)
Residential Habilitation (DD)
Supported Employment (SLS), (DD)
Supported Community Connector (CHRP), (DD)
Supported Living Programs (SLP)Substance Abuse Counseling (BI)
Therapeutic Life Limiting Illness Support (CLLI)
Transition Set-Up and Coordination (SCI), (EBD), (CMHS), (BI), (SLS)
Transitional Living Programs (TLP)Transition Support (CHRP)
Youth Day Services (CES)

The above services when feasible may be delivered temporarily through virtual means in the participant's residential setting or other Department identified locations to ensure the client's health, safety, and welfare in accordance with HIPAA requirements. This could include:

- The participant's private home;
- A provider owned or controlled or extended family home;
- Community center or designated community gathering center;
- Hotel/paid lodging;
- Newly rented room; or
- Other residential setting.

Room and board is not currently included within the respite rate. If respite is required in a non-traditional setting (i.e. hotel), the Department may need to include amounts in addition to the base rate in order to account for room and board outside of the client's regular cost to the existing residential provider.

Professional evaluations for the Home Accessibility and Adaptations, Vehicle Modifications, and Assistive Technology benefits may be completed virtually when the client has live video sharing capabilities with the professional in accordance with HIPAA requirements.

v.___ Temporarily provide services in out of state settings (if not already permitted in the state's approved waiver). [Explanation of changes]

c.__X_ Temporarily permit payment for services rendered by family caregivers or legally responsible individuals if not already permitted under the waiver. Indicate the services to which this will apply and the safeguards to ensure that individuals receive necessary services as authorized in the plan of care, and the procedures that are used to ensure that payments are made for services rendered.

Allow relatives, spouses, and legally responsible persons to provide:

CDASS (SCI), (EBD), (CMHS), (BI), (SLS)
Community Connector (CES)
Day Habilitation (SLS), (DD)
Homemaker (SCI), (EBD), (CMHS), (BI)
IHSS (SCI), (CHCBS), (EBD)
Mentorship (SLS)
Peer Mentorship (SLS), (DD)
Personal care (SCI), (EBD), (CMHS), (BI), (SLS)
Respite (SCI), (CES), (EBD), (CMHS), (BI), (SLS), (CHRP), (CLLI)
Residential (CHRP)
Residential Habilitation (DD)
Supported Community Connector (CHRP)
Youth Day (CES)

The Department will apply the following safeguards to ensure individuals receive necessary services authorized through the care plan: case management monitoring and post payment review of claims paid.

d.__X_ Temporarily modify provider qualifications (for example, expand provider pool, temporarily modify or suspend licensure and certification requirements).

i.__X_ Temporarily modify provider qualifications.

[Provide explanation of changes, list each service affected, list the provider type, and the changes in provider qualifications.]

The Department will review any request to waive caregiver age from (18) to (16) for the following services on a case-by-case basis.

CDASS (SCI), (EBD), (CMHS), (BI), (SLS)
Homemaker (SCI), (CES), (EBD), (CMHS), (BI), (SLS)
IHSS (SCI), (CHCBS), (EBD),
Personal Care (SCI), (EBD), (CMHS), (BI), (SLS)

When necessary, allow the Authorized Representative (AR) to also be the care attendant for CDASS.

Waive training requirements for new CDASS Authorized Representatives.

ii._X__ Temporarily modify provider types.

[Provide explanation of changes, list each service affected, and the changes in the provider type for each service].

Any licensed professional with the relevant training and associated licensure through the Colorado Department of Regulatory Agencies (DORA) that provides professional services through the State Plan will be temporarily permitted to provide services to HCBS waiver participants, applicable to:

Behavioral management and Education (BI)
Behavioral Services (SLS), (DD)
Bereavement Counseling (CLLI)
Complementary and Integrative Health Services (SCI)
Expressive Therapy (CLLI)
Independent Living Skills Training (BI)
Intensive Support (CHRP)
Massage Therapy (CES), (SLS), (CHRP), (CLLI)
Mental Health Therapy (BI)
Movement Therapy (CES), (SLS), (CHRP)
Parent Education Services (CES)
Substance Abuse Counseling (BI)
Therapeutic Life Limiting Illness Support services (CLLI)

Any licensed Home Care Agency or Hospice Agency that provides services through the State Plan is temporarily permitted to provide skilled and unskilled services through the waiver to HCBS participants, applicable to:

Adult Day (SCI), (EBD), (CMHS), (BI)
Day Treatment (BI)
Homemaker (SCI), (EBD), (CMHS), (BI), (SLS)
IHSS (SCI), (CHCBS), (EBD),
Independent Living Skills Training (BI)
Life Skills Training (SCI), (EBD), (CMHS), (BI)
Massage Therapy (CES)
Movement Therapy (CES)
Parent Education (CES)
Palliative and Supportive Care Services (CLLI)
Peer Mentorship (SCI), (EBD), (CMHS), (BI), (DD), (SLS)
Personal Care (SCI), (EBD), (CMHS), (BI), (SLS)
Respite (SCI), (EBD), (CMHS), (BI), (SLS), (CHRP), (CLLI)

Any licensed Home Care agency providing HCBS services is temporarily permitted to provide services outside of their enrolled specialties, to include but not limited to:

Adult Day (SCI), (EBD), (CMHS), (BI)
Community Connector (CES)
Day Treatment (BI)
Day Habilitation (SLS), (DD)
Health Maintenance (SLS)
Homemaker (SCI), (CES), (EBD), (CMHS), (BI), (SLS)
Life Skills Training (SCI), (EBD), (CMHS), (BI), (SLS)
Independent Living Skills Training (BI)
Mentorship (SLS)
Non-Medical Transportation (SCI), (EBD), (CMHS), (BI), (SLS), (DD)
Peer Mentorship (SCI), (EBD), (CMHS), (BI), (SLS), (DD)
Personal Care (SCI), (EBD), (CMHS), (BI), (SLS)
Respite (SCI), (CES), (EBD), (CMHS), (BI), (SLS), (CHRP), (CLLI)
Transition Set-Up and Coordination (EBD), (SCI), (CMHS), (BI), (SLS), (DD)
Youth Day (CES)

The Department has expanded the provider type for Home Delivered Meals to include:

- Hospitals;
- Schools;
- Restaurants;
- Home Health Agency;
- Senior Center;
- Social Service Agency;
- Church; and
- Any Entity Providing Home Delivered Meals. (SCI), (EBD), (CMHS), (BI), (SLS), (DD)

iii.__X_ Temporarily modify licensure or other requirements for settings where waiver services are furnished.

[Provide explanation of changes, description of facilities to be utilized and list each service provided in each facility utilized.]

State certification survey staff are, on a case-by-case basis, postponing agency certification and licensure reviews for services that are surveyed by the Department of Public Health and Environment, Health Facilities and Emergency Section Division until the area is no longer in a state of emergency. This is for the safety of the survey staff and individuals who are utilizing these services. Certification and licensure surveys will be conducted for abuse and neglect complaints, immediate jeopardy concerns, as well as new licensure and certification requests for new providers

e. __X_ Temporarily modify processes for level of care evaluations or re-evaluations (within regulatory requirements). [Describe]

The initial Level of Care (LOC) assessment and yearly re-assessment requirement will be modified to include the option for a telephone or other technological contact for participants of the HCBS waiver in accordance with HIPAA requirements. The case manager will document, in the Log Notes and the assessment the contact with the participant and/or guardian. The CMA will be able to receive the signed form up to 60 days after start date if the member does not have ability to receive forms by email.

The Department will exclude the Patient Medical Information Page (PMIP) from the initial LOC process for the length of the State Disaster Plan to prevent a portion of the LOC process from occurring after services are rendered. CMA will document in the Log Notes and the assessment this information.

For the SLS and DD waivers, the Initial Supports Intensity Scale assessment may be completed up to 60 days following enrollment.

f._X__ Temporarily increase payment rates

The Department is requesting the ability to increase, supplement, or provide additional fee-for-service payment(s) to all HCBS providers, to ensure continuity of operations and assurance of client health, safety, and welfare within waiver benefits.

The Department requests the ability to pay 8% enhanced rates to the following services:

Adult Day Services (SCI), (EBD), (CMHS), (BI)
Adult Day Service Transportation (SCI), (EBD), (CMHS), (BI)
Adaptive Therapeutic Recreational Equipment and Fees (CES)
Assistive Technology (CES), (SLS)
Behavioral Management and Education, Day Treatment (BI)
Behavioral Services (SLS), (CHRP), (DD)
Community Connector (CES)
Complementary and Integrative Health Services (SCI)
Consumer Directed Attendant Support Services (SCI), (EBD), (CMHS), (BI), (SLS)
Day Treatment (BI)
Day Habilitation (SLS), (DD)
Expressive Therapy (Art and Play Therapy and Music Therapy) (CLLI)
Dental (SLS), (DD)
Hippotherapy (CES)
Homemaker (SCI), (CES), (EBD), (CMHS), (BI), (SLS)
Home Delivered Meals (SCI), (EBD), (CMHS), (BI), (SLS), (DD)
Home Modification (SCI), (EBD), (CMHS), (BI), (SLS)
In-Home Support Services (SCI), (CHCBS), (EBD)
Intensive Support Services (CHRP)
Life Skills Training (SCI), (EBD), (CMHS), (BI), (SLS)
Massage therapy (CES), (CLLI)
Medication Reminder (EBD), (CMHS), (BI)
Mental Health Therapy (BI)
Mentorship (SLS)
Movement Therapy (CES)
Non-Medical Transportation (SCI), (EBD), (CMHS), (BI), (SLS), (DD)
Palliative and Supportive Care (Care Coordination and Pain and Symptom Management (skilled)) (CLLI)
Peer Mentorship (SCI), (EBD), (CMHS), (BI), (SLS), (DD)
Personal Care (SCI), (EBD), (CMHS), (BI), (SLS)
Prevocational Services (SLS), (DD)
Personal Emergency Response Systems (SCI), (EBD), (CMHS), (BI), (SLS)
Professional Services (SLS), (CHRP)
Respite (SCI), (CES), (EBD), (CMHS), (BI), (SLS), (CHRP), (CLLI)
Specialized Medical Equipment and Supplies (SCI), (EBD), (CES), (CMHS), (BI), (SLS), (DD)
Substance Abuse Counseling (BI)
Supported Community Connector (SLS)
Supported Employment (SLS), (DD)
Transition Supports (CHRP)
Transition Set-Up and Coordination (SCI), (EBD), (CMHS), (BI), (SLS)
Therapeutic Services (Bereavement Counseling, Therapeutic Life Limiting Illness Support – Individual, Group and Family) (CLLI).
Vehicle Modification (CES), (SLS)
Vision (SLS), (DD)
Youth Day (CES)

The Department requests the ability to pay a 13% enhanced rate for the following services:

Alternative Care Facility (EBD), (CMHS)
Residential Services (CHRP)
Residential Habilitation (DD)
Supported Living Programs (BI)
Transitional Living Programs (BI)

Depending on the need, the rates may need to exceed the currently approved rate methodology as delineated in this amendment. The Department has attached the current rate sheet.

g.___ Temporarily modify person-centered service plan development process and individual(s) responsible for person-centered service plan development, including qualifications.
[Describe any modifications including qualifications of individuals responsible for service plan development, and address Participant Safeguards. Also include strategies to ensure that services are received as authorized.]

h.__X_ Temporarily modify incident reporting requirements, medication management or other participant safeguards to ensure individual health and welfare, and to account for emergency circumstances. [Explanation of changes]

In the circumstance individuals in services must evacuate their current setting, the Department would develop processes to ensure the health, safety, and welfare of the client but would allow for additional flexibility in location and timeliness of reporting due to the emergent need.

i._X__ Temporarily allow for payment for services for the purpose of supporting waiver participants in an acute care hospital or short-term institutional stay when necessary supports (including communication and intensive personal care) are not available in that setting, or when the individual requires those services for communication and behavioral stabilization, and such services are not covered in such settings.
[Specify the services.]

CDASS, IHSS, and Personal Care services may be provided in an acute setting, when the service is not able to be provided by the Acute Setting provider not to exceed 30 days consecutively. There Department will ensure no duplication of services through documentation of tasks provided and a waiver form completed by the acute setting staff attesting that specific tasks needed in the acute care hospital or short-term institutional stay cannot be done by the facility staff due to system capacity or other critical service interruption and that the participant may have a trained attendant complete the specific tasks.

j._X__ Temporarily include retainer payments to address emergency related issues.
[Describe the circumstances under which such payments are authorized and applicable limits on their duration. Retainer payments are available for habilitation and personal care only.]

Retainer payments for services that include Personal Care including Adult Day Centers, Habilitation Services (Specialized Habilitation, Supported Community Connections, Pre-Vocational Services, Supported Employment Services, and Community Connector), and Personal Care Services shall be provided in response to the impact of the COVID-19 pandemic on certain Medicaid providers and shall not exceed the total amount that the provider would have received had services been provided as expected. The retainer time limit may not exceed the lesser of 30 consecutive days or the number of days for which the State authorizes a payment for "bedhold" in nursing facilities.

k.___ Temporarily institute or expand opportunities for self-direction.

[Provide an overview and any expansion of self-direction opportunities including a list of services that may be self-directed and an overview of participant safeguards]

l.___ Increase Factor C.

[Explain the reason for the increase and list the current approved Factor C as well as the proposed revised Factor C]

m._X__ **Other Changes Necessary [For example, any changes to billing processes, use of contracted entities or any other changes needed by the State to address imminent needs of individuals in the waiver program].** [Explanation of changes]

Temporarily allow HCBS members to receive one service per month for the length of the State Disaster Plan without being subject to discharge via telephonically or monthly monitoring by telehealth in accordance with HIPAA requirements.

Temporarily allow all CMA required face-to-face activities to be completed via phone or other technology-based methods with HCBS members in accordance with HIPAA requirements.

Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the request:

First Name:	Bonnie
Last Name	Silva
Title:	Office of Community Living Director
Agency:	Colorado Department of Health Care Policy and Financing
Address 1:	1570 Grant Street
Address 2:	
City	Denver
State	CO
Zip Code	80203
Telephone:	303.866.6158
E-mail	Bonnie.Silva@state.co.us
Fax Number	303-866-2828

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

First Name:	
Last Name	
Title:	
Agency:	
Address 1:	
Address 2:	
City	
State	
Zip Code	
Telephone:	
E-mail	
Fax Number	

8. Authorizing Signature

Signature: _____/S/_____
State Medicaid Director or Designee

Date:	**03/36/2020**

First Name:	Tracy
Last Name	Johnson
Title:	Medicaid Director
Agency:	Colorado Department of Health Care Policy and Financing
Address 1:	1570 Grant Street
Address 2:	
City	Denver

State	Colorado
Zip Code	80203
Telephone:	303-866-2993
E-mail	Tracy.Johnson@state.co.us
Fax Number	303-866-2828

Section A---Services to be Added/Modified During an Emergency

Complete for each service added during a time of emergency. For services in the approved waiver which the state is temporarily modifying, enter the entire service definition and highlight the change. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	Consumer Directed Attendant Support Services (CDASS)

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

Service Definition (Scope)**:**

Services that assist an individual to accomplish activities of daily living including health maintenance, personal care, homemaker activities, and protective oversight.

Health maintenance activities are those routine and repetitive activities of daily living, furnished to an eligible client in the client's home or in the community, which require skilled assistance for health and normal bodily functioning, and which would be carried out by an individual with a disability if he or she were physically/cognitively able.

Personal Care services are those routine and repetitive activities of daily living, furnished to an eligible client in the client's home or in the community, which require non-skilled assistance for health and normal bodily functioning and which would be carried out by an individual with a disability if he or she were physically/cognitively able.

Homemaker services are general household activities provided in the home of an eligible client to maintain a healthy and safe home environment for a client, when the person ordinarily responsible for these activities is absent or unable to manage these tasks.

Protective oversight is supervision of the client to prevent at risk behavior that may result in harm to the client. These services are provided by an attendant under the supervision of the client or the client's authorized representative.

The client, or the authorized representative, is responsible for referring, recruiting, training, setting wages, scheduling, and in other ways managing the attendant.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Consumer Directed Attendant Support Services offered in this waiver are limited based on the client's assessed need for services and prior authorization by case managers up to cost containment parameters.

In addition, spouses, guardians and family members may provide over the forty (40) hours of personal care in a seven (7) day period up to forty-eight (48) at this time.

Due to COVID-19, the Department waives requirements

- For a client to switch to agency-based care if a CDASS attendant cannot be in found;
- Permit a client to receive both CDASS services and agency-based services or State Plan Long-Term Home Health (LTHH) if a CDASS attendant cannot be found; and
- Allow clients to exceed monthly budget caps and allocation caps, as necessary

The Department will ensure that there is no duplication of consumer directed and agency-based services by reviewing with the FMS vendor the CDASS members timesheets. CDASS members will maintain time sheets to

ensure no duplication of services. In addition, the Department will audit claims submitted for services to ensure that duplication has not occurred. The Department will conduct training with CDASS attendants, FMS Vendors, and agency-based providers to ensure that duplication of services does not occur.

Coverage is distinct under Consumer Directed Attendant Support Services (CDASS) due to the method of service delivery being materially different due to it being a participant directed option unavailable under the State Plan.

Provider Specifications				
Provider Category(s) *(check one or both)*:	▪	Individual. List types:	☐	Agency. List the types of agencies:
	The program participant or representative is the common law employer of workers hired, trained and managed by the participant or representative			

Specify whether the service may be provided by *(check each that applies):*	▪	Legally Responsible Person	▪	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
The program participant or representative is the common law employer of workers hired, trained and managed by the participant or representative			The Department contracts with three Financial Management Service Vendors to review the hiring agreements between the client and their selected CDASS attendant to ensure all forms are complete and follow employment qualifications established by the federal and state government. At minimum, attendants must be at least 16 years of age, trained to perform appropriate tasks to meet the client's needs, and demonstrate the ability to provide support to the client and/or the authorized representative as defined in the client's Attendant Support Management Plan and Hiring Agreement. When necessary, the Authorized Representative (AR) may also be the care attendant due to the COVID-19 emergency. Sections 12-38-103 (8), 12-38-103 (11), 12-38-123 (1) (a), 12-38.1-102 (5) and 12-38.1-117 (1)(b) C.R.S (2007) shall not

			apply to Attendants employed through CDASS and who are acting within the scope of such employment. However, such person may not represent him or herself to the public as a licensed nurse, certified nurse aide, a licensed practical or professional nurse, a registered nurse or a registered professional nurse. This exclusion shall not apply to any person who has his or her license as a nurse or certification as a nurse aide suspended or revoked or his or her application for such license or certification denied.

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
	Financial Management Service Organization and the Department of Health Care Policy and Financing, Community Based Long Term Services and Supports Division	The FMS shall ensure that the attendant's initial training certification is on file prior to the provision of CDASS services and is updated on a continual basis when there is a change in services listed on the Attendant Support Management Plan.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	▪	Participant-directed as specified in Appendix E	☐	Provider managed

Section A---Services to be Added/Modified During an Emergency

Complete for each service added during a time of emergency. For services in the approved waiver which the state is temporarily modifying, enter the entire service definition and highlight the change. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	**Behavioral Services**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
Service Definition (Scope)**:**	
Behavioral Services are services related to an individual's intellectual and developmental disability which assist a client to acquire or maintain appropriate interactions with others. Behavioral Services include: 1) Behavioral Consultation Services include consultations and recommendations for behavioral interventions and development of behavioral support plans that are related to the individual's intellectual and developmental disability and are necessary for the individual to acquire or maintain appropriate adaptive behaviors, interactions with others and behavioral self-management. Intervention modalities shall relate to an identified challenging behavioral need of the individual. Specific goals and procedures for the Behavioral Services must be established. Individuals with co-occurring diagnoses of developmental disabilities and Medicaid covered mental health conditions shall have identified needs met by each of the appropriate systems without duplication but with coordination by the Behavioral Services professional to obtain the best outcome for the individual. 2) Behavioral Plan Assessment Services include observations, interviews of direct staff, functional behavioral analysis and assessment, evaluations, and completion of a written assessment document. 3) Individual/Group Counseling Services include psychotherapeutic or psychoeducational intervention related to the intellectual and developmental disability in order for the individual to acquire or maintain appropriate adaptive behaviors, interactions with others and behavioral self-management, and to positively impact the individual's behavior or functioning. Counseling may be provided in an individual or group setting and may include Cognitive Behavior Therapy, Systematic Desensitization, Anger Management, Biofeedback, and Relaxation Therapy. 4) Behavioral Line Services include direct 1:1 implementation of the behavioral support plan, under the supervision and oversight of a Behavioral Consultant for acute, short term intervention at the time of enrollment from an institutional setting or to address an identified challenging behavior of an individual at risk of institutional placement and that puts the individual's health and safety and/or the safety of others at risk.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
Exclusions: This waiver service is only provided to individuals age 21 and over. All medically necessary Behavioral Services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit. Behavioral services must not duplicate or supplant Behavioral Health Organization services offered under the Medicaid State Plan. Services for a covered mental health diagnosis in the Medicaid State Plan, covered by a third-party source or available from a natural support shall not be reimbursed.	

Services for the sole purpose of training in basic life skills such as activities of daily living, social skills and adaptive responding are excluded and shall not be reimbursed under Behavioral Services.

Limits:

1) Behavioral Consultation Services are limited to 80 units per Service Plan Year. One unit is equal to 15 minutes of service.

2) Behavioral Plan Assessment Services are limited to 40 units. There is a limit of one Behavioral Assessment per Service Plan year. One unit is equal to 15 minutes of service.

3) Counseling Services may exceed the 208 units per Service Plan year depending on need due to the COVID-19 emergency. One unit is equal to 15 minutes of service.

4) Behavioral Line Services may exceed the 960 units per Service Plan year depending on need due to the COVID-19 emergency. One unit is equal to 15 minutes of service. Requests for Behavioral Line Services units must be prior authorized in accordance with the Department's procedures.

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	▪	Agency. List the types of agencies:
				Program Approved Service Agency
				Community Centered Board (CCB)/Organized Health Care Delivery System (OHCDS)
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Program Approved Service Agency	Behavioral Services may be provided by licensed individuals as required, who are in good standing, as described in "other standard" below.	Department Program Approval. Behavioral Services may be provided by individuals with appropriate certification as required, as described in "other standard" below.	Behavioral Consultants shall meet one of the following minimum requirements: 1. Shall have a Master's degree or higher in behavioral, social or health sciences or education and be nationally certified as a "Board Certified Behavior Analyst" (BCBA), or certified by a similar nationally recognized organization. Shall have at least 2 years of directly supervised experience developing and implementing behavioral support plans utilizing established approaches including Behavioral Analysis or Positive Behavioral Supports that are consistent with best practice and research on effectiveness for

			people with intellectual and developmental disabilities; or 2. Shall have a Baccalaureate degree or higher in behavioral, social or health sciences or education and be 1) certified as a "Board Certified Assistant Behavior Analyst" (BCABA) or 2) be enrolled in a BCABA or BCBA certification program or completed a Positive Behavior Supports training program and 3) working under the supervision of a certified or licensed Behavioral Services Provider. Counselors shall meet one of the following minimum requirements: 1. Shall hold the appropriate license or certification for the provider's discipline according to state law or federal regulations and represent one of the following professional categories: Licensed Clinical Social Worker, Certified Rehabilitation Counselor, Licensed Professional Counselor, Licensed Clinical Psychologist, or BCBA and must demonstrate or document a minimum of two years' experience in providing counseling to individuals with intellectual and developmental disabilities; or 2. Have a Baccalaureate degree or higher in behavioral, social or health science or education and work under the supervision of a licensed or certified professional as set forth above in requirement one (1). Behavioral Plan Assessor shall meet one of the following minimum qualifications: 1. Shall have a Master's degree or higher in behavioral, social or health science or education and be nationally certified as a BCBA or certified by a similar nationally recognized organization. Shall have at least 2 years of directly supervised experience developing and implementing behavioral support plans utilizing

			established approaches including Behavioral Analysis or Positive Behavioral Supports that are consistent with best practice and research on effectiveness for people with intellectual and developmental disabilities; or 2. Shall have a Baccalaureate degree or higher in behavioral, social or health science or education and be 1) certified as a "Board Certified Assistant Behavior Analyst" (BCABA) or 2) be enrolled in a BCABA or BCBA certification program or completed a Positive Behavior Supports training program and working under the supervision of a certified or licensed Behavioral Services provider. Behavioral Line Staff shall meet the following minimum requirements: Must be at least 18 years of age, graduated from high school or earned a high school equivalency degree and have a minimum of 24 hours training, inclusive of practical experience in the implementation of positive behavioral supports and/or applied behavioral analysis and that is consistent with best practice and research on effectiveness for people with intellectual and developmental disabilities. Works under the direction of a Behavioral Consultant.
Community Centered Board (CCB)/Organized Health Care Delivery System (OHCDS)	Behavioral Services may be provided by licensed individuals as required, who are in good standing, as described in “other standard” below.	Department Program Approval. Behavioral Services may be provided by individuals with appropriate certification as required, as described in “other standard” below.	Behavioral Consultants shall meet one of the following minimum requirements: 1. Shall have a Master's degree or higher in behavioral, social or health sciences or education and be nationally certified as a "Board Certified Behavior Analyst" (BCBA), or certified by a similar nationally recognized organization. Shall have at least 2 years of directly supervised experience developing and implementing behavioral support plans utilizing established approaches including Behavioral Analysis or Positive Behavioral Supports that are consistent with best practice and research on effectiveness for

			people with intellectual and developmental disabilities; or 2. Shall have a Baccalaureate degree or higher in behavioral, social or health sciences or education and be 1) certified as a "Board Certified Assistant Behavior Analyst" (BCABA) or 2) be enrolled in a BCABA or BCBA certification program or completed a Positive Behavior Supports training program and 3) working under the supervision of a certified or licensed Behavioral Services Provider. Counselors shall meet one of the following minimum requirements: 1. Shall hold the appropriate license or certification for the provider's discipline according to state law or federal regulations and represent one of the following professional categories: Licensed Clinical Social Worker, Certified Rehabilitation Counselor, Licensed Professional Counselor, Licensed Clinical Psychologist, or BCBA and must demonstrate or document a minimum of two years' experience in providing counseling to individuals with intellectual and developmental disabilities; or 2. Have a Baccalaureate degree or higher in behavioral, social or health science or education and work under the supervision of a licensed or certified professional as set forth above in requirement one (1). Behavioral Plan Assessor shall meet one of the following minimum qualifications: 1. Shall have a Master's degree or higher in behavioral, social or health science or education and be nationally certified as a BCBA or certified by a similar nationally recognized organization. Shall have at least 2 years of directly supervised experience developing and implementing behavioral support plans utilizing

			established approaches including Behavioral Analysis or Positive Behavioral Supports that are consistent with best practice and research on effectiveness for people with intellectual and developmental disabilities; or 2. Shall have a Baccalaureate degree or higher in behavioral, social or health science or education and be 1) certified as a "Board Certified Assistant Behavior Analyst" (BCABA) or 2) be enrolled in a BCABA or BCBA certification program or completed a Positive Behavior Supports training program and working under the supervision of a certified or licensed Behavioral Services provider. Behavioral Line Staff shall meet the following minimum requirements: Must be at least 18 years of age, graduated from high school or earned a high school equivalency degree and have a minimum of 24 hours training, inclusive of practical experience in the implementation of positive behavioral supports and/or applied behavioral analysis and that is consistent with best practice and research on effectiveness for people with intellectual and developmental disabilities. Works under the direction of a Behavioral Consultant.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Program Approved Service Agency	Community Centered Board as the Organized Health Care Delivery System, The Department of Health Care Policy & Financing, The Department of Public Health & Environment.	Verification of provider qualification is completed upon initial Medicaid enrollment and every five years through provider revalidation, as well as through the DPHE survey process initially and every three years.
Community Centered Board (CCB)/Organized	The Department of Health Care Policy & Financing and Department of Public Health & Environment	Verification of provider qualification is completed upon initial Medicaid enrollment and

Health Care Delivery System (OHCDS)		every five years through provider revalidation, as well as through the DPHE survey process initially and every three years.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	▪	Provider managed

Section A---Services to be Added/Modified During an Emergency

Complete for each service added during a time of emergency. For services in the approved waiver which the state is temporarily modifying, enter the entire service definition and highlight the change. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	**Expressive Therapy**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
Service Definition (Scope)**:**	
Expressive Therapy means provision of creative art, music or play therapy which gives children the ability to creatively and kinesthetically express their medical situation. Expressive therapy functions as the interface between the mind and the body. These therapies are based on the theory that creative activity improves the capacity of the body to heal. Therapies may include book writing, painting, music therapy and scrapbook making. Use of these therapies can decrease a client's feelings of isolation, improve communications skills, decrease emotional suffering due to health status and develop coping skills. Expressive therapy is an activity which is not for recreation but related to the care and treatment of the patients disabling health problems.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
During the COVID-19 emergency period, Expressive Therapy unit limit may be exceeded when there is a demonstrated need.	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	▪	Individual. List types:	▪	Agency. List the types of agencies:
	Individual Therapist		Home Health Agency	
			Hospice Agency	
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Home Health Agency	Department of Public Health and Environment, Health Facilities and Emergency Section Division is currently licensing all home health providers in the state of Colorado	Medicare/Medicaid Certified. Certified as a Medicaid provider of home health State Plan benefits. 10 C.C.R. 2505-10, Section 8.520.	The individuals employed by the agency utilizing music therapy must hold a Bachelor's, Master's or Doctorate in Music Therapy and maintain certification from the Certification Board for Music Therapists. The individuals employed by the agency utilizing art or play therapy shall hold any of the following licenses: LCSW, LPC, LSW, LISW, Licensed Psychologist, Non-denominational/Spiritual/Bereavement

			Counselor. All individuals providing Expressive Therapy must have at least one year of experience in provision of art/play therapy or music therapy to pediatric/adolescent clients.
Individual Therapist	Providers utilizing art or play therapy shall hold any of the following licenses: LCSW, LPC, LSW, LISW, Licensed Psychologist, Non-denominational/Spiritual/Bereavement Counselor Individual Licensed by State of Colorado and/or Licensed individual	Providers utilizing music therapy must hold a Bachelor's, Master's or Doctorate in Music Therapy and maintain certification from the Certification Board for Music Therapists.	At least one year of experience in provision of art/play therapy or music therapy to pediatric/adolescent clients.
Hospice Agency	Hospice agency must be a licensed Medicare/Medicaid hospice provider in Colorado.	Medicare/Medicaid Certified as a Medicaid provider of Hospice services. 10 C.C.R. 2505-10, Section 8.550.	The individuals employed by the agency utilizing music therapy must hold a Bachelor's, Master's or Doctorate in Music Therapy and maintain certification from the Certification Board for Music Therapists. The individuals employed by the agency utilizing art or play therapy shall hold any of the following licenses: LCSW, LPC, LSW, LISW, Licensed Psychologist, Non-denominational/Spiritual/Bereavement Counselor. All individuals providing Expressive Therapy must have at least one year of experience in provision of art/play therapy or music therapy to pediatric/adolescent clients.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home Health Agency	Department of Public Health and Environment, Health Facilities and Emergency Section Division	Department of Public Health and Environment, Health Facilities and Emergency Services Division. According to survey cycle mandated by the Centers for Medicare and Medicaid Services (CMS).
Individual Therapist	Colorado Department of Regulatory Agencies and Medicaid Fiscal Agent	All Individual provider qualifications are verified by the Department's Fiscal

		Agent upon initial enrollment and in a revalidation cycle; at least every 5 years.
Hospice Agency	Department of Public Health and Environment, Health Facilities and Emergency Section Division	Department of Public Health and Environment, Health Facilities and Emergency Services Division. According to survey cycle, at least every 5 years for hospice agencies.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	▪	Provider managed

Section A---Services to be Added/Modified During an Emergency

Complete for each service added during a time of emergency. For services in the approved waiver which the state is temporarily modifying, enter the entire service definition and highlight the change. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	**Home Delivered Meals**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
Service Definition (Scope)**:**	
Home Delivered Meals services offer nutritional counseling and meal planning, preparation, and delivery to support a client. Services do not include the provision of items outside of the nutritional meals identified in the meal planning, such as additional food items or cooking appliances. To access Home Delivered Meals, a client must participate in a needs assessment through which they demonstrate a need for the service based on the following: • The client demonstrates a need for nutritional counseling, meal planning, and preparation; • The client shows documented special dietary restrictions or specific nutritional needs; • The client cannot prepare meals with the type of nutrition vital to meeting their special dietary restrictions or special nutritional needs; • The client has limited or no outside assistance, services, or resources through which they can access meals with the type of nutrition vital to meeting their special dietary restrictions or special nutritional needs; and • The client's need demonstrates a risk to health, safety, or institutionalization; and • The client has been affected by the COVID-19 pandemic.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
Home Delivered Meal services are available during the extent of the state disaster plan due to the COVID-19 pandemic. The unit designation for Home Delivered Meal services is per meal. Meals are limited to two meals per day. Home Delivered Meals is not available when the person resides in a provider owned or controlled setting. Exceptions will be granted based on extraordinary circumstances.	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	▪	Agency. List the types of agencies:
				Home Delivered Meals Provider
				Hospitals, Schools, Restaurants. Home Health Agency, Senior Center, Social Service Agency, Church, and Any Entity Providing Home Delivered Meals.

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Home Delivered Meals Provider	The provider must be a legally constituted entity or foreign entity (outside of Colorado) registered with the Colorado Secretary of State Colorado with a Certificate of Good Standing to do business in Colorado. Foreign entities must have a physical presence within the state for delivering the items. The provider shall have all licensures required by the State of Colorado Department of public health and Environment (CDPHE) for the performance of the service or support being provided, including necessary Retail Food License and Food Handling License for Staff.	The provider must meet the certification standards in §8.487.20 (10 CCR 2505-10). The provider must have an on-staff or contracted certified Registered Dietitian (RD) or Registered Dietitian Nutritionist (RDN).	

Hospitals, Schools, Restaurants. Home Health Agency, Senior Center, Social Service Agency, Church, and Any Entity Providing Home Delivered Meals.	The provider must be a legally constituted entity or foreign entity (outside of Colorado) registered with the Colorado Secretary of State Colorado with a Certificate of Good Standing to do business in Colorado. Foreign entities must have a physical presence within the state for delivering the items. The provider shall have all licensures required by the State of Colorado Department of public health and Environment (CDPHE) for the performance of the service or support being provided, including necessary Retail Food License and Food Handling License for Staff.	The provider must meet the certification standards in §8.487.20 (10 CCR 2505-10).	Providers must comply with all state and local health regulations and ordinances concerning food preparation, handling and serving of food as defined under Colorado 6 CCR 1010-2 Insulated hot and cold containers must be used to assure that food is delivered at appropriate temperatures

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home Delivered Meals Provider	Department of Health Care Policy and Financing	Initially and at submission of renewed license upon expiration of each required license. In addition, if CDPHE receives a complaint involving client care, the findings of the investigation may be grounds

		for CDPHE to initiate a full survey of the provider agency regardless of the date of their last survey.
Hospitals, Schools, Restaurants. Home Health Agency, Senior Center, Social Service Agency, Church, and Any Entity Providing Home Delivered Meals.	Department of Health Care Policy and Financing	Initially and at submission of renewed license upon expiration of each required license. In addition, if CDPHE receives a complaint involving client care, the findings of the investigation may be grounds for CDPHE to initiate a full survey of the provider agency regardless of the date of their last survey.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	▪	Provider managed

Section A---Services to be Added/Modified During an Emergency

Complete for each service added during a time of emergency. For services in the approved waiver which the state is temporarily modifying, enter the entire service definition and highlight the change. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	**In-Home Support Services (IHSS)**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
Service Definition (Scope)**:**	
Services that are provided by an attendant and include health maintenance activities support for activities of daily living or instrumental activities of daily living, personal care services, and homemaker services. Such services are provided under the direction of the client, or an authorized representative who is designated by the client. Currently, IHSS agencies are required by statute and rule to provide additional assistance to IHSS clients. The statutory requirements for IHSS agencies include providing information and referral services, systems advocacy, independent living skills training, cross-disability peer counseling and 24-hour back-up staffing. IHSS regulations further stipulate that IHSS agencies must offer intake and orientation services, assistance with selecting attendants, verification of attendant skills and competency, attendant training and oversight and monitoring by a licensed health professional. As a result of these requirements, IHSS agencies are already providing that level of support to clients who want to direct their own services."	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
In Home Support Services offered in this waiver are limited based on the clients assessed need for services and prior authorization by case managers up to cost containment parameters. During the COVID-19 emergency period, relatives employed by an IHSS agency may provide over the forty (40) hours of personal care (up to forty-eight (48)) in a seven (7) day period. A family member who is an individual's authorized representative may be reimbursed for the provision of IHSS if the individual's personal care worker is unable to meet their personal care needs Clients and/or authorized representatives choosing IHSS shall have no duplication of Personal Care services, Homemaker services and/or Health Maintenance Activities through CDASS, Personal Care agency, Homemaker agency or Home Health Agency. There is no duplication between IHSS services and case management.	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	▪	Agency. List the types of agencies:
				In-Home Support Services Agency
				Home Health Agency—Certified to provide In-Home Support Services
				Personal Care Agency—Certified to provide In Home Support Services

Specify whether the service may be provided by *(check each that applies):*	▪	Legally Responsible Person	▪	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
In-Home Support Services Agency		Certified as an IHSS agency. Certification as a Medicaid provider of In Home Support Services. 10 C.C.R. 2505-10, Section 8.487 and 8.552.7	
Home Health Agency—Certified to provide In-Home Support Services		Certified to provide IHSS. Certification as a Medicaid provider of In Home Support Services. 10 C.C.R. 2505-10, Section 8.487 and 8.552.7	
Personal Care Agency—Certified to provide In Home Support Services		Certified to provide IHSS. Certification as a Medicaid provider of In Home Support Services. 10 C.C.R. 2505-10, Section 8.487 and 8.552.7	

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
In-Home Support Services Agency	Department of Public Health and Environment, Health Facilities and Emergency Section Division	Providers are surveyed every 9-15 months for until a Risk-Based Survey Schedule is developed.
Home Health Agency—Certified to provide In-Home Support Services	Department of Public Health and Environment, Health Facilities and Emergency Section Division	Providers are surveyed every 9-15 months for until a Risk-Based Survey Schedule is developed.
Personal Care Agency—Certified to provide In Home Support Services	Department of Public Health and Environment, Health Facilities and Emergency Section Division	Providers are surveyed every 9-15 months for until a Risk-Based Survey Schedule is developed.

Service Delivery Method

Service Delivery Method *(check each that applies)*:	▪	Participant-directed as specified in Appendix E	▪	Provider managed

Section A---Services to be Added/Modified During an Emergency

Complete for each service added during a time of emergency. For services in the approved waiver which the state is temporarily modifying, enter the entire service definition and highlight the change. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	**Therapeutic Life Limiting Illness Support**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

Service Definition (Scope)**:**

Therapeutic Life Limiting Illness Support is grief/loss or anticipatory grief counseling/support provided by a Licensed Clinical Social Worker (LCSW), Licensed Social Worker (LSW) Licensed Professional Counselor (LPC), Licensed Psychologist or non-denominational Chaplain/Spiritual Care counselor with experience working with clients with life-limiting illnesses and their families and according to hospice industry established practice guidelines. Support is intended to help the child and family in the disease process.

Therapeutic Life Limiting Illness Support has three components: Individual Counseling, Family Counseling, and Group Counseling.

Individual Counseling is provided to the client to decrease emotional suffering due to health status and develop coping skills. Enabling the participant to manage this stress improves the likelihood that the child with a life-threatening condition will continue to be cared for at home, thereby preventing premature and otherwise unnecessary institutionalization. Support will include but is not limited to attending physician visits, attending hospital discharge planning meetings, connecting the family with community resources such as funding or transportation, etc.

Family Counseling is provided to the family/caregiver to alleviate the feelings of devastation and loss related to a diagnosis and prognosis for limited lifespan, surrounding the failing health status of the client, and impending death of a child. Support is provided to the family members in order to guide and help them cope with the client's illness and the related stress that accompanies the continuous, daily care required by a terminally ill child. Enabling the family members to manage this stress improves the likelihood that the child with a life-threatening condition will continue to be cared for at home, thereby preventing premature and otherwise unnecessary institutionalization. Support will include but is not limited to attending physician visits, attending hospital discharge planning meetings, connecting the family with community resources such as funding or transportation, etc.

Group Counseling may be provided to multiple clients on the waiver at the same time to decrease emotional suffering due to health status and develop coping skills.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Therapeutic Life Limiting Illness Support, during the COVID-19 emergency period, may exceed the unit maximum of 98 hours every 365 when there is a demonstrated need. Life Limiting Illness Support will be provided according to the assessment of the client in the continuum of care after a diagnosis of a life-limiting illness or condition. When a child is first diagnosed with the illness, the child and family might need a significant amount of anticipatory grief/loss counseling that may taper off during the treatment phase when the child has some improvement or remission of symptoms. As the child's health deteriorates, supportive services may be required at an intensive level.

When available and appropriate, State Plan services will be utilized prior to waiver services for the child or family.

Provider Category(s) *(check one or both)*:	▪	Individual. List types:	▪	Agency. List the types of agencies:
	Individual Therapist		Home Health Agency	
			Hospice Agency	
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Home Health Agency	Department of Public Health and Environment, Health Facilities and Emergency Section Division is currently licensing all home health providers in the state of Colorado. Services must be provided by licensed, certified, and/or registered individuals operating within the applicable scope of practice.	All Skilled home health agencies in Colorado must be certified by Medicare prior to be certified by the Department of Health Care Policy and Financing Medicare/Medicaid Certified. Certified as a Medicaid provider of home health State Plan benefits. 10 C.C.R. 2505-10, Section 8.520.	
Hospice Agency	Hospice agency must be a licensed Medicare/Medicaid hospice provider in Colorado. Services must be provided by licensed, certified, and/or registered individuals operating within the applicable scope of practice.	Medicare/Medicaid Certified as a Medicaid provider of Hospice services. 10 C.C.R. 2505-10, Section 8.550.	
Individual Therapist	LCSW, LPC, LSW, LISW, Licensed Psychologist, Individual Licensed by State of Colorado and/or Licensed individual	Non-denominational/Spiritual/Bereavement Counselor/Chaplain certified by appropriate associations.	Individual and Family Grief Loss or Bereavement counseling experience, pediatric/adolescent counseling experience of one year.

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home Health Agency	Department of Public Health and Environment, Health Facilities and Emergency Section Division	Department of Public Health and Environment, Health Facilities and Emergency Services Division. According to survey cycle mandated by the Centers for Medicare and Medicaid Services (CMS).
Hospice Agency	Department of Public Health and Environment, Health Facilities and Emergency Section Division	Department of Public Health and Environment, Health Facilities and Emergency Services Division. According to survey cycle, at least every 5 years.
Individual Therapist	LCSW, LPC, LSW, LISW, Licensed Psychologist Colorado Department of Regulatory Agencies and Medicaid Fiscal Agent	All Individual provider qualifications are verified by the Department's Fiscal Agent upon initial enrollment and in a revalidation cycle; at least every 5 years.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	▪	Provider managed

Section A---Services to be Added/Modified During an Emergency

Complete for each service added during a time of emergency. For services in the approved waiver which the state is temporarily modifying, enter the entire service definition and highlight the change. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	**Non-Medical Transportation (DD) and (SLS)**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
Service Definition (Scope)**:**	
Service offered in order to enable waiver participants to gain access to Day Habilitation and Supported Employment services as specified by the Service Plan that are not related to medical interventions as covered in the State Plan. Transportation to and from work is a benefit in conjunction with Supported Employment service except when the Supported Employment service occurs at a frequency less than the number of days worked. In that case, transportation to and from the place of employment is a benefit when the participant does not have resources available, including personal funds, natural supports, and/or third-party resources. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State plan, defined at 42 CFR §440.170(a) (if applicable), and does not replace them. Transportation services under the waiver are offered in accordance with the participant's Service Plan. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge are utilized.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
Transportation to and from day program shall be reimbursed based on the applicable transportation band. The number of units available for Transportation Services is 508 units and may be exceeded based upon need due to the COVID-19 emergency per Service Plan year. A unit is a per-trip charge for to and from Day Habilitation and Supported Employment programs.	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	▪	Agency. List the types of agencies:
				Community Centered Board (CCB)/ Organized Health Care Delivery System (OHCDS)
				Program Approved Service Agency
				Public Transportation Agency
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	▪	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Community Centered Board (CCB)/ Organized Health Care Delivery System (OHCDS)	Public Utilities Commission (PUC) permit; Colorado Driver's License or Commercial Driver's License, or		Rules: 10 CCR 2505-10 § 8.603.8 Appropriate amount of liability coverage.

	C.R.S. 40-10-101 et.seq.		
Program Approved Service Agency	Public Utilities Commission (PUC) permit; Colorado Driver's License, or Commercial Driver's License, or C.R.S. 40-10-101 et.seq.		Rules:10 CCR 2505-10 § 8.603.8 Required liability coverage.
Public Transportation Agency	As required by state law.		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Community Centered Board (CCB)/ Organized Health Care Delivery System (OHCDS)	The Department of Health Care Policy and Financing.	Verification of provider qualification is completed upon initial Medicaid enrollment and every five years through provider revalidation
Program Approved Service Agency	The Department of Health Care Policy and Financing.	Verification of provider qualification is completed upon initial Medicaid enrollment and every five years through provider revalidation
Public Transportation Agency	The Department of Health Care Policy and Financing.	Verification of provider qualification is completed upon initial Medicaid enrollment and every five years through provider revalidation

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	▪	Provider managed

Section A---Services to be Added/Modified During an Emergency

Complete for each service added during a time of emergency. For services in the approved waiver which the state is temporarily modifying, enter the entire service definition and highlight the change. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	**Non-Medical Transportation**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
Service Definition (Scope)**:**	
Service offered in order to enable individuals served on the waiver to gain access to waiver and other community services, activities, and resources, specified by the service plan. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State Plan, defined at 42 CFR 440.170 (a) (if applicable), and shall not replace them. Transportation services under the waiver shall be offered in accordance with the individual's service plan. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge will be utilized.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
Excluding transportation to Adult Day facilities, a client receive more than the equivalent of four one-way trip services per week depending on need due to the COVID-19 emergency. Non-medical transportation services offered in this waiver are limited based on the client's assessed need for services, physician's orders and prior authorization by case mangers up to the cost containment parameters. Clients may utilize a combination of NMT services up to the Department prescribed limit.	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	▪	Agency. List the types of agencies:
				Non-Medical Transportation Provider
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Non-Medical Transportation Provider	As required by State law.	Medicaid certified. Certification as a Medicaid provider o Non-medical transportation provider 10 C.C.R. 2505-10, Section 8.494: All drivers shall possess a valid Colorado drivers licensee, shall be free of physical or mental impairment that would adversely affect driving performance, and have not had two or more convictions or chargeable accidents within the past two years. All vehicles and related auxiliary equipment shall meet all applicable federal, state and local safety inspection and maintenance requirements, and shall be in	The contracted Administrative Services Organization (ASO) must be engaged in a provider agreement with the Department and comply with all regulations in C.R.S 10 C.C.R. 2505-10,

		compliance with state automobile insurance requirements.	Section 8.00 and 8.100

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Non-Medical Transportation Provider	The Department of Health Care Policy and Financing.	The Department currently reviews the provider qualifications at the time of initial application and on an annual basis.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	▪	Provider managed

Section A---Services to be Added/Modified During an Emergency

Complete for each service added during a time of emergency. For services in the approved waiver which the state is temporarily modifying, enter the entire service definition and highlight the change. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	**Remote Support Services**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
Service Definition (Scope)**:**	
Remote Support Services provide oversight and monitoring within the participant's home through an off-site electronic support system in order to reduce or replace the amount of staffing a participant needs. The purpose of Remote Support Services is to support the participant to exercise greater independence over their lives. It is integrated into the participant's overall support system and reduces the amount of staff support a person uses in their home while ensuring health and welfare. Remote Support Service includes: 1. Electronic support system installation, repair, maintenance, and back-up system; 2. Training and technical assistance for the participant and his or her support network; 3. Off-site system monitoring staff; and 4. Stand-by intervention staff for notifying emergency personnel such as police, fire, and back-up support staff. Remote Supports must be done in real time with awake staff.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	▪	Individual. List types:	▪	Agency. List the types of agencies:
				Program Approved Service Agency
				Enrolled Medicaid Provider - Personal Care Agency, Home Care Agency,
Specify whether the service may be provided by *(check each that applies):*	X	Legally Responsible Person	X	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Enrolled Medicaid Provider - Personal Care Agency, Home Care Agency,	Home Care Agency, Class A or B	Certification as a Medicaid provider of Home and Community Based Services. 26-4-601, C.R.S; 10 C.C.R. 2505-10, Section 8.489	Direct Care Staff: Be at least 18 years of age, have the ability to communicate effectively, complete required forms and reports, and follow verbal and written instructions. Have the ability to provide services in accordance with a Service Plan. Have completed minimum training based on State training guidelines. Have necessary ability to perform the required job tasks and have the

			interpersonal skills needed to effectively interact with persons with disabilities.
Program Approved Service Agency	Home Care Agency, Class A or B	The Department of Health Care Policy and Financing Program Approval	Direct Care Staff: Be at least 18 years of age, have the ability to communicate effectively, complete required forms and reports, and follow verbal and written instructions. Have the ability to provide services in accordance with a Service Plan. Have completed minimum training based on State training guidelines. Have necessary ability to perform the required job tasks and have the interpersonal skills needed to effectively interact with persons with developmental disabilities.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Enrolled Medicaid Provider - Personal Care Agency, Home Care Agency	Department of Public Health and Environment, Health Facilities and Emergency Section Division	Initially and every three years
Program Approved Service Agency	The Department of Health Care Policy and Financing The Department of Public Health and Environment	Initially and every three years

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	▪	Provider managed

Section A---Services to be Added/Modified During an Emergency

Complete for each service added during a time of emergency. For services in the approved waiver which the state is temporarily modifying, enter the entire service definition and highlight the change. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	Respite (CES)
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
Service Definition (Scope)**:**	
Respite service is provided on a short-term basis, because of the absence or need for relief to caregivers of the participant. Respite is to be provided in an age appropriate manner. Respite may be provided on an individual or group basis in the residence of the participant or respite care provider or in the community. Respite may be provided on an overnight group basis only by facilities approved to provide supervised overnight group accommodations. Federal financial participation is not to available for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence. Respite services shall be billed according to a unit rate or daily rate whichever is less. Respite shall be provided based on individual or group rates as defined below: Individual: the client receives respite in a one-on-one situation. There are no other clients in the setting also receiving respite services. Individual respite occurs for ten (10) hours or less in a twenty-four (24)-hour period. Individual day: the client receives respite in a one-on-one situation for cumulatively more than 10 hours in a 24-hour period. A full day is 10 hours or greater within a 24- hour period. Overnight group: the client receives respite in a setting which is defined as a facility that offers 24-hour supervision through supervised overnight group accommodations. The total cost of overnight group within a 24-hour period shall not exceed the respite daily rate. Group: the client receives care along with other individuals, who may or may not have a disability. The total cost of group within a 24-hour period shall not exceed the respite daily rate.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
The total amount of respite provided in one plan year may exceed 30 days and 1,880 additional 15-minute units in a plan year depending on need due to the COVID-19 emergency. The Department may approve a higher amount based on a documented increase in medical or behavioral needs as reflected in the behavior plan for behavioral needs or in the medical records for medical needs.	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	▪	Agency. List the types of agencies:
				Program Approved Service Agency
				Community Centered Board (CCB)/Organized Health Care Delivery System (OHCDS)

Specify whether the service may be provided by *(check each that applies):*	▪	Legally Responsible Person	▪	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Program Approved Service Agency		Program Approval	Direct Care Staff: Be at least 16 years of age, have the ability to communicate effectively, complete required forms and reports, and follow verbal and written instructions. Have the ability to provide services in accordance with a Service Plan. Have completed minimum training based on State training guidelines. Have necessary ability to perform the required job tasks and have the interpersonal skills needed to effectively interact with persons with developmental disabilities
Community Centered Board (CCB)/Organized Health Care Delivery System (OHCDS)		Program Approval	Direct Care Staff: Be at least 16 years of age, have the ability to communicate effectively, complete required forms and reports, and follow verbal and written instructions. Have the ability to provide services in accordance with a Service Plan. Have completed minimum training based on State training guidelines. Have necessary ability to perform the required job tasks and have the interpersonal skills needed to effectively interact with persons with developmental disabilities

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Program Approved Service Agency	The Department of Health Care Policy and Financing and Department of Public Health and Environment	Verification of provider qualification is completed by HCPF upon initial Medicaid enrollment and every five years through provider revalidation, as

		well as through the CDPHE survey process initially and every three years
Community Centered Board (CCB)/Organized Health Care Delivery System (OHCDS)	The Department of Health Care Policy and Financing and Department of Public Health and Environment	Verification of provider qualification is completed by HCPF upon initial Medicaid enrollment and every five years through provider revalidation, as well as through the CDPHE survey process initially and every three years

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	▪	Provider managed

Section A---Services to be Added/Modified During an Emergency

Complete for each service added during a time of emergency. For services in the approved waiver which the state is temporarily modifying, enter the entire service definition and highlight the change. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	**Respite**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
Service Definition (Scope)**:**	
Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care. Respite may be received in the individual's home, an Alternative Care Facility (ACF), or a Nursing Facility (NF). An individual would be responsible for any prorated room and board costs for the time spent in an ACF or NF. Respite may be provided in the individual's home for the CMHS waiver.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
An individual client shall be authorized for more than 30 days of respite care in each calendar year when there is a demonstrated need.	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	▪	Agency. List the types of agencies:
				Nursing Facility
				Personal Care Agency
				Home Health Agency
				Alternative Care Facility
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	▪	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Nursing Facility		Medicaid certified nursing facility. Certification as a Medicaid Nursing Facility. 10 C.C.R. 2505-10, Section 8.430	
Personal Care Agency	Home Care Agency licensed by CDPHE as either Class A or Class B		
Home Health Agency	Home Care Agency licensed by CDPHE	Medicaid certified Personal care provider. Certification as a Medicaid provider of Home	

	as either Class A or Class B	and Community Based Services. 10 C.C.R. 2505-10, Section 8.489	
Alternative Care Facility	Assisted Living Residence	Medicaid certified alternative care facility. Certification as a Medicaid Alternative Care Facility. 10 C.C.R. 2505-10 Section 8.495	

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Nursing Facility	Department of Public Health and Environment, Health Facilities and Emergency Section Division	Every nursing facility is surveyed by DPHE every 9-15 months
Personal Care Agency	Department of Public Health and Environment, Health Facilities and Emergency Section Division	Providers 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. During the investigation of a complaint by CDPHE, findings are severe - i.e. a systemic failure, patient harm, etc. it may cause an 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
Home Health Agency	Department of Public Health and Environment, Health Facilities and Emergency Section Division	Providers 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. During the investigation of a complaint by CDPHE, findings are severe - i.e. a systemic failure, patient harm, etc. it may cause an 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
Alternative Care Facility	Department of Public Health and Environment, Health Facilities and Emergency Section Division	ACF providers eligible for the extended survey cycle may be surveyed up to every 36 months. ACF providers are eligible for the extended survey cycle if they have been licensed for three years, have not had enforcement activity, a pattern of deficient practice or a substantiated complaint resulting in a deficiency cited at a level of actual harm or life-threatening situation. If CDPHE receives a complaint involving abuse, neglect or substandard care, the findings of the investigation may be grounds to conduct a survey regardless of the date of the last survey. In accordance with the State Operations Manual, survey of Life Safety Code issues has been designated through an interagency agreement to the Colorado Division of Fire Protection

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	▪	Provider managed

Section A---Services to be Added/Modified During an Emergency

Complete for each service added during a time of emergency. For services in the approved waiver which the state is temporarily modifying, enter the entire service definition and highlight the change. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	**Respite (SLS)**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
Service Definition (Scope)**:**	
Respite service is provided on a short-term basis, because of the absence or need for relief to caregivers of the participant. Respite is to be provided in an age appropriate manner. Respite may be provided on an individual or group basis in the residence of the participant or respite care provider or in the community. Respite may be provided on an overnight group basis only by facilities approved to provide supervised overnight group accommodations. Federal financial participation is not to available for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence. Respite services shall be billed according to a unit rate or daily rate whichever is less. Respite shall be provided based on individual or group rates as defined below: Individual: the client receives respite in a one-on-one situation. There are no other clients in the setting also receiving respite services. Individual respite occurs for ten (10) hours or less in a twenty-four (24)-hour period. Individual day: the client receives respite in a one-on-one situation for cumulatively more than 10 hours in a 24-hour period. A full day is 10 hours or greater within a 24- hour period. Overnight group: the client receives respite in a setting which is defined as a facility that offers 24-hour supervision through supervised overnight group accommodations. The total cost of overnight group within a 24-hour period shall not exceed the respite daily rate. Group: the client receives care along with other individuals, who may or may not have a disability. The total cost of group within a 24-hour period shall not exceed the respite daily rate.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
A full day is 10 hours (15-minute units x 4 x 10) or greater within a twenty-four (24) service period.	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	▪	Agency. List the types of agencies:
				Program Approved Service Agency
				Community Centered Board (CCB)/Organized Health Care Delivery System (OHCDS)

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	▪	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Program Approved Service Agency		Program Approval	Direct Care Staff: Be at least 16 years of age, have the ability to communicate effectively, complete required forms and reports, and follow verbal and written instructions. Have the ability to provide services in accordance with a Service Plan. Have completed minimum training based on State training guidelines. Have necessary ability to perform the required job tasks and have the interpersonal skills needed to effectively interact with persons with developmental disabilities
Community Centered Board (CCB)/Organized Health Care Delivery System (OHCDS)		Program Approval	Direct Care Staff: Be at least 16 years of age, have the ability to communicate effectively, complete required forms and reports, and follow verbal and written instructions. Have the ability to provide services in accordance with a Service Plan. Have completed minimum training based on State training guidelines. Have necessary ability to perform the required job tasks and have the interpersonal skills needed to effectively interact with persons with developmental disabilities

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Program Approved Service Agency	The Department of Health Care Policy and Financing and Department of Public Health and Environment	Verification of provider qualification is completed by HCPF upon initial Medicaid enrollment and every five years through provider revalidation, as well as through the CDPHE survey process initially and every three years

Community Centered Board (CCB)/Organized Health Care Delivery System (OHCDS)	The Department of Health Care Policy and Financing and Department of Public Health and Environment	Verification of provider qualification is completed by HCPF upon initial Medicaid enrollment and every five years through provider revalidation, as well as through the CDPHE survey process initially and every three years

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	▪	Provider managed

Section A---Services to be Added/Modified During an Emergency

Complete for each service added during a time of emergency. For services in the approved waiver which the state is temporarily modifying, enter the entire service definition and highlight the change. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	**Supported Community Connections**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
Service Definition (Scope)**:**	
Supported Community Connections services are provided one-on-one to deliver instruction for documented severe behavior problems that are being demonstrated by the waiver participant while in the community, i.e. physically or sexually aggressive to others and/or exposing themselves. This service is not duplicative of State Plan benefits or those services offered by the Behavioral Health Organization. These activities are conducted in a setting within the community where participants interact with non-disabled individuals (other than the individual that is providing the service to the participant). Supported Community Connections is an additional service provided by a Medicaid provider to work with the child one-on-one while in the community for no more than five (5) hours per week. The targeted behavior, measurable goal(s), and work plan must be clearly articulated in the Service Plan.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
The unit maximum of 5 hours per week may be exceeded depending on need due to the COVID-19 emergency. Requests to increase hours can be made to the Department of Health Care Policy & Financing (Department) on a case-by-case basis.	

Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	▪	Agency. List the types of agencies:
				Child Placement Agency
				Medicaid Enrolled Provider
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	▪	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Child Placement Agency			An individual providing this service must have training and/or experience commensurate with the service or support being provided and be at least 16 years of age. This service shall not be performed by a person who is employed by the same CPA

			who provides oversight to the child's current foster home.
Medicaid Enrolled Provider		An agency certified to provide Community Connector as a Program Approved Service Agency for the Home and Community Based Services- Children's Extensive Supports (HCBS-CES) wavier.	Any individual providing this service must have training and/or experience commensurate with the service or support being provided and be at least 16 years of age.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Child Placement Agency	The Department of Health Care Policy & Financing and the Colorado Department of Human Services	Verification of provider qualifications is completed upon Medicaid enrollment and every five years through provider revalidation
	The Department of Health Care Policy & Financing (HCPF) and the Department of Public Health & Environment (CDPHE)	Verification of provider qualifications is completed upon Medicaid enrollment and every five years through provider revalidation and through the CDPHE survey process every three years

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	▪	Provider managed

Section A---Services to be Added/Modified During an Emergency

Complete for each service added during a time of emergency. For services in the approved waiver which the state is temporarily modifying, enter the entire service definition and highlight the change. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	**Supplies, Equipment, and Medication Reminder**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
Service Definition (Scope)**:**	
Specialized medical equipment and supplies includes devices, controls or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. Medication Reminders refers to the supplies or appliance in the current service definition that enable individuals to increase their ability to complete activities of daily living. This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items and durable/non-durable medical equipment not available under the Medicaid State Plan. For the SCI Waiver this service will be expanded to include items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items and durable/non-durable medical equipment not available under the Medicaid State Plan.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
Items reimbursed as Medication Reminder shall be in addition to any medical equipment and supplies furnished under the Medicaid State plan. The Supplies, Equipment and Medication Reminder service under this wavier is limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives of avoiding institutionalization. The unit maximums may be exceeded when there is a demonstrated need due to COVID-19. All medically necessary items that are covered under the Durable Medical Equipment or EPSDT benefit within the state plan shall be accessed first	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	▪	Agency. List the types of agencies:
				Specialized Medical Equipment and Supplies Provider
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Specialized Medical Equipment and Supplies Provider		Certification as a Medicaid provider of durable and non-durable medical	

		equipment and supplies. 10 C.C.R. 2505-10, Section 8.590 et seq.	

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Specialized medical Equipment and Supplies Provider	Department of Health Care Policy and Financing	The Department currently reviews the provider qualifications at the time of initial application and on an annual basis.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	▪	Provider managed

Section A---Services to be Added/Modified During an Emergency

Complete for each service added during a time of emergency. For services in the approved waiver which the state is temporarily modifying, enter the entire service definition and highlight the change. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	**Youth Day**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
Service Definition (Scope)**:**	
The purpose of Youth Day Service is to provide care and supervision to clients while the primary caregiver works or seeks employment, when that care is needed due to the client's intellectual and developmental disability and not the client's age. Youth 12 years of age and older typically do not require care and supervision during the primary caregiver's absence; however, children with Intellectual and developmental disabilities in this age range typically do require care and supervision while the primary caregiver is absent from the home. In the event the cost of care and supervision during the time the parents work is greater for an eligible participant, 11 years of age or younger, than child care is for same-age typical peers, then supervision is reimbursed at the difference between the cost for care and supervision and the standard cost for child care. This service shall not duplicate the respite service or any other service that includes supervision. Youth Day Service may be provided on an individual or group basis and may be provided in the residence of the participant or Youth day service provider or in the community. Individual 15-minute unit: The client receives care and supervision in a one-on-one situation. There are no other clients in the setting also receiving Youth Day services. Group: the client receives care along with other individuals, who may or may not have a disability. Group Youth Day Services are provided to the HCBS-CES waiver participant along with other individuals who may or may not have a disability; however, reimbursement is limited to the waiver participant.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
This service is limited to clients between the ages of 12 and 17. The age of 12 years has been designated as the age appropriate for a child to be left alone for short periods of time. This standard is based upon the Colorado Child Labor Law, which deems 12 years as the minimum age for employment. (See Colorado Revised Statutes. § 8-12-105(3)). This benefit is not available to clients from birth through the age of 11 during the time the parent works because child care for children 11 years of age and younger is a typical expense for all working parents. This service may not be used to substitute for or supplant special education and related services that are included in a child's Individualized Education Plan (IEP) under the provisions of Individuals with Disabilities Education Improvement Act of 2004 (IDEA). This service may not be used to cover any portion of the cost of camp. The ten-hour maximum limitation may be exceeded when there is a demonstrated need due to the COVID-19 emergency.	

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	▪	Agency. List the types of agencies:
				Program Approved Service Agency
				Community Centered Board (CCB)/Organized Health Care Delivery System (OHCDS
Specify whether the service may be provided by *(check each that applies):*	▪	Legally Responsible Person	▪	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Program Approved Service Agency		Program Approval	Direct Care Staff: Be at least 16 years of age, have the ability to communicate effectively, complete required forms and reports, and follow verbal and written instructions. Have the ability to provide services in accordance with a Service Plan. Have completed minimum training based on State training guidelines. Have necessary ability to perform the required job tasks and have the interpersonal skills needed to effectively interact with persons with developmental disabilities
Community Centered Board (CCB)/Organized Health Care Delivery System (OHCDS		Program Approval.	Direct Care Staff: Be at least 16 years of age, have the ability to communicate effectively, complete required forms and reports, and follow verbal and written instructions. Have the ability to provide services in accordance with a Service Plan. Have completed minimum training based on State training guidelines. Have necessary ability to perform the required job tasks and have the interpersonal skills needed to effectively interact with persons with developmental disabilities

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Program Approved Service Agency	The Department of Health Care Policy and Financing and Department of Public Health and Environment	Verification of provider qualification is completed upon initial Medicaid enrollment and every five years through provider revalidation, as well as through the DPHE survey process initially and every three years.

Community Centered Board (CCB)/Organized Health Care Delivery System (OHCDS	The Department of Health Care Policy and Financing and Department of Public Health and Environment	Verification of provider qualification is completed upon initial Medicaid enrollment and every five years through provider revalidation, as well as through the DPHE survey process initially and every three years.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	▪	Provider managed