Community First Choice (CFC) State Plan Option
DRAFT: January 2024

1 [Language Added]
2 ~~{Language Removed}~~
3 Edited Language

4 **Draft SPA for Stakeholder Review**
5 **February 2024**
6 Please submit feedback by email to hcpf_cfc@state.co.us or
7 by phone to 303-866-5472
8
9 **Benefit Summary:**
10
11 **Please provide a brief general overview of the state's proposed Community First**
12 **Choice (CFC) benefit, including but not limited to an overview of services, delivery**
13 **method, impact on other long-term services and supports (LTSS) programs, and how**
14 **services will be coordinated between the CFC program and other state services**
15 **provided:**
16
17 **Services and delivery method:** Colorado's Community First Choice (CFC) option offers
18 activities of daily living (ADL) and instrumental activities of daily living (IADL) support
19 and assistance through an Agency-Provider Model, where members can choose the
20 level of self-direction they wish to have in their services, and through a Self-Directed
21 with Budget Model, Consumer Directed Attendant Support Services (CDASS). The CDASS
22 model is a Self-Directed Model with Service Budget that utilizes a Financial
23 Management Services (FMS) model to support the CFC member with administrative
24 tasks, such as payroll and tax withholdings, and allows for waiving the Nurse
25 Practitioners Act. The CFC benefit includes services to assist individuals in acquiring,
26 enhancing, and/or maintaining skills necessary to accomplish activities of daily living,
27 instrumental activities of daily living, and health-related tasks, backup systems, and
28 voluntary training on selecting, managing, and dismissing attendants. In addition,
29 Colorado is choosing to incorporate three optional services in the CFC benefit,
30 transition setup, remote supports, and home-delivered meals.
31
32 **Impact on other LTSS programs:** The Department has made the following alterations
33 to current Long-Term Services and Supports (LTSS) to prevent duplication of services:
34 1. Services offered in CFC will be accessed through the 1915(k) authority and
35 will no longer be available through a 1915(c) waiver after the member
36 transitions to CFC. If a 1915(c) per diem residential service includes a task
37 offered through CFC, the waiver member will still have access through the
38 1915(c) waivers.
39 2. The current 1915(c) waivers will be amended to remove personal care,
40 homemaker, health maintenance activities, In-Home Support Services (IHSS),

41 Consumer Directed Attendant Support Services (CDASS), electronic
42 monitoring (including personal emergency response system (PERS) and
43 medication reminders), remote supports, and home delivered meals.
44 3. Colorado's Medicaid Management Information System (MMIS) will have
45 safeguards to ensure duplication of services does not occur. For example, a
46 member receiving agency-based personal care services through CFC will be
47 prevented from accessing self-directed personal care services at the same
48 time.
49
50 **Coordination between CFC and other State Services:** The Department coordinates
51 CFC with other services by using:
52 1. An assessment process (the Colorado Single Assessment) that allows all
53 individuals potentially eligible for CFC to experience a single assessment for
54 eligibility determination and have an informed choice about CFC and other
55 state plan services.
56 2. A Person-Centered Support Plan and Needs Assessment that includes all LTSS
57 services.
58
59 **Community First Choice Development and Implementation Council**
60
61 **Name of State Development and Implementation Council:**
62 Community First Choice Council (CFCC)
63 **Date of 1st Council meeting:** May 4, 2022
64
65 ☒ **The state has consulted with its Development and Implementation Council**
66 **before submitting its CFC State Plan amendment.**
67
68 ☒ **The state has consulted with its Development and Implementation Council on**
69 **its assessment of compliance with home and community-based settings**
70 **requirements, including on the settings the state believes overcome the**
71 **presumption of having institutional qualities.**
72
73 ☒ **The state has sought public input on home and community-based settings**
74 **compliance beyond the Development and Implementation Council. If yes,**
75 **please describe:**
76
77 Beginning in May of 2022, the Department coordinated monthly meetings with the
78 Community First Choice Council (CFCC) to gather input and guidance on each component

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79 of Colorado's CFC benefit. The majority of CFCC members are individuals with
80 disabilities, elderly individuals, and their representatives. Additionally, the Department
81 created a CFC workgroup to specifically address policy for one of Colorado's participant-
82 directed service delivery options, Consumer-Directed Attendant Support Services
83 (CDASS). This workgroup was created to review, prioritize, and investigate key CDASS
84 policy areas as the Department works to integrate CDASS into the CFC benefit. The
85 workgroup met for four months with key stakeholders, many of whom also regularly
86 attend the CFC Council Meetings.

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

92 The Department has also sought broader public input on home- and community-based
93 settings compliance beyond that provided by the CFCC. The Department has gathered
94 input from HCBS participants and advocates, providers, case management agencies, and
95 other members of the public on home- and community-based settings compliance. This
96 stakeholder engagement consisted of the following:

97 • Presented to and spoke with numerous groups, including those representing
98 people with disabilities, providers, case management agencies, Long-Term Care
99 Ombudsmen, and adult protective services (2016-2022);

100 • Held public question-and-answer sessions (2018, 2021);

101 • Convened Rights Modification Stakeholder Workgroup to develop Colorado's
102 codification of federal rule, informed consent template, and other materials
103 (2019-2020);

104 • Continued this work via Open Meeting Series (2020-2021);

105 • Held town halls to discuss heightened scrutiny determinations (2021 and 2023);

106 • Conducted formal stakeholder engagement as part of finalizing the state's
107 codification of the federal rule (2021); and

108 • Developed separate stakeholder communications plan reflecting these and other
109 approaches (2022).

110 Additional detail on these stakeholder engagement initiatives is located in Table 1 (red)
111 in Colorado's Statewide Transition Plan (STP), pages 4-6.

112 The Department's first batch of heightened scrutiny determinations was open for public
113 comment from June 10, 2021, through July 10, 2021. The Department hosted three

114 public town halls in connection with these determinations. The Department's second
115 batch of heightened scrutiny determinations was open for public comment from April
116 25, 2023, through May 25, 2023. The Department hosted one public town hall in
117 connection with this smaller batch of determinations. The Department reviewed and
118 addressed the comments received during and after each public comment period, as set
119 out in the updated summary sheets for each setting. Additional detail on stakeholder
120 engagement relating to heightened scrutiny is located in Table 2 (orange) in Colorado's
121 STP, row 10, subrow on heightened scrutiny, pages 10-11.

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122 **Community First Choice Eligibility**
123
124 ☒ Individuals are eligible for medical assistance under an eligibility group
125 identified in the state plan.
126
127 ☒ Categorically Needy Individuals

128 ☒ Medically Needy Individuals

129 ☒ Medically Needy individuals receive the same services that are
130 provided to Categorically Needy individuals
131
132 ☐ Different services than those provided to Categorically Needy
133 individuals are provided to Medically Needy individuals. (If this box is
134 checked, a separate template must be submitted to describe the CFC
135 benefits provided to Medically Needy individuals)
136
137 The state assures the following:
138
139 ☒ Individuals are in eligibility groups in which they are entitled to nursing facility
140 services, or
141
142 ☐ If individuals are in an eligibility group under the state plan that does not
143 include nursing facility services, and to which the state has elected to make
144 CFC services available (if not otherwise required), such individuals have an
145 income that is at or below 150 percent of the Federal poverty level (FPL)
146
147 **Level of Care**
148
149 ☒ The state assures that absent the provision of home and community-based
150 attendant services and supports provided under CFC, individuals would require
151 the level of care furnished in a long- term care hospital, a nursing facility, an
152 intermediate care facility for individuals with intellectual disabilities, an
153 institution providing inpatient psychiatric services for individuals under age 21,
154 or an institution for mental diseases for individuals age 65 or over.
155
156 **Recertification**
157
158 ☐ The state has chosen to permanently waive the annual recertification of level
159 of care requirement for individuals in accordance with 441.510(c)(1) & (2).
160
161 Please indicate the levels of care that are

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162 **being waived:**

163 ☐ **Long-term care hospital**

164 ☐ **Nursing facility**
165
166 ☐ **Intermediate care facility for individuals with intellectual**
167 **disabilities**
168
169 ☐ **Institution providing psychiatric services for individuals**
170 **under age 21**
171
172 ☐ **Institution for mental diseases for individuals age 65**

173 **or over**

174 **Describe the state process for determining an individual's level of care:**
175
176 Members will be assessed for institutional level of care using the Colorado Single Assessment
177 Level of Care Screen. The Colorado Single Assessment supports a comprehensive, person-
178 centered approach to the identification of a member's needs, preferences, goals, and covers
179 a set of life domains that critically affect independence and quality of life. The Level of
180 Care Screen includes the Level of Care Eligibility Determination outcome that is based on an
181 individual's performance level as documented in the screen, in areas including, but not
182 limited to, completing Activities of Daily Living, memory and cognition, sensory and
183 communication, and behavior, as well as other criteria specific to applicable program and
184 specific to age appropriateness. The Level of Care Eligibility Determination assesses for:
185
186 ▪ Nursing Facility Level of Care Eligibility for ages four (4) and older.
187 ▪ Nursing Facility Level of Care Eligibility Criteria for individuals zero to three (0-3)
188 years of age.
189 ▪ Nursing Facility Level of Care Eligibility Alternative Criteria.
190 ▪ Hospital Level of Care Eligibility Criteria.
191 ▪ Intermediate Care Facility Level of Care Eligibility Criteria.
192
193 For initial level of care eligibility determinations, the Professional Medical Information Page
194 (PMIP) must be completed by a treating medical professional who verifies the individual's
195 need for institutional level of care. The Department oversees eligibility determinations
196 completed by Case Management Agencies.

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197 **Informing Individuals Potentially Eligible for the Community First Choice Option**
198
199 **Indicate how the state ensures that individuals potentially eligible for CFC**
200 **services and supports are informed of the program's availability and services:**
201
202 ☐ **Letter**

203 ☐ **Email**

204 ☒ **Other - Describe:**
205
206 Agencies serving as access points for publicly funded Long-Term Services and Supports
207 (LTSS).
208
209 **Please describe the process used for informing beneficiaries:**
210 The Department will work with contracted Case Management Agencies to inform current
211 1915(c) waiver members, and current members receiving state plan services, about CFC.
212 The Department will send letters, emails, and brochures to Medicaid providers, nursing
213 facility administrators, social workers and discharge planners, hospital transition
214 coordinators, and options counseling agencies to ensure providers are equipped to inform
215 potential members of CFC services. Medicaid providers will be given CFC program
216 information and resources to share with beneficiaries to ensure that all individuals seeking
217 Long-Term Services and Supports (LTSS) can make an informed decision about CFC
218 regardless of where the member enters the Health First Colorado Medicaid system. The
219 Department will provide briefings and presentations about CFC to other state departments,
220 agencies, and stakeholder groups.
221 The Department will work with the CFC Council to identify additional advocacy groups and
222 populations in need of targeted outreach. Additionally, the Department will conduct specific
223 outreach to inform Colorado's native tribes of the availability of CFC services. All
224 communications regarding CFC will be created in multiple languages. In the first year of
225 CFC, each 1915(c) Waiver member shall be informed by their case manager, in a manner
226 prescribed by the Department, about the CFC program and will be supported to transition to
227 the CFC program during the Person-Centered Support Planning process.
228 **Assurances (All assurances must be checked).**
229
230 ☒ **Services are provided on a statewide basis.**
231
232 ☒ **Individuals make an affirmative choice to receive services through the CFC**
233 **option.**
234
235 ☒ **Services are provided without regard to the individual's age, type or nature**
236 **of disability, severity of disability, or the form of home and community-based**
237 **attendant services and supports that the individual needs to lead an**

238 **independent life.**
239
240 **☒ Individuals receiving services through CFC will not be precluded from**
241 **receiving other home and community-based long-term care services and**
242 **supports through other Medicaid state plan, waiver, grant or**
243 **demonstration authorities.**
244
245 **☒ During the five-year period that begins January 1, 2014, spousal**
246 **impoverishment rules are used to determine the eligibility of individuals**
247 **with a community spouse who seek eligibility for home and community-based**
248 **services provided under 1915(k).**

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249 **CFC Service Models**
250
251 **Indicate which service models are used in the state's CFC program to provide**
252 **consumer-directed home and community-based attendant services and supports**
253 **(Select all that apply):**
254
255 ☒ **Agency-Provider Model**
256
257 ☒ **Self-Directed Model with Service**

258 **Budget**

259 ☐ **Other Service Model. Describe:**

260 The Department elects to utilize two service delivery options for Colorado's Community
261 First Choice (CFC) benefit: the Agency-Provider model and the Self-Directed Model with
262 Service Budget.
263
264 **Agency-Provider Model** – In this model, the employer of record is the agency. Attendants
265 are employed by an agency that determines the rate of pay and training needs. This service
266 delivery model allows members to determine the level of self-direction they desire.
267 Members not interested in directing their own Activities of Daily Living (ADL) and
268 Instrumental Activities of Daily Living (IADL) support can choose to utilize CFC personal care
269 providers and CFC homemaker providers to receive support and services for their needs. The
270 member has a choice in the agency they select to provide their services, with the agency
271 responsible for staffing, training, and oversight of service delivery. Members who wish to
272 choose an attendant and waive the Nurse Practice Act can utilize an In-Home Support
273 Service (IHSS) Agency to access their ADL/IADL services. Using an IHSS Agency, the member
274 and/or authorized representatives have the right to:
275 • Present a person(s) of his/her/their choosing to the provider agency as a potential
276 attendant.
277 • Train and schedule attendant(s) to meet his/her/their needs.
278 • Dismiss attendants who are not meeting his/her/their needs.
279
280 **Self-Direction with Service Budget Model** – In this model, the member is the employer of
281 record. Attendants are employed by the member. The member determines the rate of pay
282 and training needs. This service delivery model, called Consumer Directed Attendant
283 Support Services (CDASS), allows members to completely self-direct all aspects of their
284 service delivery by becoming the legal employer of attendants with the assistance of a
285 Financial Management Service (FMS) provider. With CDASS, members have budget and
286 employer authority and accept more responsibility and control over the services and
287 supports. The member recruits, hires, trains, and supervises their CDASS Attendant.
288 Members unable to fulfill their obligations under the CDASS budget model may authorize an
289 authorized representative to do so on their behalf. Under this model, members must choose
290 an FMS provider to work with who will assist them with fulfilling their responsibilities as an

employer of their attendants. FMS providers provide the following assistance:

- Collect and process timesheets submitted by attendants within agreed-upon timeframes as identified in FMS vendor materials and websites.
- Conduct payroll functions, including withholding employment-related taxes such as workers' compensation insurance, and unemployment benefits, withholding all federal and state taxes, and compliance with federal and state laws regarding overtime pay and minimum wage.
- Distribute paychecks in accordance with agreements made with the member or authorized representative and timelines established by the Colorado Department of Labor and Employment.
- Submit authorized claims for CDASS provided to an eligible member.
- Track and report the utilization of a member's allocations.

Financial Management Services

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

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

☐ **A Medicaid Service**

☒ **An Administrative Activity**

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

If applicable, please describe the types of activities that the financial management service entity will be providing, in addition to the regulatory requirements at 42 CFR 441.545(B)(1).

The Financial Management Service (FMS) entity is required to monitor the member's and/or authorized representative's submittal of required timesheet information to determine that it is complete, accurate, and timely; manage the payment of state-required sick time and family and medical leave benefits on behalf of CDASS members and/or authorized representatives; work with the case manager to address member performance problems; provide monthly reports to the member and/or authorized representative for the purpose of financial reconciliation, and monitoring the expenditure of the annual allocation.

328
329 **Specify the type of entity that provides financial management services:**
330 ☐ **A Medicaid Agency**
331 ☐ **Another State Agency - Specify:**

332 Click or tap here to enter text.

333 ☒ **Vendor Organization**
334 **Describe:**
335 Financial Management Services (FMS) vendor is contracted with the
336 Department and chosen by the member, or authorized representative, to
337 complete employment-related functions for CDASS attendants and to track and
338 report individual member CDASS allocations. The FMS acts as fiscal/employer
339 agent (F/EA), providing FMS by performing payroll and administrative functions
340 for member receiving CDASS benefits. The F/EA pays attendants for CDASS
341 services and maintains workers' compensation policies on the member-
342 employer's behalf. The F/EA withholds, calculates, deposits, and files withheld
343 Federal Income Tax and member-employer and attendant-employee Social
344 Security and Medicare taxes.

345 **Other Payment Methods**
346
347 **The state also provides for the payment of CFC services through the following methods:**
348 ☐ **Use of Direct Cash Payments - The state elects to disburse cash**
349 **prospectively to CFC participants. The state assures that all Internal**
350 **Revenue Service (IRS) requirements regarding payroll/tax filing functions**
351 **will be followed, including when participants perform the payroll/tax**
352 **filing functions themselves. Describe:**
353 **Click or tap here to enter text.**

354 ☐ **Vouchers- Describe:**

355 Click or tap here to enter text.

356 **Service Budget Methodology**
357
358 **Describe the budget methodology the state uses to determine the individual's service**
359 **budget amount. Also describe how the state assures that the individual's budget**
360 **allocation is objective and evidence- based utilizing valid, reliable cost data and can be**
361 **applied consistently to individuals:**
362 As part of the assessment and Person-Centered Support Planning process, the Person-
363 Centered Budget Algorithm (PCBA) will help identify the right amount of support for
364 members based on assessed needs, strengths, and preferences identified during the
365 assessment and contribute to a Person-Centered Support Plan. The PCBA is an important
366 component of the assessment and support planning process to ensure a consistent method
367 for assigning budgets for all members receiving HCBS.

368
369 The purpose of the PCBA is to support the Department's ability to make service allocation
370 decisions that are objective, transparent, equitable, and consistent across Colorado. To
371 help accomplish these goals, the Department will assign each member to a tier that
372 indicates their relative need compared to others receiving services. The PCBA Budget Tiers
373 are developed to be an objective, transparent and equitable resource allocation
374 methodology wherein the member has the flexibility to choose services based on their
375 needs, preferences, and goals, and as they articulate these in their Person-Centered
376 Support Plan process. The Budget range Tiers 1-6 are based on the acuity of needs
377 identified through the Colorado Single Assessment (Needs Assessment). This tier will serve
378 as one of several considerations in the Department's Person-Centered Planning process. The
379 tier is not intended to be the sole determinant of relative need, and exceptions will be
380 made, as needed, to ensure members have access to necessary services.
381
382 The validity and reliability of the PCBA will be evaluated through two major steps. First, the
383 variables used in the model will be reviewed based on information from several sources to
384 ensure that only variables relevant to resource use will be used in the model. Second, after
385 the model has been developed, the statistical validity of the model will be measured. The
386 key validation step in the variable identification process is the evaluation of variables
387 considering professional, stakeholder, and clinical input. This information is gathered from
388 existing literature, experiences from state staff, and meetings with stakeholders.
389
390 The statistical validation step looks at the model from a few different perspectives. First,
391 the data are examined for outliers which may have a disproportionate impact on the model.
392 Second, the overall predictive power of the model is measured and compared to other
393 existing models. The predictive power should be similar to or greater than that of existing
394 models. Third, the output of the model is compared to a separate validation sample that
395 was not used in model development to ensure that the outputs of the model accurately
396 predict resource use. This process will not only be done for the overall resource use
397 prediction from the model but also for specific budget components or add-ons, such as CFC.

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

402 Colorado's Single Assessment generates the budget the member has available for CFC
403 services and supports. The Colorado Single Assessment includes the Level of Care
404 Screen and the Needs Assessment, which generates a service budget based on
405 assessed need. The CFC service budget is used during the Person-Centered Support
406 Planning process following the Needs Assessment. The Person-Centered Support
407 Planning process ensures the member support needs and goals are met. The case
408 manager provides notification to the member of eligible service and authorization
409 after the service planning process has been completed.

410

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

414 The member can work with the provider and case manager to adjust services as needed. In
415 the event the member has a change in condition and requires an increase to the budget on a
416 longer-term or permanent basis, the case manager can complete a new Needs Assessment
417 with the member to adjust the budget. An unscheduled reassessment is available at any
418 time upon member request and/or change of condition. If the member requires only a
419 temporary increase to the service budget, due to an acute or time-limited reason, the case
420 manager can request an exception on behalf of the member. The exception process is
421 available at any time and is subject to Department approval.

422

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

425 The Person-Centered Support Plan development and revision occurs no less than annually or
426 as warranted by the member's needs or change in condition. The case manager shall
427 continually identify individual strengths, needs, and preferences for services and supports as
428 they change or as indicated by the occurrence of critical incidents.

429

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

432 The Case Management Agency shall provide the long-term care notice of action
433 form to members within eleven (11) business days regarding their appeal rights in
434 accordance with state regulations.

435

436 **Describe the procedures used to safeguard individuals when the budgeted service**
437 **amount is insufficient to meet the individual's needs:**

438 In the event a member's needs exceed the service budget limit, the case manager will
439 submit an exception process review request to the Department's third-party Utilization
440 Review Vendor. This vendor will review the member's assessed needs and additional

441 documentation provided by the case manager to justify the need for an exception to be
442 granted to exceed the budget limit. If the member is not granted this exception, the case
443 manager will work with the member to identify additional informal support mechanisms to
444 ensure the member's safety and wellbeing needs are met.
445

446 **Describe how the state notifies individuals of the amount of any limit to the**
447 **individual's CFC services and supports:**
448 Case managers provide service authorization limit information at the time of support
449 plan development and members are notified if any adjustments are needed.
450

451 **Describe the process for making adjustments to the individual's budget when a**
452 **reassessment indicates there has been a change in his or her medical condition,**
453 **functional status, or living situation:**
454 The reassessment process accounts for adjustments to the individual's budget when there
455 has been a change in his/her/their medical condition, functional status, or living situation.
456 If such change is needed, the Needs Assessment is reviewed with the member, and adjusted
457 by the case manager, resulting in a change to the individual's service budget.

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458 **Mandatory Services and Supports**
459 **1. Assistance with activities of daily living (ADLs), instrumental activities of**
460 **daily living (IADLs), and health-related tasks through hand-on assistance,**
461 **supervision, and/or cueing.**
462
463 **Identify the activities to be provided by applicable provider type and describe**
464 **any service limitations related to such activities.**
465
466 **☒ Personal Attendant Services. Describe:**

467 Personal care means services that are furnished to an eligible member to meet the
468 member's physical, maintenance, and supportive needs through hands-on assistance,
469 supervision and/or cueing. These services do not require a nurse's supervision or
470 physician orders. Personal care shall not duplicate the acquisition, maintenance, or
471 enhancement of skill training services. Tasks may include the following activities:

472 - Eating/Feeding
473 - Hair care
474 - Nail care
475 - Shaving
476 - Mouth Care
477 - Respiratory Care
478 - Skin Care
479 - Bladder/Bowel
480 - Exercise
481 - Dressing
482 - Transfers
483 - Mobility
484 - Positioning
485 - Medication Reminders
486 - Medical Equipment
487   a. Attendant provides maintenance and cleaning of medical equipment,
488   i.e., oxygen tubing, etc.
489 - Bathing
490 - Accompanying
491 - Protective Oversight
492   a. Attendant provides intervention to prevent or mitigate disability-related
493   behaviors that may result in imminent harm to people or property i.e.,
494   verbal redirection for wandering behavior.
495
496
497 **Provider Type:** CFC Personal Care Provider, IHSS Agency, CDASS Attendant

498 **☒ License Required**
499 Agency-Provider Model providers must have a Class A or B license in good standing with the

500 Colorado Department of Health and Environment (CDPHE).
501
502 ☒ **Certification Required. Describe:**
503 IHSS agencies must have the additional certification as an IHSS agency through CDPHE.
504
505 ☐ **Education-Based Standard. Describe:**
506 Click or tap here to enter text.
507
508 ☒ **Other Qualifications Required for this Provider Type. Describe:**
509 CDASS Attendant providers must meet individual member-defined requirements. Additional
510 training identified through the Person-Centered Support Planning process by the member.
511
512 ☐ **Companion Services. Describe:**
513 Click or tap here to enter text.
514
515 **Provider Type:** Click or tap here to enter text.
516 ☐ **License Required**
517 Click or tap here to enter text.
518
519 ☐ **Certification Required. Describe:**
520 Click or tap here to enter text.
521
522 ☐ **Education-Based Standard. Describe:**
523 Click or tap here to enter text.
524
525 ☐ **Other Qualifications Required for this Provider Type. Describe:**
526 Click or tap here to enter text.
527
528

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529 ☒ **Homemaker/Chore. Describe:**

530 General household activities provided by an attendant in a member's home to
531 maintain a healthy and safe environment for the member through hands-on
532 assistance, supervision and/or cueing. homemaker activities shall be provided only
533 in the primary living space of the member, and multiple attendants may not be
534 reimbursed for duplicating homemaker tasks. Homemaker services shall not
535 duplicate the authorized acquisition, maintenance, or enhancement of skill training
536 services. Tasks may include the following activities:

537 - Routine housekeeping such as dusting, vacuuming, mopping, and cleaning bathroom
538 and kitchen areas
539 - Meal preparation
540 - Dishwashing
541 - Bed making
542 - Laundry
543 - Shopping for necessary items to meet basic household needs.

544 **Provider Type:** CFC Homemaker Provider, IHSS Agency, CDASS Attendant

545 ☒ **License Required**
546 IHSS Agencies must have a Class A or B license in good standing with CDPHE.
547

548 ☒ **Certification Required. Describe:**
549 CFC Homemaker Provider must have a recommendation for certification as a Homemaker
550 Program Approved Service Agency (PASA) or must have a Class A or B license in good
551 standing through the Colorado Department of Health and Environment (CDPHE).
552

553 IHSS agencies must have the additional certification as an IHSS agency through CDPHE.
554

555 ☐ **Education-Based Standard. Describe:**
556 Click or tap here to enter text.
557

558 ☒ **Other Qualifications Required for this Provider Type. Describe:**
559 CDASS Attendant providers must meet individual member-defined requirements. Additional
560 training identified through the Person-Centered Support Planning process by the member.
561

562 ☒ **Other Services. Describe:**

563 **Health Maintenance Activities (HMA):**
564 Activities include routine and repetitive health-related tasks furnished to an eligible
565 member in the community or in the member's home, which is necessary for health
566 and normal bodily functioning that a person with a disability is physically unable to
567 carry out. These activities include skilled tasks typically performed by a Certified

568 Nursing Assistant (CNA) or licensed nurse that do not require the clinical assessment
569 and judgment of a licensed nurse. Tasks may include the following activities:

570 - Skin Care
571 - Nail Care
572 - Mouth Care
573 - Dressing
574 - Feeding
575 - Exercise
576 - Transfers
577 - Bowel
578 - Bladder
579 - Medical Management
580 - Respiratory Care
581 - Medication Assistance
582 - Bathing
583 - Mobility
584 - Accompanying
585 - Positioning
586 - Shaving
587 - Hair Care

588

589 **Provider Type:** IHSS Agency, CDASS Attendant

590 ☒ **License Required**
591 IHSS Agency providers must have a Class A or B license in good standing with the Colorado
592 Department of Health and Environment (CDPHE).
593

594 ☒ **Certification Required. Describe:**
595 IHSS Agency providers must have IHSS certification through CDPHE.
596

597 ☐ **Education-Based Standard. Describe:**
598 Click or tap here to enter text.
599

600 ☒ **Other Qualifications Required for this Provider Type. Describe:**
601 CDASS Attendants providers must meet individual member-defined requirements. Additional
602 training identified through the Person-Centered Support Planning process by the member.

DRAFT

603
604 **2. The acquisition, maintenance, and enhancement of skills necessary**
605 **for the individual to accomplish ADLs, IADLs, and health-related tasks.**
606
607 **Identify the activities to be provided by applicable provider type, and any**
608 **describe any service limitations related to such activities:**
609
610 Services and supports related to functional skills training that are necessary for
611 the member to accomplish ADL/IADLs health-related tasks to increase member
612 independence and reduce supports needed in the home and community.
613 Detailed, task-related goals shall be documented by the case manager in the
614 Person-Centered Support Plan, including documentation monitoring progress and
615 any decreased human assistance previously authorized. Acquisition,
616 maintenance, and enhancement (AME) will be tasks available in personal care
617 and homemaker services and can be provided in conjunction with these services
618 but shall not duplicate authorized service tasks for the homemaker, personal
619 care, or other services reimbursed by Medicaid.
620 • Personal hygiene
621 • Mobility
622 • Money management
623 • Household tasks
624 • Menu planning and meal preparation
625
626 **Provider Type:** CFC Personal Care Provider, CFC Homemaker Provider, IHSS Agency,

627 CDASS Attendant

628 ☒ **License Required**
629
630 CFC Personal Care Providers and IHSS Agencies must have a Class A or B license in good
631 standing with the Colorado Department of Health and Environment (CDPHE).
632
633 ☒ **Certification Required. Describe:**
634
635 CFC Homemaker Provider must have a recommendation for certification as a Homemaker
636 Program Approved Service Agency (PASA) or must have a Class A or B license in good
637 standing through the Colorado Department of Health and Environment (CDPHE). IHSS
638 Agency providers must have IHSS certification through CDPHE.
639
640 ☐ **Education-Based Standard. Describe:**
641 **Click or tap here to enter text.**

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

643 Additional training identified through the Person-Centered Support Planning process by the
644 member.

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645
646 **3. Individual back-up systems or mechanisms to ensure continuity of services and**
647 **supports.**
648
649 **Identify the systems or mechanisms to be provided and**

650 **limitations for:**

651 ☒ **Personal Emergency Response Systems**

652 ☐ **Pagers**

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

654 Electronic Monitoring means the installation, purchase, or rental of
655 electronic monitoring devices that:
656 • Enables the individual to secure help in the event of an
657 emergency.
658 • May be used to provide reminders to the individual of medical
659 appointments, treatments, or medication schedules.
660 • Are required because of the individual's illness, impairment, or
661 disability, as documented on the Colorado Single Assessment and
662 the Person-Centered Support Plan.
663 • Electronic monitoring services shall include personal emergency
664 response systems (PERS) and medication reminders via an
665 automated medication dispensing system.
666

667 **Describe any limitations for the systems or mechanisms provided:**
668 The following are not benefits of electronic monitoring services:
669 • Augmentative communication devices and communication boards
670 • Hearing aids and accessories
671 • Phonic ears
672 • Environmental control units, unless required for the medical safety of a member living
673 alone unattended
674 • Computers and computer software
675 • Wheelchair lifts for automobiles or vans
676 • Exercise equipment, such as exercise cycles
677 • Hot tubs, Jacuzzis, or similar items.
678 For individuals who do not have an assessed need for Electronic Monitoring, the case manager,
679 during the Person-Centered Planning Process, will discuss additional supports available for
680 continuity of care needs.

DRAFT

681 **Provider Type:** Electronic Monitoring Provider

682 ☐ **License Required**
683 Click or tap here to enter text.
684

685 ☐ **Certification Required. Describe:**
686 Click or tap here to enter text.
687

688 ☐ **Education-Based Standard. Describe:**
689 Click or tap here to enter text.
690

691 ☐ **Other Qualifications Required for this Provider Type. Describe:**
692 Additional training identified through the Person-Centered Support Planning
693 process by the member.

DRAFT

694 **4. Voluntary training on how to select, manage and dismiss attendants.**
695
696 **The state will claim costs associated with voluntary training as (check one)**

697 **☐ Medicaid Service**
698 **☒ An Administrative Activity**
699
700 **Describe the voluntary training program the state will provide to individuals on**
701 **selecting, managing and dismissing attendants:**
702 Members and/or authorized representatives will access supportive training based on the
703 philosophy and responsibilities of participant-directed care. At a minimum, this training
704 includes: an overview of the program, member and/or authorized representative rights
705 and responsibilities, planning and organizing attendant services, managing personnel
706 issues, communication skills, recognizing and recruiting quality attendant support,
707 managing health, allocation budgeting, accessing resources, safety, and prevention
708 strategies, managing emergencies, and working with the Financial Management Services
709 vendor.
710 **Provider Type**: Training and Support Contractor

711 **☐ License Required**
712 **Click or tap here to enter text.**
713
714 **☐ Certification Required. Describe:**
715 **Click or tap here to enter text.**
716
717 **☐ Education-Based Standard. Describe:**
718 **Click or tap here to enter text.**
719
720 **☐ Other Qualifications Required for this Provider Type. Describe:**
721 Provider must have an executed contract with Department. Additional training
722 identified through the Person-Centered Support Planning process by the member.

DRAFT

Optional Services and Supports:

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

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

☒ **Rental and Security Deposits**

Description and Limitations:

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

☒ **Utility Security Deposits**

Description and Limitations:

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

☐ **First Month's Rent**

Description and Limitations:

Click or tap here to enter text.

☐ **First Month's Utilities**

Description and Limitations:

Click or tap here to enter text.

☒ **Basic Kitchen Supplies**

762 **Description and Limitations:**
763 Transition Setup covers the purchase of one-time, non-recurring expenses up to 30 days
764 post-transition necessary for a member to establish a basic household as they transition
765 from an institutional setting to a community setting, including basic kitchen supplies.
766 Transition Setup expenses must not exceed $2,000 per eligible member. The Department
767 may authorize additional funds above the $2,000 limit, not exceeding a total value of
768 $2,500, when it is demonstrated as necessary to ensure the member's health, safety, and
769 welfare. Transition Setup is not available when the person is moving to a provider-owned or
770 - controlled setting.
771 ☒ **Bedding and Furniture**
772 **Description and Limitations:**
773 Transition Setup covers the purchase of one-time, non-recurring expenses up to 30 days
774 post-transition necessary for a member to establish a basic household as they transition
775 from an institutional setting to a community setting, including bedding and furniture.
776 Transition Setup expenses must not exceed $2,000 per eligible member. The Department
777 may authorize additional funds above the $2,000 limit, not to exceed a total value of
778 $2,500, when it is demonstrated as a necessary expense to ensure the health, safety, and
779 welfare of the member. Transition Setup is not available when the person is moving to a
780 provider-owned or - controlled setting.
781 ☒ **Other Household Items**
782 **Description and Limitations:**
783 Transition Setup covers the purchase of one-time, non-recurring expenses up to 30 days
784 post-transition necessary for a member to establish a basic household as they transition
785 from an institutional setting to a community setting including other essential household
786 furnishings required to occupy and use a community domicile, including window coverings,
787 food preparation items, or bath linens. Transition Setup expenses must not exceed $2,000
788 per eligible member. The Department may authorize additional funds above the $2,000
789 limit, not to exceed a total value of $2,500, when it is demonstrated as a necessary
790 expense to ensure the health, safety, and welfare of the member. Transition Setup is not
791 available when the person is moving to a provider-owned or - controlled setting.
792 ☒ **Other coverable necessities linked to an assessed need to enable transition**
793 **from an institution to the community**
794 **Description and Limitations:**
795 Transition Setup covers the purchase of one-time, non-recurring expenses up to 30 days
796 post-transition necessary for a member to establish a basic household as they transition from
797 an institutional setting to a community setting including expenses incurred directly from the
798 moving, transport, provision, or assembly of household furnishings to the residence. Housing
799 application fees and fees associated with obtaining legal and/or identification documents
800 necessary for a housing application such as a birth certificate, state ID, or criminal

801 background check. Transition Setup expenses must not exceed $2,000 per eligible member.
802 The Department may authorize additional funds above the $2,000 limit, not to exceed a
803 total value of $2,500, when it is demonstrated as a necessary expense to ensure the health,
804 safety, and welfare of the member. Transition Setup is not available when the person is
805 moving to a provider-owned or - controlled setting.

DRAFT

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

Home Delivered Meals

To be eligible for Home Delivered Meals, the member must satisfy one of the following criteria:

a) The member is coming out of an institutional setting to a home and community-based setting, or the member has been discharged from the hospital or emergency department following a 24-hour admittance, and/or
b) The member demonstrates that they need Home Delivered Meals due to nutritional deficit, food insecurity, lack of access to meals, are unable to prepare their own meals and have limited or no outside assistance, or to increase independence and reduce the need for human intervention or assistance (such as meal preparation through the Homemaker service).

The Home Delivered Meals service includes:

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

Limitation/Exclusions

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

DRAFT

849 request an extension to the service past 365 days, the circumstances are reviewed on
850 a case-by-case basis, utilizing the eligibility criteria for service.
851
852 **Provider Type:** Home-Delivered Meal Provider
853 ☒ **License Required**
854 Providers must have a current license to operate a retail food establishment.
855
856 ☐ **Certification Required. Describe:**
857 **Click or tap here to enter text.**
858
859 ☐ **Education-Based Standard. Describe:**
860 **Click or tap here to enter text.**
861
862 ☒ **Other Qualifications Required for this Provider Type. Describe:**
863 Providers must have an on-staff or contracted Registered Dietitian (RD) OR Registered
864 Dietitian Nutritionist (RDN). Additional training identified through the Person-Centered
865 Support Planning process by the member.
866
867
868 **Remote Supports**
869
870 Remote Support includes live two-way support from a remote location that increases the
871 individual's independence and substitutes for human assistance. Remote Support is available
872 to the member if they desire remote coaching, prompts, supervision, or consultation to
873 perform certain tasks they identify during the person-centered support planning
874 assessment. The goal of Remote Support is to increase autonomy by providing the member
875 an opportunity to build life skills through independent learning via cueing, coaching, and
876 on-call support.
877
878 This service includes purchasing and maintaining technology equipment and training the
879 member on using the equipment. The member must be able to initiate the service when
880 needed and turn off the equipment when no longer needed.
881
882 Remote Support does not replace informal or formal support but reduces the need for in-
883 person human assistance at the member’s discretion. Only the member may initiate live
884 two-way interactions unless otherwise documented in the member’s person-centered
885 service plan. Video may only be used during live two-way support communications when the
886 member chooses.
887
888 **Provider Type:** Remote Supports Provider
889 ☐ **License Required**
890 Click or tap here to enter text.
891
892 ☒ **Certification Required. Describe:**

DRAFT

893 The provider must meet the standards for a Certified Remote Supports Medicaid provider
894 according to Department regulations and must receive the Department Remote Support
895 Provider Training Completion Certificate.
896
897 ☐ **Education-Based Standard. Describe:**
898 **Click or tap here to enter text.**
899
900 ☐ **Other Qualifications Required for this Provider Type. Describe:**
901
902 **Home and Community Based Settings**
903
904 ☐ **Each individual receiving CFC services and supports must reside in a home**
905 **or community-based setting and receive CFC services in community settings**
906 **that meet the requirements of 42 CFR 441.530**
907 Box is not checked because CFC will be available, within limits, for people residing in
908 institutions such as nursing facilities. In addition, settings such as Adult Day Service
909 centers that operate exclusively on a private-pay basis were not assessed or verified
910 for compliance with the HCBS Settings Final Rule during the transition period;
911 however, if and when Medicaid-funded CFC services were to be provided in such
912 centers, they would be covered by the state's codification of the rule, which specifies
913 that "HCBS Setting means any physical location where Covered HCBS are provided."
914 **Setting Types (check all that apply):**
915
916 ☐ **CFC services are only provided in private residences and are not provided in**
917 **provider - owned or controlled settings.**
918 ☒ **CFC services may be provided in private residences and in provider**
919 **owned or controlled settings.**
920 ☒ **The CFC benefit includes settings that have been determined home and**
921 **community-based through the heightened scrutiny process.**
922
923 **Provider-owned or controlled settings:**
924
925 1. **Please identify all residential setting types in which an individual may**
926 **receive services under the CFC benefit.**
927
928 Individuals may receive CFC in the following residential settings:
929
930 - Residential settings owned or leased by individuals receiving HCBS or their families
931 (personal homes).

932 - Certified Foster Care Homes.

933 • Institutions (individuals may receive only Transition Setup services and authorization
934 for home-delivered meals (HDMs) to be provided after moving out of the institution).

935 **2. Please identify all residential setting types in which an individual may**
936 **receive services under the CFC benefit.**
937
938 Individuals may receive CFC in the following residential settings:
939
940 • Residential settings owned or leased by individuals receiving HCBS or their families
941 (personal homes).

942 • Certified Foster Care Homes.

943 • Institutions (individuals may receive only Transition Setup services and authorization
944 for home-delivered meals (HDMs) to be provided after moving out of the institution).

945

946 **3. Please identify all non-residential setting types in which a person may**
947 **receive services under the CFC benefit.**
948
949 Individuals may receive CFC in the following nonresidential settings:

950 • Physical locations that are nonresidential and not owned, leased, operated, or
951 managed by an HCBS provider or by an independent contractor providing
952 nonresidential services. (Locations in the community where HCBS can be provided—
953 examples include grocery stores, parks, and events).

954 • Day Habilitation settings for individuals with intellectual and developmental
955 disabilities (IDD).

956 • Adult Day Services and Day Treatment settings for individuals with disabilities.

957

DRAFT

958
959 **Setting Assurances- The state assures the following:**
960
961 ☐ **CFC services will be furnished to individuals who reside in a home or community**
962 **setting, which does not include a nursing facility, institution for mental diseases,**
963 **an intermediate care facility for individuals with intellectual disabilities, or a**
964 **hospital providing long-term care services.**
965
966 Box is not checked because CFC will be available within limits for people residing in
967 institutions such as nursing facilities.
968
969 ☒ **Any permissible modifications of rights within a provider owned and**
970 **controlled setting is incorporated into an individual's person-centered**
971 **service plan and meets the requirements of 42 CFR 441.530(a)(vi)(F).**
972
973
974 **Additional state assurances:**
975
976 Click or tap here to enter text.
977
978 **Community First Choice Support System, Assessment and Service Plan**
979
980 **Support System**
981
982 ☒ **The support system is provided in accordance with the requirements of §441.555.**
983 **Provide a description of how the support system is implemented and**
984 **identify the entity or entities responsible for performing support**
985 **activities:**
986
987 Prior to enrolling in Community First Choice, the case manager provides
988 information about Community First Choice services and supports through
989 the Colorado Single Assessment and Person-Centered Support Planning
990 process. This process includes providing information to the member
991 regarding HCBS settings requirements and any assistance needed to make
992 an informed choice about the program. The case manager assists the
993 member in establishing assessment and support plan scheduling and
994 provides information about their rights and responsibilities regarding the
995 assessment and support plan process.
996

DRAFT

997 Upon meeting Level of Care for Community First Choice, the Needs
998 Assessment component of the Colorado Single Assessment is conducted,
999 and the Person-Centered Support Plan is developed in collaboration with
1000 the individual, the individual's authorized representative, or others who
1001 are important to the individual. The support plan is a collaborative effort
1002 where the member leads the process and identifies personal goals and
1003 supports to help achieve those goals. The case manager writes the support
1004 plan in a manner that reflects the member's own words wherever possible
1005 and allows the member to see documents and computer screens.
1006
1007 The Person-Centered Support Plan is required to address the member's
1008 needs, personal goals, preferences, unique strengths, abilities, desires,
1009 health and safety, and risk factors and strategies to mitigate identified
1010 risks. The plan establishes a personal safety and backup plan, including
1011 information on the responsibilities for reporting critical incidents and the
1012 method by which critical incidents are reported. The plan must also
1013 document decisions made through the service planning process including,
1014 but not limited to, rights modifications, the existence of appropriate
1015 services and supports and the actions necessary for the plan to be
1016 achieved. The plan requires documentation that the member has been
1017 offered a choice of services in the Home and Community-based Services or
1018 institutional care, including service delivery options, and of qualified
1019 providers.
1020
1021 Members who are eligible and interested in participant directed service
1022 delivery models are informed of their options by the case manager during
1023 the Person-Centered Support Planning phase. Additionally, the Department
1024 contracts with a Training and Support Contractor to further guide
1025 individuals through the various aspects of Colorado's participant directed
1026 service delivery models, including the attendant support management plan
1027 development process. The Training and Support Contractor works
1028 collaboratively with the Financial Management Services providers, Case
1029 Management Agencies, and the Department to ensure individuals are
1030 successful in their enrollment process.
1031
1032 **Specify any tools or instruments used as part of the risk management**
1033 **system to identify and mitigate potential risks to the individual receiving**
1034 **CFC services:**
1035
1036 Critical Incidents:
1037 Critical incidents are those incidents that create the risk of serious harm to the
1038 health or welfare of an individual receiving services and may endanger or negatively
1039 impact the mental and/or physical well-being of an individual. Critical incident

DRAFT

categories that must be reported include but are not limited to: Injury/illness; mistreatment/abuse/neglect/exploitation; damage/theft of property; medication mismanagement; lost or missing person; criminal activity; unsafe housing/displacement; or death.

Critical incidents are required to be reported by all providers. Oversight is provided by the Colorado Department of Health Care Policy and Financing and/or the Departments of Public Health and Environment (CDPHE) and Human Services (DHS).

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

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

~~{Disability Law Colorado administers the Office of the State Long Term Care Ombudsmen under contract with DHS. A network of local ombudsmen, under the auspices of the local Area Agencies on Aging, identify, investigate, and resolve complaints by residents of long-term facilities. Ombudsmen have regular contact with members residing in such facilities in order to ensure members have access to advocacy.}~~
[The Colorado State Long-Term Care Ombudsman Program is an independent program that advocates for residents of skilled nursing homes, and licensed assisted living residences. The authority of the long-term care ombudsman program comes from Title VII, Chapter 2, of the Older Americans Act, as well as Title 26, Article 11.5, of the Older Coloradans Act. The primary purpose of the Long-Term Care Ombudsman Program is to promote and protect the residents' rights guaranteed to residents under federal and state law. The Colorado Department of Human Services (CDHS) achieves this mission with a network of local offices across the state, which recruit, train, and manage teams of certified ombudsmen. Staff and volunteer ombudsmen visit long-term care facilities throughout the state to ensure residents' rights are being upheld. Certified Long-Term Care Ombudsmen are trained to receive complaints and resolve problems in situations involving quality of care, use of restraints, transfer and discharge, abuse, and other aspects of resident dignity and rights. Ombudsman services are free, confidential, and resident directed.]

The Department's interagency agreement with CDPHE requires that the agency

1085 responds to and remediates quality of care complaints about services provided by
1086 Medicaid-certified home health agencies. Case managers are responsible for following
1087 up with appropriate individuals and/or agencies in the event any issues or complaints
1088 have been presented. Each member and/or legal guardian is informed at the time of
1089 initial assessment and reassessment to notify the case manager if there are changes
1090 in the care needs and/or problems with services.
1091
1092 The Department and the contract Quality Improvement Organization (QIO) review and
1093 track critical incident reports to ensure that a resolution is met, and the member's
1094 health and safety have been maintained. The QIO is responsible for managing the
1095 Critical Incident Reporting system for the 1915(c) waivers and the 1915(k) benefit.
1096 The QIO assesses the appropriateness of both the provider and Case Management
1097 Agencies response to critical incidents, gathers, aggregates, and analyzes the critical
1098 incident report (CIR) data, and ensures that appropriate follow-up for each incident is
1099 completed. The QIO also supports OCL in the analysis of CIR data, understanding the
1100 root cause of identified issues, and providing recommendations for changes in the
1101 reporting system and other waiver management protocols aimed at
1102 reducing/preventing the occurrence of future critical incidents. The QIO conducts
1103 desk reviews of case files from Case Management Agencies.
1104
1105 Rights Modifications:
1106 As detailed in Table 2 (orange) in Colorado's STP, row 10, subrow on rights
1107 modification

1108 details, page 10:

1109 HCPF codified the rights modification requirements in rule (10 CCR 2505-10 8.484.5)
1110 and published an informed consent template to ensure all criteria are documented.
1111 Under this codification, modifications to individual rights must be based on an
1112 individualized assessed need and comply with the federal requirements for
1113 documentation and due process, including obtaining the individual's informed
1114 consent.

1115 HCPF issued extensive guidance, provided trainings and materials (including
1116 mandatory trainings for both providers and Case Management Agencies covering
1117 individual rights and the rights modification process), and updated components of the
1118 Benefits Utilization System (BUS) (a component of the case management system in
1119 place during the transition period) to support implementation of these requirements.
1120 The screens in the BUS ensured that all criteria were documented as required in the
1121 person-centered service plan. For additional information on the tools and processes
1122 developed for case managers to ensure that rights modifications are appropriately
1123 developed, documented, and consented-to, please refer to Table 5 (gray) in
1124 Colorado's STP, row 72, pages 29-30.

1125 Providers must ensure staff are trained on person-centeredness, person-centered
1126 practices, and dignity of risk. Compliance with this requirement was verified through

1127 the Provider Transition Plan (PTP) process and is a requirement under current rule. In
1128 addition, Case Management Agencies must ensure case managers are trained on
1129 person-centered planning.

1130 The Department verified provider and case management agency compliance with the
1131 rights modification requirements through the PTP process. When providers initially
1132 submitted PTPs, they were required to include policies and procedures, house rules,
1133 and other evidence demonstrating that rights modifications were used, if at all, on an
1134 individualized basis and not across-the-board. As part of its initial review and
1135 verification process, the Colorado Department of Public Health & Environment
1136 (CDPHE) often identified changes needed to these policies and procedures, house
1137 rules, etc. to avoid broad-based imposition of rights modifications. CDPHE asked
1138 some providers for examples of completed informed consent forms. CDPHE sometimes
1139 identified changes needed to the providers' examples. When providers submitted
1140 their updated PTPs demonstrating remediation, they were required to submit
1141 evidence demonstrating that all rights modifications were fully compliant with the
1142 federal criteria. This included updated policies and procedures, house rules, etc., as
1143 well as updated informed consent forms for specific individuals if required by CDPHE.

1144 In addition to what was described in the STP, more recent developments include:

1145 ▪ HCPF issued a "MythBusters FAQ" that addressed rights modification
1146 misconceptions, among other topics.

1147 ▪ HCPF published videos and resource sheets for members to help them
1148 understand their rights and the rights medication process.

1149 ▪ HCPF issued supplemental guidance and presented a training for case managers
1150 on entering rights modification information into the BUS.

1151 ▪ HCPF rolled out a new Care and Case Management System (CCM). Pending
1152 development of the rights modification screen(s) in this system, case managers
1153 are able to upload a PDF file containing the information that ultimately will be
1154 entered on the screen(s) (along the lines of what they were entering in the
1155 BUS, as described above).

1156 ▪ HCPF made available a new, web-based "Person-Centered Thinking Training for
1157 all HCBS Provider Agencies, Transition Coordination Agencies, and Case
1158 Management Agencies."

1159 ▪ HCPF has begun working with an instructional designer to develop a new self-
1160 paced e-learning module for case managers, to be housed in the new case
1161 management learning management system (LMS). The training will cover the
1162 HCBS Settings Final Rule, rights protected by the rule, rights modifications,
1163 and the case manager's role within these areas. (As noted above, prior
1164 trainings have also covered these topics.)

1165 Backup Plans:

1166 Risks are assessed as part of the Person-Centered Support Planning process
1167 during a face-to-face interview in the member's home and are documented in
1168 the member's electronic record. **Case managers are required to provide**
1169 **members with all of the choices available to the member for Long Term**
1170 **Care.** The case manager discusses the possible risks associated with the
1171 member's choice of living arrangement with the member and/or guardian.
1172 The case manager and the member then develop strategies for reducing
1173 these risks. Strategies for reducing these risks include developing backup
1174 plans. Back-up plans are designed to be person-centered and often include
1175 relying on the member's choice of family, friends, or neighbors to care for
1176 the member if a provider is unable to do so. For life or limb emergencies,
1177 members are instructed to call their emergency number (i.e. 911).

1178 Conflict-Free Case Management

1179 Case Management Redesign is the process by which Colorado achieves
1180 conflict-free case management. Case Management Redesign creates a
1181 simplified system where there is one place to go in each defined service area
1182 for case management for all Long-Term Services and Supports. Case
1183 Management Redesign allows the state to provide oversight and support to
1184 ensure high performing case management system statewide. Conflict Free
1185 Case Management ensures members enrolled in any Long-Term Services and
1186 Supports programs receive direct home and community-based services and
1187 case management from separate entities.

1188 **Provide a description of the conflict of interest standards that apply to**
1189 **all individuals and entities, public or private to ensure that a single**
1190 **entity doesn't provide the assessments of functional need and/or the**
1191 **person-centered service plan development process along with direct CFC**
1192 **service provision to the same individual:**

1193 Case managers conduct the Needs Assessment and the Person-Centered
1194 Support Plan. Case managers are conflict-free. The state assures that the
1195 conflict of interest standards required in CFR 441.555(c) for the functional
1196 Needs Assessment and development of the Person-Centered Support Plan
1197 applies to all individuals and entities, both public and private. The state
1198 assures that the individual conducting the Needs Assessment and Person-
1199 Centered Support Plan is not:

1200 1. Related by blood or marriage to the participant, or to any paid
1201 caregiver of the participant,
1202 2. Financially responsible for the participant,
1203 3. Empowered to make financial or health -related decisions on behalf of
1204 the participant,

DRAFT

4. Someone who would benefit financially from the provision of assessed needs and services,
5. A provider of state funded services for the participant, or has an interest in or is employed by a provider of state funded services for the participant.

The state has created defined service areas where Case Management Agencies will service all 1915(c) and 1915(k) members in their respective defined service areas. The establishment of defined service areas will provide individuals seeking Long-Term Services and Supports one place to obtain case management services. Members will have the option to choose their case manager at the agency in which they are assigned. The state selected Targeted Case Management (TCM) as the funding option for certain case management functions.

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

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

A Case Management Agency may be granted a Conflict-Free Case Management Waiver by the Department to provide specific direct services within their defined service area to maintain eligible service providers in rural and frontier areas across Colorado. The Case Management Agency shall submit a formal application for a Conflict-Free Case Management Waiver and shall receive formal notification from the Department via email of the receipt of the application within 10 business days. If the Conflict-Free Case Management Waiver application is approved, the Department will coordinate with the Case Management Agency for next steps in implementation and execution, if necessary. If the Conflict-Free Case Management Waiver application is denied, the Department will coordinate with the Case Management Agency for a transition period within their contract period, if necessary.

Case Management Agencies granted a Conflict-Free Case Management Waiver shall provide an annual report to the Department subject to Department approval that includes, but is not limited to:

1. A summary of individuals participating in direct services and case management;
2. How the Case Management Agency has ensured informed choice; and

DRAFT

1246 3. How the Case Management Agency continues to support the
1247 recruitment of willing and qualified providers in their catchment area.

1248 The direct service provider functions and Case Management Agency functions must be
1249 administratively separated (including staff) with safeguards in place to ensure a
1250 distinction exists between direct services and case management. If a new service
1251 provider(s) become available in the area, the Case Management Agency may continue
1252 to provide direct services while the Department and the Case Management Agency
1253 support the alternate provider(s) in stabilizing and expanding to accommodate all
1254 needs in that service area. If other service providers are available in the area, the
1255 case manager must document the offer of choice of provider in the Care and Case
1256 Management IT system. To ensure conflict of interest is being mitigated by the Case
1257 Management Agency, the Department will conduct annual quality reviews that will
1258 include, but not be limited to, reviews of documentation of provider choice and
1259 informed consent for services.

DRAFT

1260
1261 **Assessment of Need**
1262
1263 **Describe the assessment process or processes the state will use to obtain information**
1264 **concerning the individual's needs, strengths, preferences, and goals.**
1265
1266 Case managers conduct a Level of Care Screen and Needs Assessment using the Colorado
1267 Single Assessment, which collects information on Activities of Daily Living (ADLs) and
1268 Instrumental Activities of Daily Living (IADLs) functioning, behavior issues, medical
1269 concerns, and other needs. The Colorado Single Assessment supports a comprehensive,
1270 person-centered approach to the identification of a member's needs, preferences, and
1271 goals. The assessment also includes covering a set of life domains that critically affect
1272 independence and quality of life. The assessment contains information necessary to
1273 determine if a member meets institutional level of care as well as informs the
1274 development of an individualized Person-Centered Support Plan by gathering specific
1275 information on personal goals, support needs, preferences for service delivery, and
1276 personal strengths. The assessment process also informs the assignment of individual
1277 budgets, and provides information critical to the provision of services, including special
1278 accommodations needed, service intensity, staff competency, and member preferences.
1279
1280 ☒ **The state will allow the use of telemedicine or other information technology**
1281 **medium in lieu of a face-to-face assessment in accordance with §441.535. The**
1282 **individual is provided with the opportunity for an in-person assessment in lieu**
1283 **of one performed via telemedicine. Include a description about how an**
1284 **individual receives appropriate support including access to on-site support staff**
1285 **during the assessment:**
1286
1287 Case Management Agencies may use phone or telehealth to complete the Level of Care
1288 Screen and Needs Assessment when there is a documented safety risk to the case manager
1289 or member including public health emergencies as determined by state and federal
1290 government. To facilitate person-centered practices, Case Management Agencies may use
1291 phone or telehealth to engage in the development and monitoring of the Person-Centered
1292 Support Plan based on the member's preference of engagement. The member must be seen
1293 at the time of the initial evaluation and reevaluation to ensure that the member is in the
1294 home. The case manager shall perform quarterly monitoring contacts with the member, as
1295 defined by the member's certification period start and end dates. An in-person monitoring
1296 contact is required at least one (1) time during the Person-Centered Support Plan
1297 certification period. The case manager shall ensure the one (1) required in-person
1298 monitoring contact occurs, with the member physically present, in the member's place of
1299 residence or location of services. The case manager shall perform three additional
1300 monitoring contacts each certification period either in-person, on the phone, or through
1301 other technological modalities based on the member's preference of engagement.
1302 **The state will claim costs associated with CFC assessment**

DRAFT

1303 **activities as: ☐ A Medicaid Service**

1304 **☒ An Administrative Activity**

1305

1306 **Indicate who is responsible for completing the assessment prior to developing the**
1307 **CFC person-centered service plan. Also specify their qualifications:**

1308

1309 **☐ Social Worker (specify qualifications)**
1310 **Click or tap here to enter text.**

1311

1312 **☐ Registered Nurse, licensed to practice in the state, acting within scope of**
1313 **practice under state law.**

1314

1315 **☐ Licensed Practical Nurse or Vocational Nurse, acting within scope of**
1316 **practice under state law.**

1317 **☐ Licensed Physician (M.D. or O.D.), acting within scope of practice under**

1318 **state law.**

1319 **☒Case Manager (specify qualifications)**
1320 The minimum qualifications for HCBS case managers who conduct the Person-Centered
1321 Support Plan are:

1322

1323 A bachelor's degree; or

1324

1325 1. Five (5) years of experience in the field of Long-Term Support Services, which
1326 includes Developmental Disabilities; or
1327 2. Some combination of education and relevant experience appropriate to the
1328 requirements of the position.
1329 3. Relevant experience is defined as:
1330 4. Experience in one of the following areas:
1331 a. Long-Term Services and Supports, gerontology, physical rehabilitation,
1332 disability services, children with special health care needs, behavioral science,
1333 special education, public health or non-profit administration, or
1334 health/medical services, including working directly with persons with physical,
1335 intellectual or developmental disabilities, mental illness, or other vulnerable
1336 populations as appropriate to the position being filled; and/or
1337 b. Completed coursework and/or experience related to the type of administrative
1338 duties performed by case managers may qualify for up to two (2) years of
1339 required relevant experience. Safeguards to assure the health and welfare of
1340 waiver participants, including response to critical events or incidents, remain
1341 unchanged.

1342 **☐ Other (specify what type of individual and their qualifications)**
1343 **Click or tap here to enter text.**

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1345 **The reassessment process is**
1346 **conducted every:**
1347 **☒12 months**
1348
1349 **☐Other (must be in increments of time less than 12 months)**
1350 Click or tap here to enter text.

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1351

1352 **Describe the reassessment process the state will use when there is a significant**
1353 **change in the individual's needs or the individual requests a reassessment.**
1354 **Indicate if this process is conducted in the same manner and by the same entity**
1355 **as the initial assessment process or if different procedures are followed:**

1356 Case managers are required to complete a reassessment of the Level of Care Screen
1357 for members within 12 months of the initial or previous assessment. A reassessment
1358 may be completed sooner if there is a significant change in the member's condition.
1359 The case manager reviews the previous Level of Care Screen and Needs
1360 Assessments, with the member, and makes updates and/or changes as needed at
1361 reassessment.

1362 At both assessment and reassessment, a case manager performs the following tasks:

1363 1. Review Person-Centered Support Plan, service agreements, and provider
1364 contracts or agreements.
1365 2. Evaluate effectiveness, appropriateness, and quality of services and
1366 supports.
1367 3. Verify continuing Medicaid eligibility, other financial and program
1368 eligibility.
1369 4. Inform the individual's medical provider of any changes in the individual's
1370 needs.
1371 5. Maintain appropriate documentation, including type and frequency of Long-
1372 Term Services and Supports the individual is receiving for approval of
1373 continued program eligibility, if required by the program.
1374 6. Refer the individual to community resources as needed **and assist with the**
1375 **development of resources for the individual (within reason)** if the
1376 resource is not available within the individual's community.
1377 7. Submit appropriate documentation for authorization of services, in
1378 accordance with program requirements.

1379 There is an attestation at the end of both the Level of Care Screen and the Needs
1380 Assessments to confirm that the case manager reviewed and updated both in
1381 entirety, at reassessment and initial assessment.

1382

1383 **Person-Centered Service Plan**

1384

1385 **The CFC service plan must be developed using a person-centered and person-**
1386 **directed planning process. This process is driven by the individual and includes**
1387 **people chosen by the individual to participate.**

1388

1389 **The state will claim costs associated with CFC person-centered**

1390 **planning process as:**

1391 ☐ **A Medicaid Service**

1392 ☒ **An Administrative Activity**

1393

1394 **Indicate who is responsible for completing the Community First Choice person-centered**
1395 **service plan.**

1396

1397 ☒ **Case Manager. Specify qualifications**:
1398 The minimum qualifications for HCBS case managers who conduct the Person-Centered
1399 Support Plan are:

1400

1401 A bachelor's degree; or

1402

1403 1. Five (5) years of experience in the field of Long-Term Services and Supports, which
1404 includes Developmental Disabilities; or
1405 2. Some combination of education and relevant experience appropriate to the
1406 requirements of the position.
1407 3. Relevant experience is defined as:
1408 a. Experience in one of the following areas: Long-Term Services and Supports,
1409 gerontology, physical rehabilitation, disability services, children with special
1410 health care needs, behavioral science, special education, public health or non-
1411 profit administration, or health/medical services, including working directly
1412 with persons with physical, intellectual, or developmental disabilities, mental
1413 illness, or other vulnerable populations as appropriate to the position being
1414 filled; and
1415 b. Completed coursework and/or experience related to the type of administrative
1416 duties performed by case managers may qualify for up to two (2) years of
1417 required relevant experience.

1418

1419

1420 ☐ **Social Worker. Specify qualifications:**

1421 **Click or tap here to enter text.**

1422

1423 ☐ **Registered Nurse, licensed to practice in the state, acting within scope of**

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1424 **practice under state law.**

1425

1426 **☐ Licensed Practical Nurse or Vocational Nurse, acting within scope of**
1427 **practice under state law. Licensed Physician (M.D. or O.D.), acting**
1428 **within scope of practice under state law.**

1429

1430 **☐ Other. Specify provider type and qualifications:**
1431 **Click or tap here to enter text.**

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Person-Centered Service Plan Development Process:

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

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

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

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

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

The case manager develops the Person-Centered Support Plan with the member. The case manager is required to develop the plan at a time and location

1472 convenient for the member, with the member, and others chosen by the
1473 member. The Person-Centered Support Plan must have a listing of the plan
1474 meeting participants and their relationship to the member. Members and legal
1475 representatives are informed they have the authority to select and invite
1476 individuals of their choice in the Person-Centered Support Planning process,
1477 **however members are not required to invite any other individual if they so**
1478 **choose.**
1479

1480 **Describe the timing of the person-centered service plan development to assure the**
1481 **individual has access to services as quickly as possible; describe how and when it is**
1482 **updated, including mechanisms to address changing circumstances and needs or at**
1483 **the request of the individual:**

1484 The Person-Centered Support Plan development and revision occurs no less than
1485 annually or as warranted by the member's needs or change in condition. The member
1486 may also request updates to the service plan as needed. The case manager shall
1487 continually identify member's strengths, needs and preferences for services and
1488 supports as they change or as indicated by the occurrence of critical incidents. The
1489 Person-Centered Support Planning process immediately follows the eligibility
1490 determination process, using the Level of Care Screen and the Needs Assessment. The
1491 Case Management Agency shall complete the Level of Care Screen within the following
1492 time frame: For an individual who is not being discharged from a hospital or a nursing
1493 facility, the individual assessment shall be completed and documented in the
1494 Department prescribed technology system within ten (10) working days after receiving
1495 confirmation that the Medicaid application has been received by the county department
1496 of social services.
1497

1498 **Describe the state's expectations regarding the scheduling and location of**
1499 **meetings to accommodate individuals receiving services and how cultural**
1500 **considerations of the individual are reflected in the development of the person-**
1501 **centered service plan:**

1502 Case managers are required to develop the service plan at times and locations
1503 chosen by the member. Case managers are expected to reflect the cultural
1504 considerations of the individual and provide information in plain language and in a
1505 manner that is accessible to individuals with disabilities and individuals who have
1506 limited English proficiency. **[Case Management Agencies are required to take**
1507 **trainings on Disability and Cultural Competency and Equity, Diversity, Inclusion,**
1508 **and Accessibility (EDIA). Training must ensure staff are culturally competent**
1509 **and provide culturally responsive services and business practices at all levels of**
1510 **the agency. HCPF's EDIA Officer and/or their designee will offer free EDIA-**
1511 **related professional development training to Case Management Agencies upon**

1512 **request.]**
1513

1514 **Describe how the service plan development process ensures that the person-**
1515 **centered service plan addresses the individual's goals, needs (including health care**
1516 **needs), and preferences and offers choices regarding the services and supports**
1517 **they receive and from whom. Please include a description of how the state**
1518 **records in the person-centered service plan the alternative home and community**
1519 **based settings that were considered by the individual:**
1520 The Person-Centered Support Plan is required to address the individual's needs,
1521 personal goals, preferences, unique strengths, abilities, desires, health and safety,
1522 and risk factors. The process offers informed choices to the member regarding the
1523 services and supports they receive and from whom, as well as the documentation of
1524 services needed, including type of service, specific functions to be performed,
1525 duration and frequency of service, and type of provider. Through standard monitoring
1526 responsibilities, the case manager shall assure the quality of services and supports in
1527 accordance with the Person-Centered Support Plan and make necessary adjustments
1528 to the plan as needed to meet member's goals, needs, and preferences. The plan
1529 must also document decisions made through the service planning process including,
1530 but not limited to, rights modifications, the existence of appropriate services and
1531 supports and the actions necessary for the plan to be achieved. The plan requires
1532 documentation that the member has been offered a choice of services in the Home
1533 and Community-Based Services or institutional care, including service delivery
1534 options, and of qualified providers.

DRAFT

1535

1536 **Describe the strategies used for resolving conflict or disagreements within the process:**

1537 Case Management Agencies shall have procedures setting forth a process for the timely
1538 resolution of grievances or complaints. Use of the grievance procedure shall not prejudice
1539 the future provision of appropriate services or supports. The grievance procedure shall be
1540 provided, orally and in writing, to all members receiving services, the parents of a minor,
1541 guardian and/or authorized representative, as applicable, at the time of submission and at
1542 any time that changes to the procedure occur. The grievance procedure shall, at a
1543 minimum, include the following:

1544 1. Contact information for a person within the Case Management Agency who will receive
1545 grievances.

1546 2. Identification of support person(s) who can assist the member in submitting a grievance.

1547 3. An opportunity to find a mutually acceptable solution. This could include the use of
1548 mediation if both parties voluntarily agree.

1549 4. Timelines for resolving the grievance.

1550 5. Consideration by the agency director or designee if the grievance cannot be resolved at
1551 a lower level.

1552 6. Assurances that no member shall be coerced, intimidated, threatened, or retaliated
1553 against because the member has exercised his or her right to file a grievance or has
1554 participated in the grievance process.

1555

1556 **Please describe how the person-centered service plan development process**
1557 **provides for the assignment of responsibilities for the development of the plan and**
1558 **to implement and monitor the plan.**

1559 Case managers are responsible for the Person-Centered Support Plan development
1560 and monitoring. **[The case manager is required to explain the minimum monitoring**
1561 **requirements to the member during plan development, and all case manager**
1562 **responsibilities are outlined in Case Management Agency contracts and state rules**
1563 **and regulations.]** The case managers shall ensure that individuals obtain authorized
1564 services in accordance with their Person-Centered Support Plan and monitor the
1565 quality of the services and supports. The case manager shall make necessary
1566 adjustments to the plan as needed to meet member's goals, needs, and preferences.
1567 Case managers are required to conduct an in-person monitoring contact with the
1568 member in their place of residence at least once per certification period. Case
1569 managers are also required to contact the member when significant changes occur in
1570 the member's physical or mental condition. The case manager shall assure the health
1571 and welfare of the individual, and individual safety, satisfaction, and quality of life
1572 by monitoring service providers to ensure the appropriateness, timeliness, and
1573 number of services provided.

1574

1575 **☒The state assures that assessment and service planning will be**
1576 **conducted according to 441.540(B) 1-12.**

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DRAFT

1578 **The person-centered service plan is reviewed and**
1579 **updated every:**
1580 **☐ 3 months**
1581 **☐ 6 months**
1582 **☒ 12 months**
1583 **☐ Other (must less than 12 months)** **Click or tap here to enter text.**
1584 **AND**
1585 **☒ When an individual's circumstances or needs change significantly or at the**
1586 **individuals request.**
1587
1588 **Describe the person-centered service plan review process the state will use. In the**
1589 **description please indicate if this process is conducted in the same manner and by**
1590 **the same entity as the initial service plan review process or if different procedures**
1591 **are followed:**
1592
1593 The case manager reviews the Level of Care Screen, Needs Assessment, and Person-
1594 Centered Support Plan with the member no less than annually at the time of their
1595 Continued Stay Review (CSR). The member may also request updates to the Person-
1596 Centered Support Plan as needed throughout the member's certification period. The
1597 case manager shall continually identify member's strengths, needs and preferences
1598 for services and supports as they change or as indicated by the occurrence of critical
1599 incidents. If a new assessment is warranted, the case manager follows the same
1600 procedure for the Level of Care Screen, Needs Assessment, and Person-Centered
1601 Support Plan as during the initial review. **[Upon Department approval, the CSR may**
1602 **be completed by the case manager at an alternate location from the member's**
1603 **place of residence or via the telephone for situations where there is a**
1604 **documented safety risk to the case manager or member.]**

DRAFT

1605 **Community First Choice Service Delivery Systems**
1606
1607 **Identify the service delivery system(s) that will be used for individuals**
1608 **receiving CFC services:**
1609
1610 **☒ Traditional State-Managed Fee-for-Service (4.19(b) page is**
1611 **required**
1612
1613 **☐ Managed Care Organization**
1614
1615 **☐ Other Describe:**
1616 Click or tap here to enter text.

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1617
1618 **Quality Assurance System**
1619
1620 **Please describe the state's quality improvement strategy:**
1621 The Department Quality Strategy outlined below encompasses all services provided in 1915
1622 (c) waivers and the 1915 (k) benefit.
1623
1624 System Improvements:
1625 The Department draws from multiple sources when determining the need for and methods
1626 to accomplish system design changes. Data is collected on an ongoing and continuous basis
1627 from Colorado Department of Public Health and Environment (CDPHE), Critical Incident
1628 Reporting System (CIRS), annual programmatic and administrative evaluations, and
1629 stakeholder input. The Benefits and Services Management (BSM) Division in the Office of
1630 Community Living (OCL), in partnership with the Case Management Quality and
1631 Performance (CMQP) Division and Office of Information Technology (OIT), uses an
1632 interdisciplinary approach to review and monitor the system to determine the need for
1633 design changes including those to the State's case management IT system. Work groups
1634 form as necessary to discuss prioritization and selection of system design changes.
1635
1636 Discovery and Remediation Information:
1637 The Department maintains oversight over the 1915(c) waivers and the 1915 (k) benefit in
1638 its contracts or interagency agreements through tracking of contract deliverables on a
1639 monthly, quarterly, semi-annually, and yearly basis, depending on the details of each
1640 agreement. The Department has access to and reviews all required reports,
1641 documentation, and communications. Delegated responsibilities of these agencies and
1642 vendors are monitored, corrected, and remediated by the Department.
1643
1644 Colorado selects a random sample (unless otherwise noted in the application) of
1645 participants for annual review, with a confidence level of 95% +/- 5% margin of error from
1646 the respective population. The results obtained reflect the performance of the multi-
1647 layered system, ensuring systemic responsiveness for the waiver and CFC programs and to
1648 the needs of all individuals served. The Department trends, prioritizes and implements
1649 system improvements (i.e., system design changes) warranted from the analysis of the
1650 discovery and remediation information gathered.
1651
1652 The Department uses standardized tools for Level of Care eligibility determinations,
1653 Person-Centered Support Planning, and critical incident reporting for the CFC population.
1654 Through use of the state's case management system, the data generated from Level of Care
1655 eligibility determinations, Person-Centered Support Plans, and critical incident reports and
1656 their concomitant follow-up are electronically available to Case Management Agency and
1657 the Department allowing effective access and use for clinical and administrative functions
1658 as well as for system improvement activities. This standardization and electronic
1659 availability provide comparability across Case Management Agencies and facilitates ongoing
1660 analysis. The Department implemented a new case management system in July 2023 which
1661 streamlines processes for identifying member needs and coordinating support. This new

1662 system eliminates the need for case managers to complete documentation in multiple
1663 systems which effectively reduces the chance for errors and/or missing information.
1664
1665 Service providers that are required by Medical Assistance Program regulations to be
1666 surveyed by the Colorado Department of Public Health & Environment (CDPHE), must
1667 complete the survey prior to certification ensuring compliance with licensing, qualification
1668 standards, and training requirements. The Department is provided with monthly and annual
1669 reports detailing the number and types of provider agencies that have been surveyed, the
1670 number of agencies that have deficiencies and types of deficiencies cited, the date
1671 deficiencies were corrected, as well as the number of provider complaints received,
1672 number investigated, number substantiated, and number resolved. Providers who are not
1673 in compliance with CDPHE and other state standards receive deficient practice citations.
1674 Department staff review all provider surveys to verify deficiencies have been remediated
1675 and to identify patterns and/or problems on a statewide basis by service area. The results
1676 of these reviews assist the Department in determining providers' need for technical
1677 assistance, training resources, and other needed interventions.
1678
1679 The Department initiates termination of the provider agreement for any provider who is in
1680 violation of any applicable certification standard, licensure requirements, or provision of
1681 the provider agreement and who does not adequately respond to a plan of correction
1682 within the prescribed period of time. Following Medicaid provider certification, the fiscal
1683 agent enrolls all providers in accordance with program regulations and maintains provider
1684 enrollment information in Colorado's Medicaid Management Information System (MMIS), the
1685 interChange. All provider qualifications are verified by the fiscal agent upon initial
1686 enrollment and in a revalidation cycle; at least every five years.
1687
1688 The interChange is designed to meet federal certification requirements for claims
1689 processing and submitted claims are adjudicated against interChange edits prior to
1690 payment. Claims are submitted through the Department's fiscal agent for reimbursement.
1691 The Department also engages in a post-payment review of claims to ensure the integrity of
1692 provider billings. The information gathered from the Department's monitoring processes is
1693 used to determine areas that need additional training/technical assistance, system
1694 improvements, and quality improvement plans.
1695
1696 Trending:
1697 The Department uses performance results to establish baseline data that undergoes
1698 trending and analysis over time. The Department's data aggregation and root cause analysis
1699 are incorporated into annual reports that provide information to identify aspects of the
1700 system which require action or attention.
1701
1702 Prioritization:
1703 The Department relies on a variety of resources to prioritize changes in the State's case
1704 management IT system. In addition to using information from annual reviews, analysis of
1705 performance measure data, and feedback from case managers, the Department factors in
1706 appropriation of funds, legislation, and federal mandates. For changes to the interChange,

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1707 the Department has developed a Priority and Change Board that convenes monthly to
1708 review and prioritize system modifications and enhancements. Change requests are
1709 presented to the Board, which discusses the merits and risks of each proposal, then ranks it
1710 according to several factors including implementation dates, level of effort, required
1711 resources, code contention, contracting requirements, and risk. Change requests are
1712 tabled, sent to the fiscal agent for an order of magnitude, or cancelled. If an order of
1713 magnitude is requested, it is reviewed at the next scheduled Board meeting. If selected for
1714 continuance, the Board decides where in the priority list the project is ranked.
1715
1716 The Department continually works to enhance coordination with its sister agency, CDPHE.
1717 The Department engages in quarterly meetings with CDPHE to maintain oversight of
1718 delegated responsibilities - report findings and analysis, provider licensure/certification
1719 and surveys, provider investigations, corrective actions and follow-up. Documentation of
1720 inter-agency meeting minutes, decisions and agreements are maintained in accordance
1721 with state record maintenance protocol. Quality improvement activities and results are
1722 reviewed and analyzed amongst benefit administrators, case management specialists, and
1723 critical incidents administrators.
1724
1725 Implementation:
1726 Prior to implementation of a system-level improvement, the Department ensures the
1727 following are in place:
1728 o Process to address the identified need for the system-level improvement,
1729 o Policy and instructions to support the newly created process,
1730 o Method to measure progress and monitor compliance with the system-level improvement
1731 activities including identifying the responsible parties,
1732 o Communication plan,
1733 o Evaluation plan to measure the success of the system-level improvement activities post-
1734 implementation, and
1735 o Implementation strategy.
1736
1737
1738 **Describe the methods the state will use to continuously monitor the health and**
1739 **welfare of each individual who receives home and community-based attendant**
1740 **services and supports, including a process for the mandatory reporting,**
1741 **investigation, and resolution of allegations of neglect, abuse, or exploitation in**
1742 **connection with the provision of such services and supports:**
1743 Critical incidents are those incidents that create the risk of serious harm to the health or
1744 welfare of an individual receiving services and may endanger or negatively impact the
1745 mental and/or physical well-being of an individual. Critical incident categories that must
1746 be reported include but are not limited to: Injury/illness;
1747 mistreatment/abuse/neglect/exploitation; damage/theft of property; medication
1748 mismanagement; lost or missing person; criminal activity; unsafe housing/displacement; or
1749 death.
1750

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Critical incidents are required to be reported by all providers. Oversight is provided by the Colorado Department of Health Care Policy and Financing and/or the Departments of Public Health and Environment (CDPHE) and Human Services (DHS).

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

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

~~{Disability Law Colorado administers the Office of the State Long Term Care Ombudsmen under contract with DHS. A network of local ombudsmen, under the auspices of the local Area Agencies on Aging, identify, investigate, and resolve complaints by residents of long-term facilities. Ombudsmen have regular contact with members residing in such facilities in order to ensure members have access to advocacy.}~~

[The Colorado State Long-Term Care Ombudsman Program is an independent program that advocates for residents of skilled nursing homes, and licensed assisted living residences. The authority of the long-term care ombudsman program comes from Title VII, Chapter 2, of the Older Americans Act, as well as Title 26, Article 11.5, of the Older Coloradans Act. The primary purpose of the Long-Term Care Ombudsman Program is to promote and protect the residents' rights guaranteed to residents under federal and state law. The Colorado Department of Human Services (CDHS) achieves this mission with a network of local offices across the state, which recruit, train, and manage teams of certified ombudsmen. Staff and volunteer ombudsmen visit long-term care facilities throughout the state to ensure residents' rights are being upheld. Certified Long-Term Care Ombudsmen are trained to receive complaints and resolve problems in situations involving quality of care, use of restraints, transfer and discharge, abuse, and other aspects of resident dignity and rights. Ombudsman services are free, confidential, and resident directed.]

The Department's interagency agreement with CDPHE requires that the agency responds to and remediates quality of care complaints about services provided by Medicaid-certified home health agencies. Case managers are responsible for following up with appropriate individuals and/or agencies in the event any issues or complaints have been presented. Each member and/or legal guardian is informed at the time of initial assessment and reassessment to notify the case manager if there are changes in the care needs and/or

DRAFT

1796 problems with services.
1797
1798 The Department and the contract Quality Improvement Organization (QIO) review and
1799 track critical incident reports to ensure that a resolution is met, and the member's health
1800 and safety have been maintained. The QIO is responsible for managing the Critical Incident
1801 Reporting system for the 1915(c) waivers and 1915(k) benefit. The QIO assesses the
1802 appropriateness of both the provider and Case Management Agencies response to critical
1803 incidents, gathers, aggregates, and analyzes the critical incident report (CIR) data, and
1804 ensures that appropriate follow-up for each incident is completed. The QIO also supports
1805 OCL in the analysis of CIR data, understanding the root cause of identified issues, and
1806 providing recommendations for changes in the reporting system and other waiver
1807 management protocols aimed at reducing/preventing the occurrence of future critical
1808 incidents. The QIO conducts desk reviews of case files from Case Management Agencies.
1809
1810 **Describe how the state measures individual outcomes associated with the**
1811 **receipt of home and community-based attendant services and supports as set**
1812 **forth in the person-centered service plan, particularly for the health and**
1813 **welfare of individuals receiving such services and supports. (These measures**
1814 **must be reported to CMS upon request.)**
1815 Case managers are required to conduct quarterly monitoring with participants. The
1816 monitoring includes verifying that services are furnished in accordance with the
1817 service plan. The case management system for Prior Authorization (PAR)
1818 development and submission allows case managers to see the unit decrement on
1819 the PAR. Additionally, case managers verify with individuals and provider agencies
1820 to ensure services are delivered in accordance with the Person-Centered Support
1821 Plan. The quarterly monitoring requires that case managers monitor the access to
1822 services, if services are meeting the individual's needs, the use of the contingency
1823 plan, health and safety, including follow-up to any critical incident reports, and
1824 use of non-waiver services.
1825
1826 **Describe the standards for all service delivery models for training,**
1827 **appeals for denials and reconsideration procedures for an individual's**
1828 **person-centered service plan:**
1829 Training:
1830 Members are first informed that they have a choice of how they receive services,
1831 either through an agency-based model or through a participant-directed model. If a
1832 member chooses a participant directed model, members and/or authorized
1833 representatives will access supportive training based on the philosophy and
1834 responsibilities of participant-directed care. At a minimum, this training includes:
1835 members or their authorized representative is informed of the ability to choose
1836 provider, an overview of the program, member and/or authorized representative
1837 rights and responsibilities, planning and organizing attendant services, managing

1838 personnel issues, communication skills, recognizing and recruiting quality attendant
1839 support, managing health, accessing resources, safety and prevention strategies, and
1840 managing emergencies. If the member utilizes the self-direction with service budget
1841 model, they will also be trained on allocation budgeting and working with the
1842 Financial Management Services vendor.
1843
1844 Denials and Reconsiderations Procedures:
1845 Members who have a dispute regarding their assessed service needs have the ability to
1846 initiate an appeal before an Administrative Law Judge. The Case Management Agency
1847 shall provide the member with a Long-Term Care Waiver Program Notice of Action
1848 (LTC 803) to inform the member of their appeal rights in accordance with the Code of
1849 Colorado Regulation 10 CCR 2505- 10, section 8.057.
1850
1851 A member has the right to request a review of their assessed service needs identified
1852 in their assessment at any time through their case manager. If the member and/or
1853 authorized representative report a change in functioning which requires a
1854 modification to the member's Person-Centered Support Plan, the case manager
1855 performs a reassessment.
1856
1857 **Describe the methods used to monitor provider qualifications:**
1858 Some service types require licensing or certification. Providers interested in providing these
1859 services to Colorado Medicaid members must obtain certification from the Department.
1860 Licensing and certification are obtained by a provider after undergoing a survey by the
1861 Colorado Department of Public Health and Environment (CDPHE). CDPHE will recommend a
1862 provider for Medicaid certification after the provider has successfully completed a survey.
1863 The Department will review the recommendation by CDPHE and either certify the provider
1864 or ask that the provider improve the conformance to rules and/or regulations before
1865 certifying the provider. Service types that do not require licensure are not required to
1866 complete a CDPHE survey and obtain certification directly from the Department. All
1867 provider qualifications, including those types not requiring CDPHE license or
1868 recommendation, are verified by the fiscal agent upon initial enrollment and in a
1869 revalidation cycle; at least every five years. Data reports verifying non-surveyed providers
1870 continually meet CFC requirements are maintained by the Department's provider enrollment
1871 compliance staff.
1872
1873 The Department currently reviews provider qualifications for desired HCBS services to
1874 furnish at the time of initial application to become a Medicaid-enrolled provider and then
1875 every five years through provider re-validation. Review includes confirmation of any and all
1876 licenses, certificates, or other standards required to furnish desired service at time of initial
1877 Medicaid provider enrollment and any waiver service specific provider requirements.
1878
1879 The CDPHE interagency agreement (IA) is to manage aspects of provider qualifications,
1880 surveys, complaints and critical incidents for provider types that require CDPHE licensing or
1881 certification. The IA requires monthly and annual reports detailing number and types of

1882 agencies surveyed, the number of agencies with deficiencies, types of deficiencies cited,
1883 date deficiencies were corrected, number of complaints received, investigated, and
1884 substantiated. Oversight is through monthly meetings and reports. Issues that impact the
1885 agreement, problems discovered at specific agencies or widespread issues and solutions are
1886 discussed. Oversight is provided by the Department, CDPHE, and/or DHS. The response to a
1887 critical incident is unique to the type of incident and the parties involved. However, the
1888 Department and/or the contract Quality Improvement Organization (QIO) vendor reviews all
1889 critical incidents. Critical Incidents involving providers surveyed by CDPHE which meet
1890 occurrence reporting criteria must be reported to the Department and CDPHE and are
1891 responded to by CDPHE.
1892
1893 Providers of HCBS services that require CDPHE survey are surveyed at a minimum every 36.9
1894 months. Risk-based surveys may occur more often if a credible complaint is received by
1895 CDPHE. Credible complaints are ones that are validated; when investigated they have not
1896 been found to be fabricated allegations or misinterpreted impressions of something that did
1897 not occur. If during the investigation of a complaint by CDPHE, the findings are severe (i.e.,
1898 a systemic failure, patient harm, etc.) it may trigger the investigation to be converted to a
1899 full survey at the time the investigation is underway. The findings of the investigation may
1900 be grounds for CDPHE to initiate a full recertification survey of the provider agency
1901 regardless of the date of the last survey.
1902

1903 **Describe the methods for assuring that individuals are given a choice**
1904 **between institutional and community-based services:**

1905 Case Management Agency responsibilities include informing the participant or
1906 their legally authorized representative (e.g., parents of a minor, guardian if
1907 within the scope of the guardianship order) during the Person-Centered Support
1908 Planning process of the freedom of choice between institutional and home and
1909 community-based service and service options to inform that choice. A signature
1910 from the participant or their legally authorized representative is required on
1911 the state's designated form confirming this informed choice.

1912

1913 **Describe the methods for assuring that individuals are given a choice of**
1914 **services, supports and providers:**

1915 Each Case Management Agency is required to provide members with a free
1916 choice of willing and qualified providers. Case Management Agencies have
1917 developed individual methods for providing choice to their members. To
1918 ensure that members continue to exercise free choice of providers, the
1919 Department has added a signature section to the Person-Centered Support
1920 Plan that allows members to indicate whether they have been provided with
1921 free choice of providers.

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1922

1923 **Describe the methods for monitoring that the services and supports provided**
1924 **to each individual are appropriate:**

1925 [After the development of the Needs Assessment and Person-Centered Support
1926 Plan, case managers conduct four monitoring contacts during the member's
1927 certification period. These contacts include monitoring the delivery and quality of
1928 services and supports identified in the Person-Centered Support Plan including
1929 ensuring that services are delivered in accordance with the scope, frequency, and
1930 duration documented. These monitoring contacts are separate from the initial
1931 Level of Care function assessment, Needs Assessment, and Person-Centered
1932 Support Planning meeting(s), as well as the Continued Stay Review meeting
1933 (required annually or once during the certification period) where the case
1934 manager reviews these assessments more formally with the member to determine
1935 any changes necessary for the upcoming certification period.

1936 The case manager may meet the member at the residence, monitoring service
1937 delivery, health, and welfare. An in-person monitoring contact is required at least
1938 one (1) time during the Person-Centered Support Plan certification period. The
1939 case manager shall ensure the one (1) required in-person monitoring contact
1940 occurs, with the member physically present, in the member's place of residence
1941 or location of services. Upon Department approval in advance, this contact may be
1942 completed by the case manager at an alternate location, via the telephone, or
1943 using a virtual technology method. Such approval may be granted for situations in
1944 which in-person face-to-face meetings would pose a documented safety risk to the
1945 case manager or member (e.g. natural disaster, pandemic, etc.). The case
1946 manager shall perform three additional monitoring contacts each certification
1947 period either in-person, on the phone, or through other technological modalities
1948 based on the member's preference of engagement.

1949 The monitoring contacts include:

1950 - The evaluation and assessment strategies for meeting the needs,
1951 preferences, and goals of the member.
1952 - Evaluating and obtaining information concerning the member's satisfaction
1953 with the services, the effectiveness of services being provided, an informal
1954 assessment of changes in the member's function, service appropriateness,
1955 and service cost-effectiveness.
1956 - Monitoring the health, safety, and welfare of members, including the
1957 provider agencies' procedures to address the member's needs.
1958 - Evaluating the member's satisfaction with services and choice in providers.
1959 - Ensuring that services are delivered in a way that promotes a member's

DRAFT

1960 ability to engage in self-determination, self-representation, and self-
1961 advocacy.

1962 • Case manager shall contact the provider agency to coordinate, arrange, or
1963 adjust services to address and resolve quality issues or concerns.]

1964 ~~{The case manager shall perform quarterly monitoring contacts with the member,~~
1965 ~~as defined by the member's certification period start and end dates. An in-person~~
1966 ~~monitoring contact is required at least one (1) time during the Person-Centered~~
1967 ~~Support Plan certification period. The case manager shall ensure the one (1)~~
1968 ~~required in-person monitoring contact occurs, with the member physically~~
1969 ~~present, in the member's place of residence or location of services. The case~~
1970 ~~manager reviews the Level of Care Screen, Needs Assessment, and Person-~~
1971 ~~Centered Support Plan with the member during the required monitoring contact or~~
1972 ~~sooner if requested. The contact includes the evaluation and assessment strategies~~
1973 ~~for meeting the needs, preferences, and goals of the member. It also includes~~
1974 ~~evaluating and obtaining information concerning the member's satisfaction with~~
1975 ~~the services, the effectiveness of services being provided, an informal assessment~~
1976 ~~of changes in the member's function, service appropriateness, and service cost-~~
1977 ~~effectiveness. At this time the case manager may meet the member at the~~
1978 ~~residence, monitoring service delivery, health, and welfare. Upon Department~~
1979 ~~approval in advance, this contact may be completed by the case manager at an~~
1980 ~~alternate location, via the telephone, or using a virtual technology method. Such~~
1981 ~~approval may be granted for situations in which in-person face-to-face meetings~~
1982 ~~would pose a documented safety risk to the case manager or member (e.g. natural~~
1983 ~~disaster, pandemic, etc.).~~

1984 ~~The case manager shall perform three additional monitoring contacts each~~
1985 ~~certification period either in-person, on the phone, or through other technological~~
1986 ~~modalities based on the member's preference of engagement.}~~

1987 The Person-Centered Support Plan is required to address the individual's needs,
1988 personal goals, preferences, unique strengths, abilities, desires, health and safety,
1989 and risk factors. The plan must also document decisions made through the service
1990 planning process including, but not limited to, rights suspension/modifications, the
1991 existence of appropriate services and supports and the actions necessary for the
1992 plan to be achieved. The plan requires documentation that the member has been
1993 offered a choice of HCBS services or institutional care, including service delivery
1994 options, and of qualified providers.

1995 **Describe the state process for ongoing monitoring of compliance with the home**
1996 **and community-based setting requirements, including systemic oversight and**
1997 **individual outcomes:**

1998 As detailed in the gray table (pages 29-31) in Colorado's STP, the ongoing monitoring

1999 process includes the following initiatives:

- 2000 Including HCBS Settings Final Rule-related performance measures regarding rights 2001 modifications within the current 1915(c) waiver quality improvement system (QIS).
- 2002 Developing process(es) for case managers to confirm with individuals that the settings 2003 at which they receive services are compliant.
- 2004 Ensuring that after the transition period, settings are monitored by state agencies for 2005 compliance with HCBS Settings Final Rule criteria.
- 2006 Identifying and publicizing process(es) for waiver participants, case managers, and 2007 others to report potential violations of HCBS Settings Final Rule criteria. After the 2008 STP was finalized, the Department added a dedicated "Ask a Question/Report a 2009 Concern" section to its HCBS Settings Final Rule website and explained how 2010 individuals can report concerns as part of new videos and resource sheets for waiver 2011 participants on their rights and the rights modification process.
- 2012 Monitoring data from member experience surveys related to outcomes relevant under 2013 the HCBS Settings Final Rule.

2014 **ii. Frequency of monitoring efforts**

- 2015 Performance measures are assessed annually.
- 2016 Case managers assess the adequacy of information supporting a proposed rights 2017 modification when they discuss the proposal with the individual and enter that 2018 information into the BUS/CCM. This happens for all new rights modifications as they 2019 are implemented and for all continuing modifications as they come up for 2020 review/renewal (at least every 12 months). An additional tool to support case 2021 managers in identifying broader compliance issues at HCBS settings (beyond just 2022 rights modification concerns) has been developed and is being finalized. Case 2023 managers will be asked to use this tool during quarterly case management monitoring 2024 contacts.
- 2025 State agency monitoring: CDPHE cross-trained its survey staff on HCBS Settings Final 2026 Rule criteria so that they could address these criteria as part of new provider 2027 enrollment as well as routine quality assurance surveys. Regarding such surveys:
  - 2028 Under an Interagency Agreement (IA) between the Department and CDPHE, 2029 CDPHE surveys prospective HCBS providers before it recommends them to HCPF 2030 for certification as Medicaid waiver providers. As relevant to CFC, provider 2031 types subject to certification include adult day programs, program approved 2032 service agencies (PASAs) serving the waivers for individuals with IDD (providing 2033 services such as day habilitation), and home care agencies (HCAs) (providing 2034 personal care, homemaker, etc.). These initial certification surveys address 2035 compliance with the HCBS Settings Final Rule. (For Medicaid-certified settings.

2036 Settings such as Adult Day Service centers that operate exclusively on a
2037 private-pay basis are not covered by this process.)

2038 ○ In addition, CDPHE routinely surveys provider types subject to (re)certification
2039 (see list above) on a three-year cycle. Recertification surveys include visiting
2040 private homes where individuals receive Individual Residential Services and
2041 Supports (IRSS). Recertification surveys address compliance with the HCBS
2042 Settings Final Rule.

2043 ○ Similarly, under an IA between the Department and CDHS, CDHS surveys
2044 prospective CHRP residential habilitation providers, and annually resurveys
2045 current providers, to confirm their compliance with the applicable regulations.
2046 CDHS's regulations for CHRP providers cross-reference HCPF's, which in turn
2047 now include the HCBS Settings Final Rule. (If included in the first bullet point
2048 above, certain providers may instead be surveyed by CDPHE.)

2049 • Stakeholder reporting of potential violations occurs on an as-needed basis.

2050 • Member experience surveys occur at different times, depending on the survey. The
2051 Individual/Family/Advocate (IFA) Survey, which is specific to the HCBS Settings Final
2052 Rule, currently remains open and may be completed as often as desired.

2053 **iii. Summary of findings**

2054 • Performance measures are collected and shared with case management agencies
2055 through annual quality improvement strategies. Any identified performance measures
2056 falling below 86% compliance are reported to CMS through annual 372 reporting.

2057 • The Department identified certain concerns regarding case managers' entry of
2058 information relating to rights modifications into the BUS. The Department addressed
2059 these concerns in an Operational Memo and Technical Assistance session (webinar
2060 recording; slide deck). The additional tool mentioned above is not yet in use but is
2061 expected to help ensure that even settings excluded from the CDPHE/CDHS IA survey
2062 processes still experience ongoing monitoring and oversight.

2063 • To our knowledge, all deficiencies identified in provider surveys are corrected upon
2064 being identified.

2065 • We occasionally hear from advocates, case management agencies, and/or providers
2066 with questions or concerns that are addressed when raised.

2067 • Reporting on member experience surveys depends on the survey. Reports on and
2068 analysis of IFA Survey responses were previously available on the Department's
2069 website, and are available upon request. Updated reporting on that particular survey
2070 was disrupted by the pandemic, and the survey currently has little in the way of
2071 ongoing uptake/responses.

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

- Deficiencies in performance on QIS measures are addressed as stated in each relevant waiver and as negotiated with CMS. Approaches to remediation may include a continuous quality improvement plan to correct identified issues.
- The Department may implement corrective action plans with case management agencies if needed.
- When CDPHE identifies deficiencies in the course of surveys, it ordinarily offers the provider an opportunity to remedy the deficiencies pursuant to a Plan of Correction. If that process proves unsuccessful, CDPHE recommends decertification to HCPF. The process that CDHS follows as to foster care homes is similar.
- The Department's response to stakeholder concerns depends on the nature of the concern. Department staff may directly contact the provider or case management agency to correct the noncompliance, and/or file a complaint with CDPHE to initiate an investigation and possible enforcement action. If on review, the concern does not involve noncompliance with the HCBS Settings Final Rule, the Department may refer the concern elsewhere and/or seek to educate the stakeholder on what the rule does and does not require. Finally, for recurring concerns, statewide training of providers and/or case management agencies, as well as development of additional resources for members, may be warranted.
- Survey responses identifiable to specific providers/settings or case management agencies have been addressed through the Provider Transition Plan (PTP) process, CDPHE investigation work, outreach to case management agencies, and other measures, depending on the type of concern.

Choice and Control
Describe the quality assurance system's methods to (1) maximize consumer independence and control,
(2) provide information about the provisions of quality improvement to each individual receiving CFC services and supports:

Each Case Management Agency is required to provide members with a free choice of willing and qualified providers. Case Management Agencies have developed individual methods for providing choice to their members. In order to ensure that members continue to exercise free choice of providers, the Department has added a signature section to the Person-Centered Support Plan that allows members to indicate whether they have been provided with free choice of providers. As part of the state's Quality Assurance strategy, the Department reviews data collected on members in a representative sample whose Person-Centered Support Plan document a choice between and among HCBS services and qualified service providers.

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

The case manager may meet the member at the residence, monitoring service delivery, health, and welfare. An in-person monitoring contact is required at least one (1) time during the Person-Centered Support Plan certification period. The case manager shall ensure the one (1) required in-person monitoring contact occurs, with the member physically present, in the member's place of residence or location of services. Upon Department approval in advance, this contact may be completed by the case manager at an alternate location, via the telephone, or using a virtual technology method. Such approval may be granted for situations in which in-person face-to-face meetings would pose a documented safety risk to the case manager or member (e.g. natural disaster, pandemic, etc.). The case manager shall perform three additional monitoring contacts each certification period either in-person, on the phone, or through other technological modalities based on the member's preference of engagement.

The monitoring contacts also include:

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

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adjust services to address and resolve quality issues or concerns.]

~~{The case manager shall perform quarterly monitoring contacts with the member, as defined by the member's certification period start and end dates. An in-person monitoring contact is required at least one (1) time during the Person-Centered Support Plan certification period. The case manager shall ensure the one (1) required in-person monitoring contact occurs, with the member physically present, in the member's place of residence or location of services. The case manager reviews the Level of Care Screen, Needs Assessment, and Person-Centered Support Plan with the member during the required monitoring contact or sooner if requested. At this time the case manager may meet the member at the residence, monitoring service delivery, health, and welfare. The contact includes the evaluation and assessment strategies for meeting the needs, preferences, and goals of the member. It also includes evaluating and obtaining information concerning the member's satisfaction with the services, the effectiveness of services being provided, an informal assessment of changes in the member's function, service appropriateness, and service cost-effectiveness. Upon Department approval in advance, this contact may be completed by the case manager at an alternate location, via the telephone, or using a virtual technology method. Such approval may be granted for situations in which in-person face-to-face meetings would pose a documented safety risk to the case manager or member (e.g. natural disaster, pandemic, etc.).~~

~~The case manager shall perform three additional monitoring contacts each certification period either in-person, on the phone, or through other technological modalities based on the member's preference of engagement. }~~

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

The Department performs monitoring of the Case Management Agency and the Department's Case Management Agency reviewers survey a random sample of members records. Included in the record review is an examination of the LTC 803 Form(s) to ensure that each Case Management Agency is using the

DRAFT

2188 approved form to convey information to the member on fair hearing rights.
2189 The Department monitors also have access to the state's case management IT
2190 system which allows them to review LTC 803 forms as reviewers receive
2191 individual complaints.

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2192

2193 **Stakeholder Feedback**
2194 **Describe how the state will elicit feedback from key stakeholders to**
2195 **improve the quality of the community-based attendant services and**
2196 **supports benefit:**
2197 The Department elicits and incorporates stakeholder feedback into its quality
2198 improvement strategy in the following ways:
2199 1. The Department will hold Community First Choice Council (CFCC)
2200 meetings regularly to elicit feedback from individuals with disabilities,
2201 older adults, and their advocates on the quality of the CFC community-
2202 based services and supports. The CFCC also serves as a way for the
2203 Department to present to members information about CFC, its services,
2204 and any improvements that are underway.
2205 2. The Department will continue to outreach specific communities and
2206 populations historically underrepresented in stakeholder engagement in
2207 Colorado regularly. The Department will elicit feedback from these
2208 communities and present information and updates about the CFC program
2209 to these communities.
2210 3. The Department will continue to attend meetings held by associations,
2211 advocacy groups, and other stakeholder groups, such as the Participant
2212 Directed Programs Policy Collaborative, to elicit feedback and present
2213 information.
2214 4. The Department will continue to update information about CFC on the
2215 program website and will ensure the CFC email address and phone line for
2216 members to provide feedback is easily accessible on the website.
2217 5. The Department will continue to hold webinars and community forums
2218 when major changes are under consideration or are in the process of
2219 implementation.
2220
2221 **Identify the stakeholders from whom the state will elicit feedback:**
2222
2223 ☒ **The state will elicit feedback from the following stakeholders: (1) Individuals**
2224 **receiving CFC services and if applicable, their representatives, (2) disability**
2225 **organizations, (3) providers, (4) families of elderly individuals or individuals**
2226 **with disabilities, (5) and members of the community**
2227
2228 ☐ **Other Describe:**
2229 Click or tap here to enter text.

2230

2231 **State Assurances**

2232

2233 ☒ **The state assures there are necessary safeguards in place to protect the**
2234 **health and welfare of individuals provided services under this state Plan**
2235 **Option, and to assure financial accountability for funds expended for CFC**
2236 **services.**

2237

2238 ☒ **With respect to expenditures during the first full year in which the state**
2239 **plan amendment is implemented, the state will maintain or exceed the**
2240 **level of state expenditures for home and community-based attendant**
2241 **services and supports provided under section 1905(a), section 1915,**
2242 **section 1115, or otherwise to individuals with disabilities or elderly**
2243 **individuals attributable to the preceding year.**

2244

2245 ☒ **The state assures the collection and reporting of information, including data**
2246 **regarding how the state provides home and community-based attendant**
2247 **services and supports and other home and community-based services, the**
2248 **cost of such services and supports, and how the state provides individuals**
2249 **with disabilities who otherwise qualify for institutional care under the state**
2250 **plan or under a waiver the choice to instead receive home and community-**
2251 **based services in lieu of institutional care, and the impact of CFC on the**
2252 **physical and emotional health of individuals.**

2253

2254 ☒ **The state shall provide the Secretary with the following information**
2255 **regarding the provision of home and community-based attendant services**
2256 **and supports under this subsection for each fiscal year such services and**
2257 **supports are provided:**

2258

2259 **(i)** **The number of individuals who are estimated to receive home and**
2260 **community-based attendant services and supports under this option**
2261 **during the fiscal year.**
2262 **(ii)** **The number of individuals that received such services and supports during**
2263 **the**
2264 **preceding fiscal year.**
2265 **(iii)** **The specific number of individuals served by type of disability, age,**
2266 **gender, education level, and employment status.**
2267 **(iv)** **Whether the specific individuals have been previously served under**
2268 **any other home and community based services program under the**
2269 **state plan or under a waiver.**

2270

2271 ☒ **The state assures that home and community-based attendant services and**
2272 **supports are provided in accordance with the requirements of the Fair**
2273 **Labor Standards Act of 1938 and applicable Federal and state laws.**

DRAFT