Community First Choice (CFC) State Plan Option
DRAFT: October 2023

Draft SPA for Stakeholder Review
October 2023

Please submit feedback by email to hcpf_cfc@state.co.us or
by phone to Adam Tucker at 303-866-5472

Benefit Summary:

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

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

Impact on other LTSS programs: The Department has made the following alterations to current Long-Term Services and Supports (LTSS) to prevent duplication of services:

1. Services offered in CFC will be accessed through the 1915(k) authority and will no longer be available through a 1915(c) waiver after the member transitions to CFC. If a 1915(c) per diem residential service includes a task offered through CFC, the waiver member will still have access through the 1915(c) waivers.
2. The current 1915(c) waivers will be amended to remove personal care, homemaker, health maintenance activities, In-Home Support Services (IHSS), Consumer Directed Attendant Support Services (CDASS), electronic

monitoring (including personal emergency response system (PERS) and medication reminders), remote supports, and home delivered meals.

3. Colorado's Medicaid Management Information System (MMIS) will have safeguards to ensure duplication of services does not occur. For example, a member receiving agency-based personal care services through CFC will be prevented from accessing self-directed personal care services at the same time.

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

1. An assessment process (the Colorado Single Assessment) that allows all individuals/ potentially eligible for CFC to experience a single assessment for eligibility determination and have an informed choice about CFC and other state plan services.

2. A Person-Centered Support Plan and Needs Assessment that includes all LTSS services, including other state plan services.

Community First Choice Development and Implementation Council

Name of State Development and Implementation Council:
Community First Choice Council (CFCC)

Date of 1st Council meeting: May 4, 2022

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

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

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

Beginning in May of 2022, the Department coordinated monthly meetings with the Community First Choice Council (CFCC) to gather input and guidance on each component of Colorado's CFC benefit. The majority of CFCC members are individuals with disabilities, elderly individuals, and their representatives. Additionally, the Department created a CFC workgroup to specifically address policy for one of Colorado's participant-

directed service delivery options, Consumer-Directed Attendant Support Services (CDASS). This workgroup was created to review, prioritize, and investigate key CDASS policy areas as the Department works to integrate CDASS into the CFC benefit. The workgroup met for four months with key stakeholders, many of whom also regularly attend the CFC Council Meetings.

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

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

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

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

The Department's first batch of heightened scrutiny determinations was open for public comment from June 10, 2021, through July 10, 2021. The Department hosted three public town halls in connection with these determinations. The Department's second batch of heightened scrutiny determinations was open for public comment from April 25, 2023, through May 25, 2023. The Department hosted one public town hall in

connection with this smaller batch of determinations. The Department reviewed and addressed the comments received during and after each public comment period, as set out in the updated summary sheets for each setting. Additional detail on stakeholder engagement relating to heightened scrutiny is located in Table 2 (orange) in Colorado's STP, row 10, subrow on heightened scrutiny, pages 10-11.

Community First Choice Eligibility

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

☒ **Categorically Needy Individuals**

☒ **Medically Needy Individuals**

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

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

The state assures the following:

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

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

Level of Care

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

Recertification

☐ **The state has chosen to permanently waive the annual recertification of level of care requirement for individuals in accordance with 441.510(c)(1) & (2).**

Please indicate the levels of care that are

being waived:

☐ **Long-term care hospital**

☐ **Nursing facility**

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

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

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

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

Members will be assessed for institutional level of care using the Colorado Single Assessment Level of Care Screen. The Colorado Single Assessment supports a comprehensive, person-centered approach to the identification of a member's needs, preferences, goals, and covers a set of life domains that critically affect independence and quality of life. The Level of Care Screen includes the Level of Care Eligibility Determination outcome that is based on an individual's performance level as documented in the screen, in areas including, but not limited to, completing Activities of Daily Living, memory and cognition, sensory and communication, and behavior, as well as other criteria specific to applicable program and specific to age appropriateness. The Level of Care Eligibility Determination assesses for:

- Nursing Facility Level of Care Eligibility for ages four (4) and older.
- Nursing Facility Level of Care Eligibility Criteria for individuals zero to three (0-3) years of age.
- Nursing Facility Level of Care Eligibility Alternative Criteria.
- Hospital Level of Care Eligibility Criteria.
- Intermediate Care Facility Level of Care Eligibility Criteria.

For initial level of care eligibility determinations, the Professional Medical Information Page (PMIP) must be completed by a treating medical professional who verifies the individual's need for institutional level of care. The Department oversees eligibility determinations completed by Case Management Agencies.

Informing Individuals Potentially Eligible for the Community First Choice Option

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

☐ **Letter**

☐ **Email**

☒ **Other – Describe:**

Agencies serving as access points for publicly funded LTS

Please describe the process used for informing beneficiaries:

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

The Department will work with the CFC Council to identify additional advocacy groups and populations in need of targeted outreach. Additionally, the Department will conduct specific outreach to inform Colorado's native tribes of the availability of CFC services. All communications regarding CFC will be created in multiple languages. In the first year of CFC, each 1915(c) Waiver member shall be informed by their case manager, in a manner prescribed by the Department, about the CFC program and will be supported to transition to the CFC program during the Person-Centered Support Planning process.

Assurances (All assurances must be checked).

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

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

☒ **Services are provided without regard to the individual's age, type or nature of disability, severity of disability, or the form of home and community-based attendant services and supports that the individual needs to lead an independent life.**

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

☒ **During the five-year period that begins January 1, 2014, spousal impoverishment rules are used to determine the eligibility of individuals with a community spouse who seek eligibility for home and community-based services provided under 1915(k)**

CFC Service Models

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

☒ **Agency-Provider Model**

☒ **Self-Directed Model with Service Budget**

☐ **Other Service Model. Describe:**

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

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

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

Self-Direction with Service Budget Model – In this model, the member is the employer of record. Attendants are employed by the member. The member determines the rate of pay and training needs. This service delivery model, called Consumer Directed Attendant Support Services (CDASS), allows members to completely self-direct all aspects of their service delivery by becoming the legal employer of attendants with the assistance of a Financial Management Service (FMS) provider. With CDASS, members have budget and employer authority and accept more responsibility and control over the services and supports. The member recruits, hires, trains, and supervises their CDASS Attendant. Members unable to fulfill their obligations under the CDASS budget model may authorize an authorized representative to do so on their behalf. Under this model, members must choose 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.

Specify the type of entity that provides financial management services:

☐ **A Medicaid Agency**

☐ **Another State Agency – Specify:**

Click or tap here to enter text.

☒ **Vendor Organization**

Describe:

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

Other Payment Methods

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

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

Click or tap here to enter text.

☐ **Vouchers- Describe:**

Click or tap here to enter text.

Service Budget Methodology

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

As part of the assessment and Person-Centered Support Planning process, the Person-Centered Budget Algorithm (PCBA) will help identify the right amount of support for members based on assessed needs, strengths, and preferences identified during the assessment and contribute to a Person-Centered Support Plan. The PCBA is an important component of the assessment and support planning process to ensure a consistent method for assigning budgets for all members receiving HCBS.

The purpose of the PCBA is to support the Department's ability to make service allocation decisions that are objective, transparent, equitable, and consistent across Colorado. To help accomplish these goals, the Department will assign each member to a tier that indicates their relative need compared to others receiving services. The PCBA Budget Tiers are developed to be an objective, transparent and equitable resource allocation methodology wherein the member has the flexibility to choose services based on their needs, preferences, and goals, and as they articulate these in their Person-Centered Support Plan process. The Budget range Tiers 1-6 are based on the acuity of needs identified through the Colorado Single Assessment (Needs Assessment). This tier will serve as one of several considerations in the Department's Person-Centered Planning process. The tier is not intended to be the sole determinant of relative need, and exceptions will be made, as needed, to ensure members have access to necessary services.

The validity and reliability of the PCBA will be evaluated through two major steps. First, the variables used in the model will be reviewed based on information from several sources to ensure that only variables relevant to resource use will be used in the model. Second, after the model has been developed, the statistical validity of the model will be measured. The key validation step in the variable identification process is the evaluation of variables considering professional, stakeholder, and clinical input. This information is gathered from existing literature, experiences from state staff, and meetings with stakeholders.

The statistical validation step looks at the model from a few different perspectives. First, the data are examined for outliers which may have a disproportionate impact on the model. Second, the overall predictive power of the model is measured and compared to other existing models. The predictive power should be similar to or greater than that of existing models. Third, the output of the model is compared to a separate validation sample that was not used in model development to ensure that the outputs of the model accurately predict resource use. This process will not only be done for the overall resource use prediction from the model but also for specific budget components or add-ons, such as CFC.

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

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

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

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

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

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

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

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

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

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

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

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

Case managers provide service authorization limit information at the time of support plan development and Members are notified if any adjustments are needed.

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

The reassessment process accounts for adjustments to the individual’s budget when there has been a change in his or her medical condition, functional status, or living situation. If such change is needed, the Needs Assessment is reviewed with the Member, and adjusted by the case manager, resulting in a change to the individual’s service budget.

Mandatory Services and Supports

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

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

☒ **Personal Attendant Services. Describe:**

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

- Eating/Feeding
- Hair care
- Nail care
- Shaving
- Mouth Care
- Respiratory Care
- Skin Care
- Bladder/Bowel
- Exercise
- Dressing
- Transfers
- Mobility
- Positioning
- Medication Reminders
- Medical Equipment
    a. Attendant provides maintenance and cleaning of medical equipment, i.e., oxygen tubing, etc.
- Bathing
- Accompanying
- Protective Oversight
    a. Attendant provides intervention to prevent or mitigate disability-related behaviors that may result in imminent harm to people or property i.e., verbal redirection for wandering behavior.

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

☒ **License Required**

Agency-Provider Model providers must have a Class A or B license in good standing with the

Colorado Department of Health and Environment (CDPHE).

☒ **Certification Required. Describe:**
IHSS agencies must have the additional certification as an IHSS agency through CDPHE.

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

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

☐ **Companion Services. Describe:**
Click or tap here to enter text.

Provider Type: Click or tap here to enter text.

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

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

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

☐ **Other Qualifications Required for this Provider Type. Describe:**
Click or tap here to enter text.

☒ **Homemaker/Chore. Describe:**

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

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

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

☒ **License Required**

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

☒ **Certification Required. Describe:**

CFC Homemaker Provider must have a recommendation for certification as a Homemaker Program Approved Service Agency (PASA) or must have a Class A or B license in good standing through the Colorado Department of Health and Environment (CDPHE).

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

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

Click or tap here to enter text.

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

CDASS Attendant providers must meet individual member-defined requirements. Additional training identified through the Person-Centered Support Planning process by the member.

☒ **Other Services. Describe:**

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

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

- Skin Care
- Nail Care
- Mouth Care
- Dressing
- Feeding
- Exercise
- Transfers
- Bowel
- Bladder
- Medical Management
- Respiratory Care
- Medication Assistance
- Bathing
- Mobility
- Accompanying
- Positioning
- Shaving
- Hair Care

Provider Type: IHSS Agency, CDASS Attendant

☒ **License Required**

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

☒ **Certification Required. Describe:**

IHSS Agency providers must have IHSS certification through CDPHE.

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

Click or tap here to enter text.

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

CDASS Attendants providers must meet individual member-defined requirements. Additional training identified through the Person-Centered Support Planning process by the member.

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

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

Services and supports related to functional skills training that are necessary for the member to accomplish ADL/IADLs health-related tasks to increase member independence and reduce supports needed in the home and community. Detailed, task-related goals shall be documented by the case manager in the Person-Centered Support Plan, including documentation monitoring progress and any decreased human assistance previously authorized. Acquisition, maintenance, and enhancement (AME) will be tasks available in personal care and homemaker services and can be provided in conjunction with these services but shall not duplicate authorized service tasks for the homemaker, personal care, or other services reimbursed by Medicaid.

- Personal hygiene
- Mobility
- Money management
- Household tasks
- Menu planning and meal preparation

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

☒ **License Required**

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

☒ **Certification Required. Describe:**

CFC Homemaker Provider must have a recommendation for certification as a Homemaker Program Approved Service Agency (PASA) or must have a Class A or B license in good standing through the Colorado Department of Health and Environment (CDPHE). IHSS Agency providers must have IHSS certification through CDPHE.

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

Click or tap here to enter text.

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

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

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

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

☒ **Personal Emergency Response Systems**

☐ **Pagers**

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

Electronic Monitoring means the installation, purchase, or rental of electronic monitoring devices that:

- Enables the individual to secure help in the event of an emergency.
- May be used to provide reminders to the individual of medical appointments, treatments, or medication schedules.
- Are required because of the individual's illness, impairment, or disability, as documented on the Colorado Single Assessment and the Person-Centered Support Plan.
- Electronic monitoring services shall include personal emergency response systems (PERS) and medication reminders via an automated medication dispensing system.

Describe any limitations for the systems or mechanisms provided:

The following are not benefits of electronic monitoring services:

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

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

Provider Type: Electronic Monitoring Provider

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

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

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

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

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

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

☐ **Medicaid Service**

☒ **An Administrative Activity**

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

Members and/or authorized representatives will access supportive training based on the philosophy and responsibilities of participant-directed care. At a minimum, this training includes: an overview of the program, member and/or authorized representative rights and responsibilities, planning and organizing attendant services, managing personnel issues, communication skills, recognizing and recruiting quality attendant support, managing health, allocation budgeting, accessing resources, safety, and prevention strategies, managing emergencies, and working with the Financial Management Services vendor.

Provider Type: Training and Support Contractor

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

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

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

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

Provider must have an executed contract with Department. Additional training identified through the Person-Centered Support Planning process by the member.

Optional Services and Supports:

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

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

☒ **Rental and Security Deposits**

Description and Limitations:

Transition Setup covers the purchase of one-time, non-recurring expenses up to 30 days post-transition necessary for a member to establish a basic household as they transition from an institutional setting to a community setting, including security deposits required to obtain a lease on an apartment or home. Transition Setup 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**

Description and Limitations:

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

☒ **Bedding and Furniture**

Description and Limitations:

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

☒ **Other Household Items**

Description and Limitations:

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

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

Description and Limitations:

Transition Setup covers the purchase of one-time, non-recurring expenses up to 30 days post-transition necessary for a member to establish a basic household as they transition from an institutional setting to a community setting including expenses incurred directly from the moving, transport, provision, or assembly of household furnishings to the residence. Housing application fees and fees associated with obtaining legal and/or identification documents necessary for a housing application such as a birth certificate, state ID, or criminal

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

☒ **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

request an extension to the service past 365 days, the circumstances are reviewed on a case-by-case basis, utilizing the eligibility criteria for service.

Provider Type: Home-Delivered Meal Provider

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

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

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

☒ **Other Qualifications Required for this Provider Type. Describe:**
Providers must have an on-staff or contracted Registered Dietitian (RD) OR Registered Dietitian Nutritionist (RDN). Additional training identified through the Person-Centered Support Planning process by the member.

Remote Supports

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

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

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

Provider Type: Remote Supports Provider

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

☒ **Certification Required. Describe:**

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

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

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

Home and Community Based Settings

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

Box is not checked because CFC will be available, within limits, for people residing in institutions such as nursing facilities. In addition, settings such as Adult Day Service centers that operate exclusively on a private-pay basis were not assessed or verified for compliance with the HCBS Settings Final Rule during the transition period; however, if and when Medicaid-funded CFC services were to be provided in such centers, they would be covered by the state's codification of the rule, which specifies that "HCBS Setting means any physical location where Covered HCBS are provided."

Setting Types (check all that apply):

☐ **CFC services are only provided in private residences and are not provided in provider - owned or controlled settings.**

☒ **CFC services may be provided in private residences and in provider owned or controlled settings.**

☒ **The CFC benefit includes settings that have been determined home and community-based through the heightened scrutiny process.**

Provider-owned or controlled settings:

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

Individuals may receive CFC in the following residential settings:

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

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

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

Individuals may receive CFC in the following residential settings:

- Residential settings owned or leased by individuals receiving HCBS or their families (personal homes).
- Certified Foster Care Homes.
- Institutions (individuals may receive only Transition Setup services and authorization for home-delivered meals (HDMs) to be provided after moving out of the institution).

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

Individuals may receive CFC in the following nonresidential settings:

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

Setting Assurances- The state assures the following:

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

Box is not checked because CFC will be available within limits for people residing in institutions such as nursing facilities.

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

Additional state assurances:

Click or tap here to enter text.

Community First Choice Support System, Assessment and Service Plan

Support System

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

Prior to enrolling in Community First Choice, the case manager provides information about Community First Choice services and supports through the Colorado Single Assessment and Person-Centered Support Planning process. This process includes providing information to the member regarding HCBS settings requirements and any assistance needed to make an informed choice about the program. The case manager assists the member in establishing assessment and support plan scheduling and provides information about their rights and responsibilities regarding the assessment and support plan process.

Upon meeting Level of Care for Community First Choice, the Needs Assessment component of the Colorado Single Assessment is conducted, and the Person-Centered Support Plan is developed in collaboration with the individual, the individual's authorized representative, or others who are important to the individual. The support plan is a collaborative effort where the member leads the process and identifies personal goals and supports to help achieve those goals. The case manager writes the support plan in a manner that reflects the member's own words wherever possible and allows the member to see documents and computer screens.

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

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

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

Critical Incidents:
Critical incidents are those incidents that create the risk of serious harm to the health or welfare of an individual receiving services and may endanger or negatively impact the mental and/or physical well-being of an individual. Critical incident

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

Critical incidents are required to be reported by all providers. Oversight is provided by the 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 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 problems with services.

The Department and the contract Quality Improvement Organization (QIO) review and track critical incident reports to ensure that a resolution is met, and the member's health and safety have been maintained. The QIO is responsible for managing the Critical Incident Reporting system for the 1915(c) waivers and the 1915(k) benefit. The QIO assesses the appropriateness of both the provider and Case Management Agencies response to critical incidents, gathers, aggregates, and analyzes the critical incident report (CIR) data, and ensures that appropriate follow-up for each incident is completed. The QIO also supports OCL in the analysis of CIR data, understanding the root cause of identified issues, and providing recommendations for changes in the reporting system and other waiver management protocols aimed at

reducing/preventing the occurrence of future critical incidents. The QIO conducts desk reviews of case files from Case Management Agencies.

Rights Modifications:

As detailed in Table 2 (orange) in Colorado's STP, row 10, subrow on rights modification details, page 10:

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

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

Providers must ensure staff are trained on person-centeredness, person-centered practices, and dignity of risk. Compliance with this requirement was verified through the Provider Transition Plan (PTP) process and is a requirement under current rule. In addition, Case Management Agencies must ensure case managers are trained on person-centered planning.

The Department verified provider and case management agency compliance with the rights modification requirements through the PTP process. When providers initially submitted PTPs, they were required to include policies and procedures, house rules, and other evidence demonstrating that rights modifications were used, if at all, on an individualized basis and not across-the-board. As part of its initial review and verification process, the Colorado Department of Public Health & Environment (CDPHE) often identified changes needed to these policies and procedures, house rules, etc. to avoid broad-based imposition of rights modifications. CDPHE asked some providers for examples of completed informed consent forms. CDPHE sometimes identified changes needed to the providers' examples. When providers submitted their updated PTPs demonstrating remediation, they were required to submit evidence demonstrating that all rights modifications were fully compliant with the

federal criteria. This included updated policies and procedures, house rules, etc., as well as updated informed consent forms for specific individuals if required by CDPHE.

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

- HCPF issued a "MythBusters FAQ" that addressed rights modification misconceptions, among other topics.
- HCPF published videos and resource sheets for members to help them understand their rights and the rights medication process.
- HCPF issued supplemental guidance and presented a training for case managers on entering rights modification information into the BUS.
- HCPF rolled out a new Care and Case Management System (CCM). Pending development of the rights modification screen(s) in this system, case managers are able to upload a PDF file containing the information that ultimately will be entered on the screen(s) (along the lines of what they were entering in the BUS, as described above).
- HCPF made available a new, web-based "Person-Centered Thinking Training for all HCBS Provider Agencies, Transition Coordination Agencies, and Case Management Agencies."
- HCPF has begun working with an instructional designer to develop a new self-paced e-learning module for case managers, to be housed in the new case management learning management system (LMS). The training will cover the HCBS Settings Final Rule, rights protected by the rule, rights modifications, and the case manager's role within these areas. (As noted above, prior trainings have also covered these topics.)

<u>Backup Plans:</u>

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

Conflict-Free Case Management

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

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

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

1. Related by blood or marriage to the participant, or to any paid caregiver of the participant,
2. Financially responsible for the participant,
3. Empowered to make financial or health -related decisions on behalf of the participant,
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
3. How the Case Management Agency continues to support the recruitment of willing and qualified providers in their catchment area.

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

Assessment of Need

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

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

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

Case Management Agencies may use phone or telehealth to complete the Level of Care Screen when there is a documented safety risk to the case manager or member including public health emergencies as determined by state and federal government. To facilitate person-centered practices, Case Management Agencies may use phone or telehealth to engage in the development and monitoring of Person-Centered Support Plan based on the member's preference of engagement. The member must be seen at the time of the initial evaluation and reevaluation to ensure that the member is in the home. 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 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 state will claim costs associated with CFC assessment activities as: ☐ A Medicaid Service

☒ An Administrative Activity

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

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

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

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

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

☒Case Manager (specify qualifications)

The minimum qualifications for HCBS case managers who conduct the Person-Centered Support Plan are:

A bachelor's degree; or

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

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

Click or tap here to enter text.

The reassessment process is conducted every:

☒**12 months**

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

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

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

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

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

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

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Person-Centered Service Plan

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

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

☐ **A Medicaid Service**

☒ **An Administrative Activity**

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

☒ **Case Manager. Specify qualifications:**

The minimum qualifications for HCBS case managers who conduct the Person-Centered Support Plan are:

A bachelor's degree; or

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

☐ **Social Worker. Specify qualifications:**

Click or tap here to enter text.

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

practice under state law.

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

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

DRAFT

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

convenient for the member, with the member, and others chosen by the member. The Person-Centered Support Plan must have a listing of the plan meeting participants and their relationship to the member. Members and legal representatives are informed they have the authority to select and invite individuals of their choice in the Person-Centered Support Planning process.

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

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

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

Case managers are required to develop the service plan at times and locations chosen by the member. Case managers are expected to reflect the cultural considerations of the individual and provide information in plain language and in a manner that is accessible to individuals with disabilities and individuals who have limited English proficiency.

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

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

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

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

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

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

Case managers are responsible for the Person-Centered Support Plan development and monitoring. The case managers shall ensure that individuals obtain authorized services in accordance with their Person-Centered Support Plan and monitor the quality of the services and supports. The case manager shall make necessary adjustments to the plan as needed to meet member's goals, needs, and preferences. Case managers are required to conduct an in-person contact and observation with the member in their place of residence at least once per certification period. Case managers are also required to contact the member when significant changes occur in the member's physical or mental condition. Case Management Agencies may use phone or telehealth to engage in the development and monitoring of Person-Centered Support Plan when there is a documented safety risk to the case manager or member, including public health emergencies as determined by state and federal government. The case manager shall assure the health and welfare of the individual, and individual safety, satisfaction, and quality of life by monitoring service providers to ensure the appropriateness, timeliness, and number of services provided.

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

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

☐ **3 months**

☒ **6 months**

☐ **12 months**

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

AND

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

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

The case manager reviews the Level of Care Screen, Needs Assessment, and Person-Centered Support Plan with the member annually at the time of their Continued Stay Review (CSR). The review can be conducted over the telephone, at the member's place of residence, service, or other appropriate setting as determined by the member's needs and preferences. The member may request updates to the plan as needed at time of CSR (or earlier if needed). The case manager shall continually identify the member's strengths, needs and preferences for services and supports as they change or as indicated by the occurrence of critical incidents. If a new assessment is warranted, the case manager follows the same procedure for the Level of Care Screen, Needs Assessment, and Person-Centered Support Plan as during the initial review.

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Community First Choice Service Delivery Systems

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

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

☐ **Managed Care Organization**

☐ **Other Describe:**

Click or tap here to enter text.

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Quality Assurance System

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

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

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

Colorado selects a random sample (unless otherwise noted in the application) of participants for annual review, with a confidence level of 95% +/- 5% margin of error from the respective population. The results obtained reflect the performance of the multi-layered system, ensuring systemic responsiveness for the waiver and CFC programs and to the needs of all individuals served. The Department trends, prioritizes and implements system improvements (i.e., system design changes) warranted from the analysis of the discovery and remediation information gathered.

The Department uses standardized tools for Level of Care eligibility determinations, Person-Centered Support Planning, and critical incident reporting for the CFC population. Through use of the state's case management system, the data generated from Level of Care eligibility determinations, Person-Centered Support Plans, and critical incident reports and their concomitant follow-up are electronically available to Case Management Agency and the Department allowing effective access and use for clinical and administrative functions as well as for system improvement activities. This standardization and electronic availability provide comparability across Case Management Agencies and facilitates ongoing analysis. The Department implemented a new case management system in July 2023 which streamlines processes for identifying member needs and coordinating support. This new

system eliminates the need for case managers to complete documentation in multiple systems which effectively reduces the chance for errors and/or missing information.

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

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

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

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

Prioritization:
The Department relies on a variety of resources to prioritize changes in the State's case management IT system. In addition to using information from annual reviews, analysis of performance measure data, and feedback from case managers, the Department factors in appropriation of funds, legislation, and federal mandates. For changes to the interChange,

the Department has developed a Priority and Change Board that convenes monthly to review and prioritize system modifications and enhancements. Change requests are presented to the Board, which discusses the merits and risks of each proposal, then ranks it according to several factors including implementation dates, level of effort, required resources, code contention, contracting requirements, and risk. Change requests are tabled, sent to the fiscal agent for an order of magnitude, or cancelled. If an order of magnitude is requested, it is reviewed at the next scheduled Board meeting. If selected for continuance, the Board decides where in the priority list the project is ranked.

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

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

Describe the methods the state will use to continuously monitor the health and welfare of each individual who receives home and community-based attendant services and supports, including a process for the mandatory reporting, investigation, and resolution of allegations of neglect, abuse, or exploitation in connection with the provision of such services and supports:

Critical incidents are those incidents that create the risk of serious harm to the health or welfare of an individual receiving services and may endanger or negatively impact the mental and/or physical well-being of an individual. Critical incident categories that must be reported include but are not limited to: Injury/illness; mistreatment/abuse/neglect/exploitation; damage/theft of property; medication mismanagement; lost or missing person; criminal activity; unsafe housing/displacement; or death.

Critical incidents are required to be reported by all providers. Oversight is provided by the 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 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 problems with services.

The Department and the contract Quality Improvement Organization (QIO) review and track critical incident reports to ensure that a resolution is met, and the member's health and safety have been maintained. The QIO is responsible for managing the Critical Incident Reporting system for the 1915(c) waivers and 1915(k) benefit. The QIO assesses the appropriateness of both the provider and Case Management Agencies response to critical incidents, gathers, aggregates, and analyzes the critical incident report (CIR) data, and ensures that appropriate follow-up for each incident is completed. The QIO also supports OCL in the analysis of CIR data, understanding the root cause of identified issues, and providing recommendations for changes in the reporting system and other waiver management protocols aimed at reducing/preventing the occurrence of future critical incidents. The QIO conducts desk reviews of case files from Case Management Agencies.

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

must be reported to CMS upon request.)
Case managers are required to conduct quarterly monitoring with participants. The monitoring includes verifying that services are furnished in accordance with the service plan. The case management system for Prior Authorization (PAR) development and submission allows case managers to see the unit decrement on the PAR. Additionally, case managers verify with individuals and provider agencies to ensure services are delivered in accordance with the Person-Centered Support Plan. The quarterly monitoring requires that case managers monitor the access to services, if services are meeting the individual's needs, the use of the contingency plan, health and safety, including follow-up to any critical incident reports, and use of non-waiver services.

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

Training:

Members are first informed that they have a choice of how they receive services, either through an agency-based model or through a participant-directed model. If a member chooses a participant directed model, members and/or authorized representatives will access supportive training based on the philosophy and responsibilities of participant-directed care. At a minimum, this training includes: members or their authorized representative is informed of the ability to choose provider, an overview of the program, member and/or authorized representative rights and responsibilities, planning and organizing attendant services, managing personnel issues, communication skills, recognizing and recruiting quality attendant support, managing health, accessing resources, safety and prevention strategies, and managing emergencies. If the member utilizes the self-direction with service budget model, they will also be trained on allocation budgeting and working with the Financial Management Services vendor.

Denials and Reconsiderations Procedures:

Members who have a dispute regarding their assessed service needs have the ability to initiate an appeal before an Administrative Law Judge. The Case Management Agency shall provide the member with a Long-Term Care Waiver Program Notice of Action (LTC 803) to inform the member of their appeal rights in accordance with the Code of Colorado Regulation 10 CCR 2505- 10, section 8.057.

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

performs a reassessment.

Describe the methods used to monitor provider qualifications:

Some service types require licensing or certification. Providers interested in providing these services to Colorado Medicaid members must obtain certification from the Department. Licensing and certification are obtained by a provider after undergoing a survey by the Colorado Department of Public Health and Environment (CDPHE). CDPHE will recommend a provider for Medicaid certification after the provider has successfully completed a survey. The Department will review the recommendation by CDPHE and either certify the provider or ask that the provider improve the conformance to rules and/or regulations before certifying the provider. Service types that do not require licensure are not required to complete a CDPHE survey and obtain certification directly from the Department. All provider qualifications, including those types not requiring CDPHE license or recommendation, are verified by the fiscal agent upon initial enrollment and in a revalidation cycle; at least every five years. Data reports verifying non-surveyed providers continually meet CFC requirements are maintained by the Department's provider enrollment compliance staff.

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

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

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

be grounds for CDPHE to initiate a full recertification survey of the provider agency regardless of the date of the last survey.

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

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

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

Each 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. 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.

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

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. The review may be conducted over the telephone, at the member's place of residence, or other appropriate settings as determined by the member's needs and preferences. The case manager reviews the Level of Care Screen, Needs Assessment, and Person-Centered Support Plan with the member during the required monitoring contact. This review 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.

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 HCBS services or institutional care, including service delivery options, and of qualified providers.

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

As detailed in the gray table (pages 29-31) in Colorado's STP, the ongoing monitoring process includes the following initiatives:

- Including HCBS Settings Final Rule-related performance measures regarding rights modifications within the current 1915(c) waiver quality improvement system (QIS).
- Developing process(es) for case managers to confirm with individuals that the settings at which they receive services are compliant.
- Ensuring that after the transition period, settings are monitored by state agencies for compliance with HCBS Settings Final Rule criteria.
- Identifying and publicizing process(es) for waiver participants, case managers, and others to report potential violations of HCBS Settings Final Rule criteria. After the STP was finalized, the Department added a dedicated "Ask a Question/Report a

Concern" section to its HCBS Settings Final Rule website and explained how individuals can report concerns as part of new videos and resource sheets for waiver participants on their rights and the rights modification process.

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

ii. Frequency of monitoring efforts

- Performance measures are assessed annually.

- Case managers assess the adequacy of information supporting a proposed rights modification when they discuss the proposal with the individual and enter that information into the BUS/CCM. This happens for all new rights modifications as they are implemented and for all continuing modifications as they come up for review/renewal (at least every 12 months). An additional tool to support case managers in identifying broader compliance issues at HCBS settings (beyond just rights modification concerns) has been developed and is being finalized. Case managers will be asked to use this tool during quarterly case management monitoring contacts.

- State agency monitoring: CDPHE cross-trained its survey staff on HCBS Settings Final Rule criteria so that they could address these criteria as part of new provider enrollment as well as routine quality assurance surveys. Regarding such surveys:

    - Under an Interagency Agreement (IA) between the Department and CDPHE, CDPHE surveys prospective HCBS providers before it recommends them to HCPF for certification as Medicaid waiver providers. As relevant to CFC, provider types subject to certification include adult day programs, program approved service agencies (PASAs) serving the waivers for individuals with IDD (providing services such as day habilitation), and home care agencies (HCAs) (providing personal care, homemaker, etc.). These initial certification surveys address compliance with the HCBS Settings Final Rule. (For Medicaid-certified settings. Settings such as Adult Day Service centers that operate exclusively on a private-pay basis are not covered by this process.)

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

    - Similarly, under an IA between the Department and CDHS, CDHS surveys prospective CHRP residential habilitation providers, and annually resurveys current providers, to confirm their compliance with the applicable regulations. CDHS's regulations for CHRP providers cross-reference HCPF's, which in turn

now include the HCBS Settings Final Rule. (If included in the first bullet point above, certain providers may instead be surveyed by CDPHE.)

- Stakeholder reporting of potential violations occurs on an as-needed basis.
- Member experience surveys occur at different times, depending on the survey. The Individual/Family/Advocate (IFA) Survey, which is specific to the HCBS Settings Final Rule, currently remains open and may be completed as often as desired.

iii. Summary of findings

- Performance measures are collected and shared with case management agencies through annual quality improvement strategies. Any identified performance measures falling below 86% compliance are reported to CMS through annual 372 reporting.
- The Department identified certain concerns regarding case managers' entry of information relating to rights modifications into the BUS. The Department addressed these concerns in an Operational Memo and Technical Assistance session (webinar recording; slide deck). The additional tool mentioned above is not yet in use but is expected to help ensure that even settings excluded from the CDPHE/CDHS IA survey processes still experience ongoing monitoring and oversight.
- To our knowledge, all deficiencies identified in provider surveys are corrected upon being identified.
- We occasionally hear from advocates, case management agencies, and/or providers with questions or concerns that are addressed when raised.
- Reporting on member experience surveys depends on the survey. Reports on and analysis of IFA Survey responses were previously available on the Department's website, and are available upon request. Updated reporting on that particular survey was disrupted by the pandemic, and the survey currently has little in the way of 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.

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

Stakeholder Feedback

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

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

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

Identify the stakeholders from whom the state will elicit feedback:

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

☐ **Other Describe:**

Click or tap here to enter text.

State Assurances

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

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

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

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

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

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