COLORADO
Department of Health Care Policy & Financing

1570 Grant Street
Denver, CO 80203

Waiver Actions Listening Log
Home and Community-Based Services (HCBS) Waiver Amendments and Renewal
February 2 – March 3, 2023

HCBS Waiver Amendments: Brain Injury (BI), Children's Extensive Support (CES), Children's Habilitation Residential Program (CHRP), Children with Life Limiting Illness (CLLI), Complementary and Integrative Health (CIH), Community Mental Health Supports (CMHS), Developmental Disability (DD), Elderly, Blind, and Disabled (EBD), and Supported Living Services (SLS)

HCBS Waiver Renewal: Children's Home and Community Based Services (CHCBS)

Comment Number	Date Received	Time Received	Individual/Organization Name	Waiver	Comment Synopsis	Department Response
1	**2/8/2023**	**9:34 a.m.**	**Mike Jordan**	**BI**	Inquired if the Day Program is available to members on the Brain Injury (BI) waiver. Wanted to know if Day Programs that service the IDD population or others could eventually enroll BI members as well. Inquired if BI members would be eligible for Host Homes like the ones providing services in the IDD waiver.	Day Habilitation services are only available to members on the Developmental Disabilities (DD) and Supportive Living Services (SLS) waivers, while Adult Day Services (ADS) are available to members on the Brain Injury (BI), Community Mental Health Supports (CMHS), Elderly, Blind and Disabled (EBD), and the Complementary and Integrated Health (CIH) waivers. While these are 2 separate day program services, with different service requirements, there are some providers who provide both Day Habilitation and Adult Day Services out of the same setting location. Although these day program services do differ in a number of ways, there are also many similarities. However, a member must be on the specific waiver, under which the service is billable, in order to receive that specific service. At this time, individualized or 1:1 Adult Day Services are not available under the BI waiver. However, looking into implementing a similar 1:1 service, as is being done with Day Habilitation services, is a great suggestion. The Department appreciates this feedback and will consider this suggestion. Thank you for this suggestion. We understand that it has been a successful model for the DD waiver and the Department can research whether or not this would be a viable option for the BI waiver in the future.
2	**2/10/2023**	**5:55 p.m.**	**Lisa Brenneman**	**DD**	Supports the option for members to receive Day Habilitation – Supported Community Connections 1:1 Requested that CNA services through LTHH benefit be allowed for members on the DD waiver.	Thank you for your response. Within the residential benefit on the DD waiver, CNA level of care is included in the rate methodology. If a member were to receive CNA services through the LTHH benefit, it would be duplicative. If a member requires RN level of care, they would be able to use Private Duty Nursing services in combination with the residential service. Please work with your provider agency to ensure the members' needs are being met, including their CNA level of care nursing services.

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3	**3/2/2023**	**4:11 p.m.**	**Ian Engle Executive Director NorthWest Colorado Center for Independence**	**DD, SLS**	Supports the Department's amendment to the Federal 1915(c) Waiver for Benefits Planning Assistance. Requested further clarification regarding reimbursement for Telehealth services and Benefits Planning services provided in an out-of-state setting. Advised that license requirements for Benefits Planning Agencies should not be required. Also requested clarification regarding the standards a Certified Medicaid provider under 10 C.C.R. 2505-10 Section 8.500.9, the revalidation cycle for Benefits Planning Agencies, and the license requirements for PASAs v. CIL-type agencies. Regarding the Verification of Provider Qualifications Frequency of Verification questioned if the Benefits Providers should have a survey cycle.	The Department thanks you for your support and looks forward to partnering with you in the future. Based on previous stakeholder feedback, the Department believes that Benefits Planning can be delivered successfully via Telehealth and that people within rural areas of the State will directly benefit from this service having a virtual option. In order for Telehealth to be approved in this benefit, the Centers for Medicare and Medicaid Services (CMS) requires specific language to be included. With respect to services provided in an out-of-state setting, the Department will be removing this language as after reviewing it was determined this setting will not be allowed for this service. The Department appreciates your keen review of provider licensure and certification requirements regarding this new provider type. Through further engagement and research, the Department determined that this level of licensure is not required for Benefits Planning and we will be modifying the provider requirements accordingly. For The certification requirements the standards cited are the same certification requirements for other services that do not require a provider to be a Program Approved Service Agency (PASA), such as Transition Set-up and Life Skills Training. Since the Department does not intend to require a provider be a PASA in order to provide Benefits Planning, the same standards were mirrored for consistency. The Department is not able to address whether individual providers meet qualifications through this Waiver Amendment Public Comment forum. The expectation regarding initial Medicaid enrollment and revalidation cycle is consistent across other Waiver services and is a requirement of the Centers for Medicare and Medicaid Services (CMS). This process for verification will not change, however, the Department reconsidered whether surveys by the Colorado Department of Public Health and Environment (CDPHE) were realistic. The outcome of this reconsideration is to rely on the verification process to ensure that Benefits Planning providers possess required certification and not to have a formal survey process for any of the Benefits Planning provider types. The Department will be exploring options to address credible complaints and other quality assurance measures as necessary.
4	**3/2/2023**	**10:32 p.m.**	**Laura Edwards**	**CES**	Requested the allowance for parents to continue perform Community Connector services after the end of the Public Health Emergency (PHE), and they also allow parents to perform Homemaker services. It is difficult to staff Community Connector or Enhanced Homemaker services.	While the Department certainly empathizes with the struggle to find service providers, unfortunately allowing legally responsible persons, which for children means parents or legal guardians, to provide Community Connector and Homemaker services outside of the Public Health Emergency (PHE) is federally prohibited.

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						Parents and Program Approves Services Agencies (PASAs) will have six (6) months to discontinue the delivery of these services by parents after the end of the PHE on May 11, 2023. At which time Community Connector and Homemaker services will need to transition to a direct care provider other than a Legally Responsible Person. This transition will officially be announced via an Operational Memo posted on the Department's 2023 Memo Series Communication webpage. During the transition period, the Department will work closely with case managers and families to ensure that these services get moved to another direct care provider.
5	**3/2/2023**	**10:38 p.m.**	**Robert Edwards**	**CES**	Requested the allowance for parents to continue perform Community Connector services after the end of the Public Health Emergency (PHE), and they also allow parents to perform Homemaker services. It is difficult to staff Community Connector or Enhanced Homemaker services.	While the Department certainly empathizes with the struggle to find service providers, unfortunately allowing legally responsible persons, which for children means parents or legal guardians, to provide Community Connector and Homemaker services outside of the Public Health Emergency (PHE) is federally prohibited. Parents and Program Approves Services Agencies (PASAs) will have six (6) months to discontinue the delivery of these services by parents after the end of the PHE on May 11, 2023. At which time Community Connector and Homemaker services will need to transition to a direct care provider other than a Legally Responsible Person. This transition will officially be announced via an Operational Memo posted on the Department's 2023 Memo Series Communication webpage. During the transition period, the Department will work closely with case managers and families to ensure that these services get moved to another direct care provider.
6	**3/2/2023**	**10:39 p.m.**	**Maria Stepanyan Executive Director Center for People with Disabilities**	**DD, SLS**	The draft rules state that “A member who does not currently have an open case with the Division of Vocational Rehabilitation (DVR) does not have to submit an application to DVR before accessing the Benefits Planning service” – this is wise and thoughtful! Thank you. Regarding the Telehealth attestation for the HIPAA compliant platform in the Benefits Planning Service, what is the process of getting provider requirements and assurances regarding HIPAA approved by State’s HIPAA Compliance Officer and how do we demonstrate this approval? Please clarify what is meant by “Benefits Planning Agencies”. Does this mean any type of agency or organization that provides Benefits Planning service?	The Department thanks you for your support and looks forward to partnering with you in the future. The Department has requirements in place regarding Telehealth that have been approved by the Centers for Medicare and Medicaid Services (CMS). The Department utilizes an attestation form that has been approved by the State’s HIPAA Compliance Officer. Use of the form is sufficient to demonstrate compliance with the quoted section. Thank you for sharing this feedback. The Department will remove the word “Agencies” at the end of the designation to avoid confusion. The Department truly appreciates your keen review of provider licensure requirements regarding this new provider type. The licensure requirements were patterned after another Waiver service that was thought to be parallel. Through further engagement and research, the Department determined that licensure is not required for Benefits Planning and we will be modifying the provider requirements accordingly.

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					We would like to recommend calling it a Benefits Planning Provider, or define what is meant by Benefits Planning Agency. What is different about Benefits Planning Agency that would require licensure? We would like to recommend removing licensure requirements for Benefits Planning Providers that offer this service and are not licensed agencies. Regarding the Frequency of Verification for "Agency-Benefits Planning Agencies": Current Benefits Planning providers like Centers for Independent Living, are not surveyed by CDPHE for other Medicaid Waiver services that we deliver. We do not have survey cycles and this frequency of verification would not be applicable or practical for this type of agency. Centers for Independent Living do participate in the revalidation process. Considering that the frequency of verification for PASAs or Individual Provider types is "*upon initial enrollment and in a revalidation cycle; at least every 5 years*", we suspect there is an error in the draft and recommend to review its accuracy.	The Department is grateful for your keen review of provider verification and survey practices regarding this new provider type. The expectation regarding initial Medicaid enrollment and revalidation cycle is consistent across other Waiver services and is a requirement of the Centers for Medicare and Medicaid Services (CMS). This process for verification will not change, however, the Department reconsidered whether surveys by the Colorado Department of Public Health and Environment (CDPHE) were realistic. The outcome of this reconsideration is to rely on the verification process to ensure that Benefits Planning providers possess required certification and not to have a formal survey process for any of the Benefits Planning provider types. The Department will be exploring options to address credible complaints and other quality assurance measures as necessary.
7	**3/3/2023**	**8:06 a.m.**	**Dennis Roy Director Program Quality Developmental Pathways**	**All**	Supports the addition of Mental Health Transitional Living Homes service to the CMHS waiver and looks forward to partnering with the Department to ensure provider adequacy. Supports the changes to Supported Employment and the addition of Workplace Assistance for the DD and SLS waivers. Supports the addition of Benefits Planning Services for the DD and SLS waivers and looks forward to partnering with the Department to support implementation. Supports the Day Habilitation Service Update to DD and SLS Waivers and proposes reviewing the language referencing the modality of service delivery. Supports the flexibility allowing spouses to provide personal care in the EBD, CMHS, CIH, and BI waivers	The Department appreciates your feedback and support of the new Mental Health Transitional Living Home benefit. Thank you for your comment, we appreciate having the Case Management Agency (CMA) perspective on new and existing services. The Department will work with CMAs to identify any additional training needs related to these benefits. The Department appreciates your support of this new service. The Department looks forward to partnering with a variety of entities in order to build provider capacity. The Department also specifically appreciates the comment regarding the need for this benefit to be accessible by diverse populations and will continue to evaluate ways in which its Equity, Diversity, Inclusion, and Accessibility framework can be leveraged. The Department appreciates your feedback and support for implementing Tier 3 Supported Community Connections services into the waivers. The Department will be updating the terms used in Appendix C for the DD and SLS waivers to only reference "Tier 3 services" and "Tier 3 Supported

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					but has identified language inconsistency within the amendments. Regarding Non-Substantive Performance Measure Language Corrections, requested clarification regarding how often QIS data should be received by CMAs and if CMAs should receive real time feedback for performance measures.	Community Connections rate" to avoid confusion with "1:1 services" and "individualized rate." The Department appreciates the suggestion for changing the term "individual annual dollar limit," however "individual annual dollar limit" is the term that best describes the service limitation and has consistently been utilized since the implementation of Tier 3 services. Developmental Pathways is encouraged to reach out to the Department for more information on how the individualized rate is determined and the approval process. The Department appreciates your review and feedback and support of allowing a member's spouse to provide personal care. The Department will be updating the Personal Care service definition in Appendix C for EBD and BI to remove the reference that payment will not be made for personal care services provided by a spouse. In Appendix C-2.d Provision of Personal Care or Similar Services by Legally Responsible Individuals of the CMHS waiver the Department will be removing the following sentence: "A client's spouse employed by a Personal Care Agency may not be reimbursed to provide personal care to his/her spouse." The Department is currently updating the waiver application to allow for more flexibility when completing quality oversight and reporting. The Department is still determining whether any changes will be made to Quality Improvement Strategies data shared with case management agencies.