STATE OF COLORADO CONTRACT MODIFICATION

CONTRACT AMENDMENT #4

State Agency
Department of Health Care Policy and Financing
Contractor
The Resource Exchange, Inc.
Original Contract Number
C24-186982
Amendment Contract Number
C24-186982A4

Contract Performance Beginning Date
April 1, 2025
Current Contract Expiration Date
June 30, 2025
Current Contract Maximum Amount
Medicaid Programs
No Maximum for any SFY

State General Fund Programs
State Fiscal Year 2024-25 $21,693,981.00
Estimated Contractor Shared $2,227,455.00

THE PARTIES HERETO HAVE EXECUTED THIS AMENDMENT

Each person signing this Amendment represents and warrants that he or she is duly authorized to execute this Amendment and to bind the Party authorizing his or her signature.

CONTRACTOR
The Resource Exchange, Inc.
Colleen Batchelor, CEO

DocuSigned by:
Colleen Batchelor
B22CCE3FDC224DB...

By: Colleen Batchelor, CEO

Date: 02/11/2025 | 11:45 PST

STATE OF COLORADO
Jared S. Polis, Governor
Department of Health Care Policy and Financing
Kim Bimestefer, Executive Director

DocuSigned by:
0B6A84797EA8493...

Date: 02/11/2025 | 12:46 MST

STATE CONTROLLER
Robert Jaros, CPA, MBA, JD
Department of Health Care Policy and Financing
Jerrod Cotosman, Controller

DocuSigned by:
Jerrod Cotosman
76F69541272B43A...

Amendment Effective Date: 02/11/2025 | 13:04 MST

In accordance with §24-30-202, C.R.S., this Amendment is not valid until signed and dated above by the State Controller or an authorized delegate.

1. PARTIES

This Amendment (the "Amendment") to the Original Contract shown on the Signature and Cover Page for this Amendment (the "Contract") is entered into by and between the Contractor and the State.

2. TERMINOLOGY

Except as specifically modified by this Amendment, all terms used in this Amendment that are defined in the Contract shall be construed and interpreted in accordance with the Contract

3. AMENDMENT EFFECTIVE DATE AND TERM

A. Amendment Effective Date

This Amendment shall not be valid or enforceable until the Amendment Effective Date shown on the Signature and Cover Page for this Amendment. The State shall not be bound by any provision of this Amendment before that Amendment Effective Date, and shall have no obligation to pay Contractor for any Work performed or expense incurred under this Amendment either before or after of the Amendment term shown in §3.B of this Amendment.

A. Amendment Term

The Parties' respective performances under this Amendment and the changes to the Contract contained herein shall commence on the Amendment Effective Date shown on the Signature and Cover Page for this Amendment.

4. PURPOSE

This Amendment updates the General Contract Provisions and Exhibit B Statement of Work.

5. MODIFICATIONS

The Contract and all prior amendments thereto, if any, are modified as follows:

A. The Contract Initial Contract Expiration Date on the Contract's Signature and Cover Page is hereby deleted and replaced with the Current Contract Expiration Date shown on the Signature and Cover Page for this Amendment.

B. The Contract Maximum Amount table on the Contract's Signature and Cover Page is hereby deleted and replaced with the Current Contract Maximum Amount table shown on the Signature and Cover Page for this Amendment.

C. The Contract Provisions is hereby updated as follows.

D. Exhibit B is hereby deleted in its entirety and replaced with Exhibit B-3 as follows. All references to Exhibit B shall now refer to Exhibit B-3.

E. Exhibit C is hereby deleted in its entirety and replaced with Exhibit C-3 as follows. All references to Exhibit C shall now refer to Exhibit C-3.

F. Exhibit D is hereby deleted in its entirety and replaced with Exhibit D-3 as follows. All references to Exhibit D shall now refer to Exhibit D-3.

6. LIMITS OF EFFECT AND ORDER OF PRECEDENCE

This Amendment is incorporated by reference into the Contract, and the Contract and all prior amendments or other modifications to the Contract, if any, remain in full force and effect except as specifically modified in this Amendment. Except for the Special Provisions contained in the Contract, in the event of any conflict, inconsistency, variance, or contradiction between the provisions of this Amendment and any of the provisions of the Contract or any prior modification to the Contract, the provisions of this Amendment shall in all respects supersede, govern, and control. The provisions of this Amendment shall only supersede, govern, and control over the Special Provisions contained in the Contract to the extent that this Amendment specifically modifies those Special Provisions.

EXHIBIT B-3, STATEMENT OF WORK

1. CASE MANAGEMENT OBLIGATIONS

1.1. Contractor's Obligations

1.1.1. Contractor shall provide case management activities outlined in this Contract for the following Home and Community Based Services (HCBS) waivers, Community First Choice (CFC), non-HCBS programs, and State General Fund programs:

1.1.1.1. CFC

1.1.1.2. Family Support Services Program (FSSP)

1.1.1.3. HCBS Children with a Life Limiting Illness Waiver (HCBS-CLLI)/HCBS Children with Complex Health Needs (CwCHN)

1.1.1.4. HCBS Children's Extensive Supports Waiver (HCBS-CES)

1.1.1.5. HCBS Children's Habilitation Residential Program Waiver (HCBS-CHRP)

1.1.1.6. HCBS Children's Home and Community Based Services Waiver (CHCBS)

1.1.1.7. HCBS Community Mental Health Supports Waiver (HCBS-CMHS)

1.1.1.8. HCBS Complimentary and Integrative Health Waiver (HCBS-CIH)

1.1.1.9. HCBS Developmental Disabilities Waiver (HCBS-DD)

1.1.1.10. HCBS Persons who are Elderly, Blind and Disabled Waiver (HCBS-EBD)

1.1.1.11. HCBS Persons with Brain Injury Waiver (HCBS-BI)

1.1.1.12. HCBS Supported Living Services Waiver (HCBS-SLS)

1.1.1.13. Hospital Back-Up Program (HBU)

1.1.1.14. Intermediate Care Facilities-Intellectual and Developmental Disabilities (ICF-IDD)

1.1.1.15. Long Term Home Health (LTHH)

1.1.1.16. Nursing Facilities (NF)

1.1.1.17. Omnibus Reconciliation Act of 1987 Specialized Services Program (OBRA-SS)

1.1.1.18. Program for All-Inclusive Care for the Elderly (PACE)

1.1.1.19. State Supported Living Services Program (State SLS)

1.1.2. Contractor shall abide by and perform its duties and obligations in conformity with relevant federal law, all pertinent federal regulations, State law, rules and regulations of the Department of Health Care Policy and Financing which include, but are not limited to:

1.1.2.1. Colorado Revised Statutes, Title 25.5, Article 6, Sections 104 through and including 107.

1.1.2.2. Colorado Revised Statute, Title 25.5, Article 10 et seq.

1.1.2.3. Colorado Department of Health Care Policy and Financing written communications.

1.1.2.4. Colorado Department of Public Health and Environment at 6 C.C.R. 1011-1 et seq.

1.1.2.5. Colorado Department of Human Services 12 C.C.R. 2509-8 7.700 et seq.

1.1.2.6. All State Medicaid regulations promulgated by the Department. These regulations include, but are not limited to:

1.1.2.6.1. CHCBS 10 CCR 2505-10, Sections 8.7101.A et seq.

1.1.2.6.2. FSSP 10 CCR 2505-10, Sections 8.7558 et seq.

1.1.2.6.3. Long-Term Care 10 CCR 2505-10, Sections 8.400 through 8.409 et seq.

1.1.2.6.4. Colorado Case Management System - 10 CCR 2505-10, Section 8.7200 et seq.

1.1.2.6.5. HCBS-BI – 10 CCR 2505-10, Section 8.7101.E et seq.

1.1.2.6.6. HCBS-CES, 10 C.C.R. 2505-10 Section 8.7101.B et seq.

1.1.2.6.7. HCBS-CHRP, 10 C.C.R. 2505-10 Section 8.7101.C et seq.

1.1.2.6.8. HCBS-CIH 10 CCR 2505-10, Section 8.7101.H et seq.

1.1.2.6.9. HCBS-CLLI 10 CCR 2505-10, Section 8.7101.D et seq.

1.1.2.6.10. HCBS-CMHS 10 CCR 2505-10, Section 8.7101.F et seq.

1.1.2.6.11. HCBS-DD, 10 C.C.R. 2505-10 Sections 8.7101.J et seq.

1.1.2.6.12. HCBS-EBD 10 CCR 2505-10, Sections 8.7101.G et seq.

1.1.2.6.13. HCBS-SLS, 10 C.C.R. 2505-10 Sections 8.7101.I et seq.

1.1.2.6.14. PACE Section 25.5-5-412, Section 6a-b., C.R.S et seq.

1.1.2.6.15. Case Management, Family Support, Laboratory and X-Ray, 10 CCR 2505-10 Section 8.600 through 8.612.5

1.1.2.6.16. State SLS Program, 10 CCR 2505-10, Section 8.7557 et seq.

1.1.2.6.17. Recipient Appeals, 10 CCR 2505-10, Section 8.057 et seq.

1.1.2.6.18. Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (Uniform Guidance), 2 CFR Chapter I, Chapter II, Part 200 et al.

1.1.2.6.19. Wellness Education Benefit, 10 CCR 2505-10, Section 8.7556 et seq.

1.1.3. Contractor shall perform its obligations in conformity with the provisions of Title XIX of the Social Security Act and other applicable federal and state laws and regulations.

1.1.4. Contractor shall ensure applicant, Member, and individual rights are protected in accordance with Title XIX of the Social Security Act, other applicable federal and state laws, and Department regulations.

1.1.5. Contractor shall comply with written Operational Memos, policies, procedures, and guidance issued by the Department.

1.1.6. The general Business Functions of Contractor shall include, but is not limited to, all the following:

1.1.6.1. Contractor shall maintain a physical, publicly accessible, and Americans with Disability Act (ADA) compliant office within the Defined Service Area and appropriate staffing pattern to serve the Defined Service Area.

1.1.6.1.1. Contractor shall ensure adequate staffing through virtual or in-person services throughout the Defined Service Area in addition to a physical office space, providing

access to its office for staff, Members, families, services providers, and others to best meet the needs of individuals based on individual preferences.

1.1.6.1.2. Contractor shall have the ability for case managers to travel, regional coverage, and provide all required Work for the counties in which the agency operates.

1.1.6.1.3. Regular business office hours of operation shall follow a Monday through Friday schedule except for federal, state, or local holidays and unplanned closures due to inclement weather or other emergencies. Regular business office hours and holiday closures must be provided to all Members upon enrollment and at least annually, posted publicly at each office location, and posted on Contractor's website. Contractor shall have a procedure for notifying Members and the public of unplanned closures or changes to regular business hours due to inclement weather or other emergencies, which includes emergency contact information

1.1.6.1.4. Contractor shall have internal procedures for accommodating individuals, Members, and families who need assistance or consultation outside regular business office hours. Non-standard business hours and method of contact information for crisis situations must be posted on Contractor's website in an easily accessible location.

1.1.6.2. Contractor shall have an emergency on-call procedure to respond to crisis situations outside of regular business hours. Procedures must clearly document how Contractor will ensure timely response to emergency situations such as hospital discharges, risk of homelessness, unexpected termination of residential services, etc. Contractor shall make the procedure available on Contractor's website. Contractor shall notify individuals, Members, families, providers, and community partners of the procedures and make it readily available through a variety of methods. Contractor shall have an internal policy and procedure to respond to all telephone calls, voicemails, and emails from Members and families on average within two Business Days of receipt by Contractor.

1.1.6.3. Contractor shall overcome any geographic barriers within the Defined Service Area, including distance from the agency office to provide timely assessment and case management services to individuals, Members and families, as required by Contract, Federal or State statutes and regulations. This may include staff who reside throughout the Defined Service Area to best meet the needs of individuals and members.

1.1.6.4. Contractor shall protect Members' rights as they relate to the responsibilities of Case Management Agencies as described in this Contract.

1.1.6.5. Contractor shall provide access to a telephone system and trained staff to ensure timely response to messages and telephone calls received after hours.

1.1.6.6. Contractor shall provide access to telecommunication devices and/or interpreters for the hearing and vocally impaired and foreign language interpreters as needed to fulfil all Work. Contractor shall conduct an assessment of the communication needs of the Members they serve and ensure their interpretation and telecommunication services sufficiently meet the Member's need in a timely fashion.

1.1.6.7. Contractor shall follow communication standards set by the Department which includes, but is not limited to, Memo Series, technical assistance documents, Provider Bulletins, training documents, and email correspondence.

1.1.6.8. Contractor shall support the Department's National Core Indicators (NCI) efforts.

1.1.6.9. Contractor shall support the Department's Equity, Diversity, Inclusion, and Accessibility (EDIA) efforts to include participation in a Department led EDIA assessment and survey. Contractor shall have a written policy and procedure on the agency's commitment to equity, diversity, inclusion, and accessibility that includes approaches to confronting racism and building opportunity for inclusion that promotes equitable treatment of historically underserved and marginalized communities. Contractor shall make the policy and procedure available to the Department upon request.

1.1.6.10. Contractor shall enroll and act as a Medicaid Targeted Case Management (TCM) provider for all HCBS waivers to include, but not limited to, providing ongoing case management and monitoring activities for the Defined Service Area.

1.1.6.11. Contractor may be granted a Conflict Free Case Management Waiver (CFCMW) by the Department to provide specific HCBS services within the Defined Service Area when one is necessary to maintain services in rural and frontier service areas.

1.1.6.11.1. Contractor shall obtain and maintain approval for the CFCMW throughout the Contract Period to meet program requirements for a Case Management Agency.

1.1.6.11.2. The Department reserves the right to revoke Contractor's CFCMW at any time.

1.1.6.11.3. Contractor shall submit an annual report to the Department that includes, but is not limited to, the following information:

1.1.6.11.3.1. Written processes in place to ensure remediation of conflict and separation of entities.

1.1.6.11.3.2. Documentation of Member choice and informed consent of the conflict of the agency being selected.

1.1.6.11.3.3. A summary of the individuals participating in direct services and case management at the agency with the CFCMW.

1.1.6.11.3.4. Policies and procedures outlining how Contractor will validate that there are no other willing and qualified providers in their Defined Service Area with capacity to provide services for all eligible members in the service area.

1.1.6.11.3.5. How Contractor is supporting the recruitment of providers in their area to remediate conflict.

1.1.6.11.4. If Contractor is denied a CFCMW for any reason, or one is revoked, Contractor must have documented written plans for transitioning individuals and Members. Contractor shall continue to provide services until a transition may be successfully implemented.

1.1.6.11.5. **DELIVERABLE**: Annual report and written processes and procedures on implementing rural exception and only willing and qualified provider requirements for CMAs that have been granted a CFCMW.

1.1.6.11.6. **DUE**: June 15th of each year or prior to contract renewal for CMAs with an approved rural exception

1.2. Collaboration with other Care Coordination Entities and Case Management Agencies

1.2.1. Contractor shall comply with written communication from the Department, provided by the Department, between Contractor and community partners and service providers that outline how Contractor will work together with these partners to coordinate care and better serve

individuals and Members. Contractor shall establish written memorandum of understanding with local care coordination entities that outline roles and responsibilities, avoidance of duplication of effort, and communication expectations. Contractor is responsible for streamlining the Member experience to ensure full range of Medicaid services are being offered and accessed based on the Member's needs. As applicable, a memorandum of understanding shall address partnerships with:

1.2.1.1. Regional Accountable Entities (RAE)

1.2.1.1.1. The RAE is responsible for coordinating for physical health services and providing and arranging for behavioral health services, including, but not limited to mental health services or other non-waiver behavioral services and supports available through Medicaid. The RAE promotes the population's health and functioning, coordinates care across disparate providers, interfaces with LTSS providers, and collaborates social, educational, justice, recreational, and housing agencies to foster healthy communities and address complex needs that span multiple agencies and jurisdictions. The RAE manages a network of primary care physical health providers and behavioral health providers to ensure access to appropriate care for Medicaid Members.

1.2.1.1.1.1. Contractor shall ensure collaboration with RAEs occurs for all shared Members that need care coordination services for physical and behavioral health services. Contractor shall identify which community agencies are responsible for facilitation, follow-up, and solution focused on next steps for each Member collaboration.

1.2.1.1.1.2. Contractor shall collaborate with the appropriate RAE when a Member needs assistance in accessing or coordinating the Member's physical, behavioral, or mental health needs. This shall include but is not limited to Members who have complex medical or behavioral support needs, change of conditions or involvement with Child Welfare or Adult Protection.

1.2.1.1.1.3. Coordinating with the RAE for shared Members who admit to a hospital, to include, but not limited to, communicating reasons for admission, Member's hospital status, and plans for discharge.

1.2.1.1.1.4. Collaborating with the RAE for shared Members discharging from the hospital to ensure all support needs are reflected in the Support Plan and the Member is connected to the necessary services to support a successful discharge.

1.2.1.1.1.5. Enter into a data sharing arrangement for the sharing of all necessary information for the RAE to assist Members in accessing and coordinating physical and behavioral health needs.

1.2.1.1.1.6. Contractor shall create a complex and creative solutions process with the RAE(s) and designated staff to address needs spanning multiple Medicaid systems for all shared Members. This shall include, but not be limited to, a regularly scheduled joint coordination meeting at a cadence that best meets the Member's needs to ensure holistic case management and care coordination. This process shall be made available upon request,

1.2.1.1.1.7. Contractor shall honor Member's preferences for case management and care coordination, when applicable, while ensuring collaboration with the RAE occurs.

1.2.2. Contractor shall work with the Department to identify a Key Performance Indicator (KPI) to measure the effectiveness of coordination between Contractor and RAE. Medicaid Eligibility Sites

1.2.2.1. County department of human/social services (counties) and Medical Assistance (MA) Sites are designated sites allowed by statute or certified by the Department of Health Care Policy and Financing (Department) to process the State-authorized Medical Assistance application for the programs that are administered by the Department and determine eligibility for said programs. The role of county departments, specified in CRS 25.5-1-118, is specific to the responsibility for the local administration of Medical Assistance. Additionally, the Department is authorized to establish MA sites by statute (CRS 25.5-4-205 et seq). Counties and MA Sites use the Colorado Benefits Management System (CBMS) to determine eligibility for Child Health Plan Plus (CHP+) and Health First Colorado (Colorado's Medicaid Program) programs.

1.2.2.2. Contractor shall ensure collaboration with all county and Medical Assistance sites pertaining to application, renewal, case changes, or re-application status for members in Contractor's designated service area.

1.2.2.3. Contractor shall collaborate with the appropriate counties and/or Medical Assistance sites to ensure proper follow-up and communication to support members in obtaining and maintaining their benefits.

1.2.3. Community Centered Boards

1.2.3.1. Community Centered Boards (CCB) are the agencies responsible for leveraging local and regional resources to meet unmet needs for individuals with Intellectual and Developmental Disabilities (IDD) and their families.

1.2.3.2. Contractor shall collaborate with CCBs, this may include, but is not limited to:

1.2.3.2.1. Receiving referrals or sharing information necessary for the CCB and/or CMA to assist individuals and Members in accessing LTSS programs targeted for individuals with intellectual and developmental disabilities or children with disabilities.

1.2.3.2.2. Coordinating care for non-waiver services for members with intellectual and developmental disabilities where applicable or appropriate.

1.3. Qualification and Training Requirements

1.3.1. Contractor's personnel, including, but not limited to, Case Manager(s) and Case Management Supervisor(s) shall meet all qualification requirements listed in 10 C.C.R. 2505-10, Sections 8.7203.A to 8.7204 et seq.

1.3.2. Contractor shall ensure all case managers meet the qualification requirements established in 10 C.C.R. 2505-10, Section 8.7203.A et seq.

1.3.3. Contractor shall ensure all staff assigned to perform the Work in this Contract pass competency-based training requirements as defined by the Department including, but not limited to disability/cultural competency, person centeredness, soft skills, as well as program specific knowledge and skills.

1.3.4. Contractor shall ensure that all case management staff receive training within 120 Calendar Days after the staff member's hire date and prior to being assigned independent case

management duties. All other case management staff must receive retraining as required by the Department, a Department-approved vendor, or Contractor.

1.3.5. Training modalities may include the Departments Learning Management System (LMS), web-based training, virtual instructor-led training, in-person training sessions and training materials available on the Department website. Contractor shall utilize training materials provided by the Department.

1.3.6. Required Case Management Training includes, but is not limited to:

1.3.6.1. Applicable Federal and State laws and regulations for LTSS programs

1.3.6.2. Critical Incident Reporting

1.3.6.3. Community First Choice

1.3.6.4. Determination of Developmental Disability or Delay

1.3.6.5. Disability and Cultural Competency

1.3.6.6. Equity, Diversity, Inclusion and Accessibility (EDIA)

1.3.6.7. Intake and Referral

1.3.6.8. Level of Care Screen and Needs Assessment (Colorado Single Assessment) or Department Prescribed Tools

1.3.6.9. Long-Term Home Health (LTHH)

1.3.6.10. Long-Term Services and Supports Eligibility

1.3.6.11. Mandatory Reporting

1.3.6.12. Notices and Appeals

1.3.6.13. Nursing Facility Admissions

1.3.6.14. Rapid Reintegration

1.3.6.15. Participant Directed Training

1.3.6.16. Person-Centered Support Planning and Person-Centered Support Plan

1.3.6.17. Pre-Admission Screening and Resident Review (PASRR)

1.3.6.18. State General Fund Program Ongoing Case Management

1.3.6.19. State General Fund Program Requirements and Services

1.3.6.20. System Documentation

1.3.6.21. Waiver Requirements and Services

1.3.7. **DELIVERABLE**: Case Management Training

1.3.8. **DUE**: Semi-Annually, trainings held between July 1st and December 31st are due January 15th, and trainings held between January 1st through June 1st are due June 15th

1.3.9. Contractor shall maintain supporting documentation demonstrating case managers attended the required trainings and make the information available to the Department upon request. Supporting documentation must include the name and description of the training, the date the training was held, case managers in attendance, and trainer sign-off showing the case manager completed the training.

1.3.10. There will be no exemptions to the above list of required trainings as all case managers shall have a basic knowledge of all case management activities regardless of ongoing duties.

1.3.11. Case Managers shall meet competency requirements determined by the Department to perform case management tasks including the correct application of the Colorado Single Assessment and Person-Centered Support Plan. Case Managers must pass assigned training competency requirements to independently perform Case Management activities.

1.3.12. Contractor shall participate in Department and vendor trainings, which will be tracked by the Department. Participation can be at the time of the presented training or, if applicable, following the training using the materials available from the Department's website or LMS.

1.3.13. For Case Managers who have a documented minimum of one-year immediate prior work experience at a different Colorado CMA, Contractor may assign independent case management activities once Contractor has verified that the Case Manager's training requirements were previously met.

1.3.14. Contractor may elect to perform additional training not outlined in the Contract, but applicable to the Scope of Work, which may include mental health first aid, crisis intervention, and trauma informed care. Contractor may utilize the Department's Case Management Training Template to identify trainings attended that are not required by the Department.

1.3.15. Case Management staff are required to retake training to address and remediate performance concerns as directed by the Department.

1.3.16. Contractor shall provide the date all case management staff, including new and existing staff, were hired and the dates of received training in the areas identified in Section 1.2.3, using the reporting template provided by the Department for review, approval, and payment.

1.3.17. Case Managers shall receive oversight reviews of their performance including their competency with completing the Level of Care Screen. Contractor shall shadow case management staff completing the Level of Care Screen on an annual basis and prior to the end of each Contract Fiscal year to establish case manager's competency administering the Level of Care Screen. Documentation on case manager performance will be maintained by Contractor and provided to the Department upon request. Supervisors, lead workers, or a case manager with at least three years of case management experience may perform the shadowing.

1.4. Care and Case Management (CCM) System Training

1.4.1. Contractor shall participate in all trainings required by the Department for the Care and Case Management (CCM) Information Technology system and the new Colorado Single Assessment and Person-Centered Support Plan.

1.4.1.1. Staff employed by Contractor shall participate in training on the Colorado Single Assessment and Person-Centered Support Plan instruments prior to performing the LOC Screen, Needs Assessment, or Person-Centered Support Plan.

1.4.1.2. Contractor shall receive a one-time payment for the training and oversight of Contractor staff in performing the Colorado Single Assessment and Person-Centered Support Plan. Payment will be calculated based on the average number of staff as specified by the Department.

1.4.1.3. **DELIVERABLE**: Colorado Single Assessment and Person-Centered Support Plan Training

1.4.1.4. **DUE**: As Provided by the Department

1.5. Community First Choice

1.5.1. Contractor shall participate in all trainings required by the Department for the implementation of Community First Choice.

1.5.1.1. Staff employed by Contractor shall participate in training provided by the Department and associated vendors on Community First Choice.

1.5.1.2. **DELIVERABLE**: Completed Case Management Training on the Community First Choice Implementation.

1.5.1.3. **DUE**: As Assigned by the Department

1.6. Complaints

1.6.1. Contractor shall develop and maintain a formal complaints procedure, notify Members annually of the procedures, and make the procedure publicly available to include posting the procedure to Contractor's website. Procedures must include requirements for member notification in accordance with 10 CCR 2505-10 9.519.20 and 10 CCR 2505-10 8.7201.D.

1.6.2. Contractor shall receive, document, and track any complaint received by Contractor as it relates to the services provided through this Contract to include, but not limited to, general business functions, administration, State General Funded Programs, and case management functions outlined in this Contract. Complaints received outside of the scope of this Contract shall not be included. Documentation shall consist of a complaint log that includes the date of complaint, name of the complainant, the nature of the complaint and the date and description of the resolution.

1.6.3. Contractor shall submit all complaints to the Community Advisory Committee for review, feedback, and input on resolving complaints.

1.6.4. Contractor shall analyze complaints for trends quarterly and shall submit all complaint-oriented trends observed since the Effective Date of this Contract and the remedial actions taken to address them to the Department.

1.6.5. Trend analysis shall include an examination of information including, but not limited to:

1.6.5.1. A comparison of complaint types and number of complaints over a period of time.

1.6.5.2. Number of type of complaint against Contractor, time, location, individual involved, staff involved, and/or any additional relevant information.

1.6.5.3. An examination of potential reasons for the increase or decrease in complaints by total number, subcontractor, individual, or staff.

1.6.5.4. An examination of preventative measures that can be implemented to reduce the number or frequency of future complaints.

1.6.5.5. Implementation of a plan of action or any future actions to take place.

1.6.5.6. An analysis of whether the plan of action and changes made were effective or if additional changes need to occur.

1.6.5.7. As part of the complaint process Contractor shall include, but is not limited to, all of the following:

1.6.5.7.1. Document complaints received.

1.6.5.7.2. Address substantiated complaints.

1.6.5.7.3. Respond to complaints received and document actions taken to resolve and/or mitigate complaints.

1.6.5.7.4. Conduct a quarterly trend analysis of all complaints received for the full period of the Contract.

1.6.5.8. Contractor shall maintain all supporting documentation related to the collection and follow-up to complaints and make it available to the Department upon request.

1.6.5.9. If Contractor received no complaints during the quarter, Contractor may submit the Complaint Trends Analysis to the Department identifying no complaints were reported during the quarter.

1.6.5.10. If Contractor received less than five complaints during the quarter and cannot establish a complaint trend, Contractor may submit the Complaint Trends Analysis to the Department with the complaint log that includes the date of complaint, name of the complainant, the nature of the complaint and the date and description of the resolution.

1.6.5.11. Contractor shall submit the Complaint Trends Analysis to the Department for review and approval.

1.6.5.11.1. **DELIVERABLE**: Complaint Trend Analysis

1.6.5.11.2. **DUE**: Quarterly, by October 15th, January 15th, April 15th and June 15th of each year.

1.7. Continuous Quality Improvement Plan

1.7.1. Contractor shall create and implement a Continuous Quality Improvement Plan for the contract period. The Continuous Quality Improvement Plan shall include, but not be limited to a description of the following:

1.7.1.1. How Contractor oversees the work performed by Case Managers as outlined in the contract to ensure all tasks are being performed according to the requirements.

1.7.1.2. How Contractor reviews work to determine whether the work is being completed in a correct and high-quality manner.

1.7.1.3. How Contractor identifies and addresses Case Management performance issues.

1.7.1.4. How Contractor notifies the Department of identified performance issues.

1.7.1.5. How Contractor will address at a minimum the following areas: operations, quality controls, staffing, training, and community engagement. Required tasks will be outlined in Department template that will be provided to Contractor yearly.

1.7.1.6. Contractor shall participate in the Department hosted Quality Community of Practice.

1.7.2. Contractor shall submit the Continuous Quality Improvement Plan to the Department for review, approval, and payment. The Department will establish a regularly scheduled cadence with Contractor to review and discuss the CQI Plan, data, and agency specific quality dashboard. Contractor shall review the plan and metrics with the Department annually.

1.7.2.1. **DELIVERABLE**: Continuous Quality Improvement Plan

1.7.2.2. **DUE**: Within 90 Business Days after the Effective Date

1.7.3. Contractor shall review its Continuous Quality Improvement Plan on an annual basis and update the plan as appropriate to account for any changes. Contractor shall submit the Continuous Quality Improvement Plan Update or document that the plan was reviewed, and changes were not required.

1.7.3.1. **DELIVERABLE**: Continuous Quality Improvement Plan Update

1.7.3.2. **DUE**: Annually, by October 1st

1.8. Appeals

1.8.1. Contractor shall represent the Department and defend any adverse action in accordance with 10 CCR 2505-10 8.7202.R et seq., and 10 CCR 2505-10 Section 8.057 et. seq. in all HCBS, CFC, LTHH, PACE, Hospital Back-Up Facilities, and Nursing Facility appeals initiated during this Contract. This section does not apply to State General Fund Programs. Contractor shall coordinate with the Department for any adverse actions necessitating Department attendance at a hearing.

1.8.1.1. Contractor shall identify and disclose to the Department immediately, and no later than 45 Calendar Days prior to a scheduled appeal hearing, any conflict of interest that would interfere with Contractor's ability to represent the Department in any appeal.

1.8.2. Contractor shall represent its actions at Administrative Law Judge hearings when the individual or Member appeals a denial or adverse action affecting individual's or Member's program eligibility or receipt of services.

1.8.3. Contractor shall process appeals in accordance with schedules published by the State of Colorado Office of Administrative Courts and rules promulgated by the Department.

1.8.4. Contractor shall develop an Appeals Packet which contains all relevant documentation to support Contractor's denial or adverse action.

1.8.5. Contractor shall develop an Appeals Packet no later than 20 Business Days prior to the date of a scheduled hearing.

1.8.6. Contractor shall submit exceptions when applicable and include all relevant information.

1.8.7. Contractor shall cooperate with the Office of the State Attorney General for any case in which it is involved.

1.8.8. Contractor shall document all appeals where Contractor attends any hearing in an Administrative Law Court.

1.8.9. Contractor shall make the Appeal Packets available to the Department upon request.

1.9. Critical Incidents

1.9.1. Critical Incident Reporting

1.9.1.1. Contractor shall be responsible for entering Critical Incident Reports (CIR) in the Department prescribed system as soon as possible, but no later than 24 hours (one business day) following notification.

1.9.1.2. Contractor shall ensure all suspected incidents of abuse, neglect, and exploitation are immediately reported consistent with current statute; Section 19-3-301 through 19-3-318

C.R.S. Colorado Children's Code, Section 18-8-115 C.R.S. (Colorado Criminal Code - Duty to Report a Crime), 18-6.5-108 C.R.S. (Colorado Criminal Code-Wrongs to At-Risk Adults), and Section 26-3.1-102, C.R.S. (Social Services Code-Protective Services).

1.9.1.3. Contractor shall document all CIR follow-up information in accordance with Department direction in the Department prescribed system and maintain detailed documentation.

1.9.2. Critical Incident Follow-Up Completion and Entry

1.9.2.1. Contractor shall ensure all CIRs follow-up is completed and entered into the Department's prescribed system within the timelines established by the Department and/or the Department's Quality Improvement Organization.

1.9.2.2. Timelines for follow-up are determined by the Department and depend on the type and severity of the CIR. The following are general timelines assigned to remediation and CIR follow up:

1.9.2.2.1. High Priority Follow Up- CIRs which require immediate attention and must be addressed to ensure the immediate health and safety of a waiver participant must be remediated within and responded to in the Department prescribed system within 24-48 hours.

1.9.2.2.2. Medium Priority Follow Up – CIRs which require additional information or follow up to ensure appropriate actions are taken and there is no immediate risk to the health and safety of the waiver participant must be completed in the Department prescribed system within three to four Business Days.

1.9.2.2.3. Low Priority Follow Up – CIRs that have been remediated by CMAs, have addressed immediate and long-term needs, have implemented services or supports to ensure health and safety, and those that have protocols in place to prevent a recurrence of a similar CIR but may require an edit to the CIR or additional information entered into the Department prescribed system. The follow-up for CIRs in this category must be completed and entered within five Business Days.

1.9.2.3. **PERFORMANCE STANDARD:** 90% of all CIRs assigned follow-up are completed and entered into the Department's prescribed system within the timelines established by the Department and/or the Department's Quality Improvement Organization each quarter.

1.10. Critical Incident Report Administrative Review

1.10.1. Contractor shall conduct a Critical Incident Report Administrative Review upon direction from the Department.

1.11. Critical Incident Report administrative reviews shall be initiated by the Department and will require the Contractor to upload documentation to the Department's prescribed system as assigned. Contractor may be required to document that the reported incident of alleged Mistreatment, Abuse, Neglect, or Exploitation (MANE) was reported to law enforcement, per mandated reporting laws, and to adult/child protection services to be screened for additional investigation by the Colorado Department of Human Services as appropriate. The Department may also request that the Contractor file a report with the Colorado Department of Public Health and Environment as necessary. Critical Incident Report administrative review may also require documentation of whether additional services might be needed as a result of the incident or gathering of additional documentation at the request of the Department.

1.12. Human Rights Committee (HRC)

1.12.1. Contractor shall establish an HRC. The HRC is composed, to the extent possible, of two professional persons trained in the application of behavior development techniques and three representatives of persons receiving services, their parents, legal guardians, or authorized representatives. An employee or board member of a service agency within the Contractor's designated service area shall not serve as a member of the HRC.

1.12.2. Contractor shall establish and facilitate a Human Rights Committee (HRC) pursuant to 10 C.C.R. 2505-10 Section 8.7202.Q et seq. Contractor shall maintain qualifications for each member of the HRC and make it available to the Department upon request.

1.12.3. Contractor shall submit a list of HRC members annually.

1.12.3.1. **DELIVERABLE**: HRC Member List

1.12.3.2. **DUE**: Annually, by August 15th

1.12.4. Contractor shall notify the Department of any changes to the HRC members within 10 Business Days of the date of change.

1.12.4.1. **DELIVERABLE**: HRC Member Updates

1.12.4.2. **DUE**: Within 10 Business Days of the date of change to the HRC members

1.12.5. Contractor shall establish at least one HRC as a third-party mechanism to safeguard the rights of persons enrolled in HCBS-CES, HCBS-CHRP, HCBS-SLS, HCBS-DD, State SLS, OBRA-SS, and FSSP. The HRC is an advisory and review body to the administration of Contractor.

1.12.6. Contractor shall develop policies and procedures which include, but are not limited to, HRC responsibilities for the committee's organization, use of Department required universal documents, the review process, mitigation of potential conflicts of interest, and provisions for recording dissenting opinions of committee members in the committee's recommendations. CMAs must also develop and adopt an HRC policy and procedure for the emergency review of Rights Modifications.

1.12.7. Contractor shall orient members regarding the duties and responsibilities of the Human Rights Committee and make this information available to the Department upon request.

1.12.8. Contractor shall provide the HRC with the necessary staff support to facilitate its functions.

1.12.9. Contractor shall keep proper documentation and record of all HRC recommendations and ensure that all documentation is a part of the members record in the Department's prescribed system.

1.12.10. Contractor shall maintain HRC meeting minutes, attendance logs, and supporting documentation related to an HRC meeting and make it available to the Department within 10 Business Days upon request.

1.12.11. Contractor shall notify the Department in writing of any changes to the HRC membership within 10 Business Days.

1.12.12. Contractor shall document all reviews within the Department's prescribed system within 10 Business Days of the date of the HRC review.

2. PRE-ENROLLMENT ACTIVITIES

2.1. LTSS LOC Referral, Intake, and Screening

2.1.1. Contractor shall perform all long-term services and supports Level of Care referral, intake, and screening functions/activities for enrollment into the following waivers and programs:

2.1.1.1. HCBS-CHCBS

2.1.1.2. Community First Choice (CFC)

2.1.1.3. Consumer-Directed Attendant Support Services (CDASS)

2.1.1.4. Family Support Services Program (FSSP)

2.1.1.5. HCBS-BI

2.1.1.6. HCBS-CESHCBS-CHRP

2.1.1.7. HCBS-CIH

2.1.1.8. HCBS-CLLI/HCBS-CwCHN

2.1.1.9. HCBS-CMHS

2.1.1.10. HCBS-DD

2.1.1.11. HCBS-EBD

2.1.1.12. HCBS-SLS

2.1.1.13. Hospital Back-Up

2.1.1.14. In Home Supports and Services (IHSS)

2.1.1.15. Intermediate Care Facilities for Individuals with Intellectual and Developmental Disabilities (ICF/IID)

2.1.1.16. Nursing Facilities

2.1.1.17. Omnibus Reconciliation Act of 1987 Specialized Services Program (OBRA-SS)

2.1.1.18. PACE

2.1.1.19. State Supported Living Services Program (State SLS)

2.2. Contractor shall perform all Long Term Supports and Services Level of Care (LTSS LOC) referral, intake, and screening functions/activities in accordance with §25.5-6-104, C.R.S. and 10 CCR 2505-10, Sections 8.7202.B., 8.7202.E, and 8.401 et seq., shall include, but not limited to, the following:

2.2.1.1. Timelines shall be applied based on the location of the applicant at the time the Contractor receives the LTSS Level of Care (LOC) referral or another intake referral:

2.2.1.1.1. Hospital

2.2.1.1.2. Skilled Nursing Facility, or

2.2.1.1.3. Community

2.2.1.1.3.1. Programs such as Hospital Back-up and PACE are subject to timelines based on the location of the applicant at the time the Contractor receives the LTSS LOC referral or another referral for LOC Assessment.

2.2.1.2. CMAs shall not require a LTSS LOC Referral form to intake a referral requesting a LOC Assessment.

2.2.1.3. Conduct and document the Colorado Intake Screen Tool (CIST), LOC Assessment, and Rapid Reintegration within required timelines set forth by the Department.

2.2.1.3.1. Conduct and document the CIST in the Department's prescribed system within 2 business days of receiving the LTSS LOC referral or any other intake referral requesting a LOC Assessment.

2.2.1.3.2. Timeline to conduct and document the CIST does not extend the LOC Assessment timelines set forth by the Department.

2.2.1.3.3. Ensure documentation includes the individual's need for LTSS and/or the individual's request for a LOC Screen even if the CIST indicates the individual may not be eligible for LTSS.

2.2.1.3.4. LTSS LOC referral form is uploaded to the Department's prescribed system.

2.2.1.3.4.1. Any other referral requesting a LOC Assessment is uploaded in the Department's prescribed system.

2.2.1.3.5. Document all efforts to contact an applicant to conduct the CIST, LOC Assessment, and any referrals made to non-LTSS services in the Department's prescribed system.

2.2.1.4. Have a written policy and procedure for expediting the LTSS LOC referral or another referral for LOC Assessment in the event that an applicant is in an emergency situation.

2.2.1.5. Conduct and document a LOC Assessment without delay if an applicant has requested a Delay Determination or Developmental Disability Determination required for HCBS-DD, HCBS-SLS, HCBS-CES, HCBS-CHRP waivers, and CFC.

2.2.1.6. For an individual who is not being discharged from a hospital or a nursing facility, the CIST, and LOC Assessment shall be conducted and documented in the Department's prescribed system within 10 business after receiving confirmation that the Medicaid application has been received by the county department of social services.

2.2.1.6.1. CMAs shall attempt to verify that a LTC Medicaid Application has been submitted after receiving a LTSS LOC referral but should not delay a LOC Assessment if the interview conducted to complete the CIST indicates that an applicant has not submitted a LTC Medicaid Application.

2.2.1.6.2. Hospital and Skilled Nursing Facility referrals do not require LTC Medicaid application verification.

2.2.1.7. Individuals shall be notified at the time of the decision of their application for publicly funded LTSS that they have the right to appeal the actions of Contractor according to 10 CCR 2505-10 section 8.057 and 8.7202.R et seq. The notification shall include the right to request a fair hearing before an Administrative Law Judge.

2.2.1.7.1. **PERFORMANCE STANDARD:** 100% of LTSS LOC Referrals and all intake referrals submitted to the Contractor are entered or uploaded into the Department prescribed system within two Business Days of the LTSS LOC Referral or intake referral receipt date.

2.3. Developmental Disability and Delay Determinations

2.3.1. Contractor shall determine whether an applicant meets the definition of an Individual with a Developmental Disability or Delay as defined under 10 CCR 2505-10, section 8.8.7100.A., in accordance with 10 C.C.R. 2505-10 section 8.607.2 et seq.

2.3.2. Contractor may expedite psychological or adaptive behavior testing for Developmental Disability Determinations when there are delays due to issues identifying a provider or scheduling testing with a provider in order complete the PASRR Level II assessments for individuals residing in skilled nursing facilities. Requests for testing funding must be submitted on the template prescribed by the Department.

2.3.3. Contractor may request funding for testing necessary to complete Delay or Developmental Determination to move forward with intake and referral activities. This includes cases where an applicant cannot access testing due to financial burden and other funding is not available if they have submitted a long-term care Medicaid application and the financial eligibility has not been determined. Requests for funding must be submitted to the Department for approval prior to funding being approved.

2.3.3.1. **DELIVERABLE**: Prior Approval for Testing Funding and Invoice

2.3.3.2. **DUE**: Monthly, by the 15th

2.3.3.3. Contractor shall maintain all supporting documentation related to the testing for DD Determination and make it available to the Department upon request.

2.3.4. Contractor shall complete the individual's determination record and assessment record in the Department prescribed system with all applicable dates and information within 10 Business Days after a determination is complete.

2.3.5. Contractor shall maintain the individual's determination, documents, and upload them to the Department's prescribed system.

2.3.6. Contractor shall ensure that all determinations are complete, in accordance with Department regulations, and the individual has been determined to have a disability or delay prior to enrollment into HCBS-DD, HCBS-SLS, HCBS-CHRP, HCBS-CES, CFC, State SLS, FSSP, and OBRA-SS.

2.3.7. Individuals shall be notified at the time of the decision of the determination that they have the right to appeal actions of Contractor to 10 CCR 2505-10 sections 8.057 et seq., 8.7202.R et seq. The notification shall include the right to request a fair hearing before an Administrative Law Judge.

2.4. Waiting List Management

2.4.1. Contractor shall maintain a program specific waiting list within the Department's prescribed system for all eligible individuals for whom funding is not available. Waiting lists may be applicable for HCBS-DD, State SLS, OBRA-SS and FSSP dependent on available funding. Contractor shall not maintain a waiting list for any of the other programs included within this Contract.

2.4.2. Contractor shall determine HCBS-DD waiting list eligibility by conducting an assessment that clearly defines detailed and member specific information that specifies how the individual meets the HCBS-DD waiver requirement for needing access to services and supports twenty-four (24) hours a day pursuant to 10 CCR 2505-10 8.7202.G et seq. and 8.7101.J et seq.

2.4.2.1. Contractor's description of daily living needs of an individual who requires access to twenty-four (24) hour a day services and support in the LOC waiting list assessment should indicate services and support needs that are only available in the HCBS-DD waiver to determine why access to services and supports twenty-four hours a day are necessary for the individual.

2.4.3. The name of a person eligible for the program shall be placed on the waiting list by Contractor making the eligibility determination.

2.4.4. When an eligible person is placed on the waiting list for Waiver services, a written notice of action including information regarding individual rights and appeals shall be sent to the person or the person's legal guardian in accordance with the provisions of 10 C.C.R. 2505-10 8.7202.J et seq.

2.4.5. When funding has been made available for an individual Contractor will remove the person from the "As Soon as Available" (ASAA) waiting list within 10 Business Days.

2.4.6. The placement date used to establish a person's order on an HCBS waiver waiting list shall be:

2.4.6.1. The date on which the person was initially determined to have a developmental disability by Contractor; or

2.4.6.2. The 14th birth date if a child is determined to have a developmental disability by Contractor prior to the age of 14.

2.4.7. When an individual is eligible for a program and funding is not available, Contractor shall:

2.4.7.1. Verify demographic information.

2.4.7.2. Compile and correct data.

2.4.8. Contractor shall complete data entry of Waiting List record into the Department prescribed system within 10 Business Days of any addition or change to the Waiting List.

2.4.9. Contractor shall conduct and document, in the Department's prescribed system, an annual follow-up with individuals 18 and older for all HCBS waivers with a Waiting List timeline of ASAA, Safety Net (SN), or "see date" to update changes in demographic information and ensure the individual is appropriately identified on waiting lists for the program and services the individual is eligible to receive.

2.4.9.1. **PERFORMANCE STANDARD**: 100% of HCBS individuals 18 and older with an ASAA, SN, or "see date" timeline on the Waiting List are contacted annually and documented within the Department's prescribed system within 10 Business Days.

2.5. Program Enrollment from the Waiting List

2.5.1. HCBS-DD Enrollment from the Waiting List

2.5.1.1. When an enrollment becomes available from the HCBS-DD Waiting List, the Department will notify Contractor of the individual who will be offered an enrollment by the order of selection date.

2.5.1.2. Contractor shall notify the individual of the enrollment offer within 5 Business Days. Contractor shall make three attempts to contact the individual within a 30-calendar day period. Contractor shall document in the Departments prescribed system all attempts to contact the individual for the enrollment offer. If the individual does not respond to the

offer of enrollment, Contractor shall change the individuals waiting list timeline to "Safety Net".

2.5.1.3. Individuals shall be notified at the time of the enrollment offer that they have the right to appeal the actions of Contractor to 10 CCR 2505-10 sections 8.7202.R et seq. and 8.057 et seq. The notification shall include the right to request a fair hearing before an Administrative Law Judge.

2.5.2. HCBS-DD Waiting List Enrollment Capacity Building

2.5.2.1. As appropriated and earmarked by the General Assembly, Contractor may receive capacity building funding to support the enrollment of members into the HCBS-DD waiver from the waiting list.

2.5.2.2. Contractor shall receive written notification of any capacity building funding for individuals enrolling into the HCBS-DD waiver from the waiting list.

2.5.2.3. If funding is allocated, Contractor shall report how the capacity building funding was used to support the enrollment of the authorized Member(s) into the HCBS-DD waiver on a template developed by the Department. Funding must be used to support Member enrollment in the following categories:

2.5.2.3.1. Staffing costs

2.5.2.3.1.1. Recruiting and hiring

2.5.2.3.1.2. Professional development

2.5.2.3.1.3. Equipment and supplies

2.5.2.3.1.4. Information technology

2.5.2.3.2. Program costs

2.5.2.3.2.1. Advertising

2.5.2.3.2.2. Equipment and supplies

2.5.2.4. **DELIVERABLE**: Capacity Building Funding Expenses

2.5.2.5. **DUE**: Quarterly, if funding is allocated, by October 31st, January 31st, April 30th, and June 15th or the Fiscal Year end close date determined by the Department

2.5.3. FSSP Enrollment from the Waiting List

2.5.3.1. In cooperation with the local Family Support Council, Contractor shall develop procedures for determining how and which individuals on the Waiting List will be enrolled into FSSP. These procedures must comply with Department regulations on waiting list and prioritization of funding.

2.5.3.2. Contractor shall select individuals from the waiting list to enroll into FSSP in accordance with 10 CCR 2505-10 8.7561et seq.

2.5.4. State SLS Enrollment from the Waiting List

2.5.4.1. Contractor shall develop procedures for determining how and which individuals on the waiting list will be enrolled into the State SLS program in accordance with 10 C.C.R. 2505-10 Section 8.7.7557. These procedures shall be made available to the Department upon request and used to select individuals from the waiting list to enroll into State SLS.

2.5.5. OBRA-SS Enrollment from the Waiting List

2.5.5.1. Contractor shall determine when funding is not available within Contractor's existing State General Fund program allocation and notify the Department that additional funding is being requested to enroll the individual into OBRA-SS within 10 Business Days of funding needs being identified.

2.5.5.2. Contractor shall place the individual on the waiting list until funding becomes available or Contractor may partially fund services when limited funding is available within existing allocations.

2.5.5.3. Contractor shall develop procedures for determining how and when individuals will be placed on the waiting list and make the procedures available to the Department upon request.

2.5.6. Waiting List Records Maintenance

2.5.6.1. Contractor shall remove individuals from the Waiting List after an enrollment is authorized to the individual and the individual or guardian accepts or refuses the authorization for enrollment within 10 Business Days after the individual or guardian's response or the last communication attempt.

2.5.6.2. If an individual or guardian declines an enrollment, Contractor shall enter the reason for declining an enrollment into the Department prescribed system Waiting List record within 10 Business Days of the enrollment being declined.

2.5.6.3. Contractor shall provide information and referrals to individuals, families and/or guardians at the time of the annual follow-up.

2.5.6.4. Contractor shall continue to refer individuals on the Waiting List to other community resources that may be available and inform individuals of their choice of providers, waivers, and services.

2.5.6.5. Contractor shall provide assistance completing Medicaid financial applications or other public assistance program applications at the time assistance is requested by the individual, family, or guardian.

2.5.6.6. Individuals shall be notified at the time of the enrollment authorization that they have the right to appeal actions of Contractor as described in 10 CCR 2505-10 section 8.057 et seq., 8.7202.R et seq. The notification shall include the right to request a fair hearing before an Administrative Law Judge.

2.6. Compilation and Correction of Waiting List Data

2.6.1. Contractor shall correct 100% of Waiting List data errors discovered by the Department within 10 Business Days of notification from the Department of an error.

2.6.1.1. **PERFORMANCE STANDARD:** 100% of Waiting List data corrected within 10 Business Days of notification.

2.7. Authorization and Reporting of HCBS-DD Enrollments

2.7.1. Contractor shall obtain prior authorization from the Department for all enrollments into the HCBS-DD waiver.

2.7.2. In accordance with 10 CCR 2505 Section 8.7101.J, Contractor shall inform the Department of all vacancies in the HCBS-DD waiver. Vacancies shall be submitted to the Department monthly on the date and template prescribed by the Department.

2.7.3. Individuals shall be notified at the time of the enrollment authorization that they have the right to appeal the actions of Contractor to 10 CCR 2505-10 section 8.7202.R and 8.057 et seq. The notification shall include the right to request a fair hearing before an Administrative Law Judge.

2.7.3.1. **DELIVERABLE**: HCBS-DD Vacancy Reporting

2.7.3.2. **DUE**: Monthly, by the 15th on the template prescribed by the Department

2.7.4. Contractor shall report all enrollment dates or changes to enrollment status for the HCBS-DD waiver to the Department monthly on the date and template prescribed by the Department.

2.7.4.1. **DELIVERABLE**: HCBS-DD Enrollment Date and Enrollment Change Reporting

2.7.4.2. **DUE**: Monthly, by the 15th on the template prescribed by the Department

3. SCREENING AND ASSESSMENT

3.1. Contractor shall perform the Level of Care (LOC) (100.2) Assessment as indicated in Section 3.2 or the LOC Screen and Needs Assessment as indicated in Section 3.3 for each Member as directed by the Department.

3.2. Contractor shall not perform both a LOC Assessment (100.2) and a LOC Screen and Needs Assessment for the same Member unless directed to do so by the Department.

3.3. Level of Care Assessment (100.2)

3.3.1. Contractor shall provide staff that meet the case manager qualifications set forth in state statutes and regulations to perform all LOC Assessments.

3.3.2. Contractor shall utilize and conduct the Department prescribed tools for the Initial LOC Assessment for all new applicants to the HCBS waivers, CFC, PACE, Nursing Facilities, Hospital Back-Up, and ICF-IDD. Initial Level of Care Assessment include the following Assessment Event types: Initial Review, HCBS-DD Waitlist, Deinstitutionalization (DI), and Reverse Deinstitutionalization. Continued Stay Review LOC Assessment include the following Assessment Event types: Continued Stay Review and Unscheduled Review.

3.3.3. An Unscheduled Review Assessment Event Type shall be utilized when a LOC Assessment is completed due to a significant change in the Member functioning and support needs including documented medical conditions, post hospitalization, or significant change in activities of daily living.

3.3.3.1. Contractor shall schedule an in-person Initial LOC Assessment in accordance with 10 CCR 2505-10 8.7202.E. and shall adhere to the following processes and timelines based on type:

3.3.3.1.1. Hospital to HCBS or CFC

3.3.3.1.1.1. Contractor conducts and documents the LOC Assessment within 2 Business Days of receiving a LTSS LOC referral for LOC Assessment.

3.3.3.1.1.2. LOC Eligibility Determination start date for Assisted Care Facility may be the date of referral on the LTSS LOC referral form received by the Contractor.

3.3.3.1.1.3. Contractor generates a LOC Eligibility Determination in the Department's prescribed system within 2 Business Days of the LTSS LOC referral or another referral requesting a LOC Assessment.

3.3.3.1.1.4. Referral to LOC Eligibility Determination not to exceed 2 Business Days.

3.3.3.1.2. Hospital to Skilled Nursing Facility

3.3.3.1.2.1. Contractor conducts and documents the LOC Assessment Screen and PASRR Level I Screen within 2 Business Days of receiving a LTSS LOC referral or another referral for LOC Assessment.

3.3.3.1.2.2. Contractor completes and documents the Nursing Facility Length of Stay form to indicate the length of stay necessary to meet the applicant's needs.

3.3.3.1.2.3. LOC Eligibility Determination date may be the date of LTSS LOC referral form is received by the Contractor.

3.3.3.1.2.4. Contractor generates a LOC Eligibility Determination in the Department's prescribed system within 2 Business Days of the LTSS LOC Referral or another referral requesting a LOC Assessment.

3.3.3.1.2.5. Referral to LOC Eligibility Determination not to exceed 2 Business Days.

3.3.3.1.2.6. Hospital timelines apply to any applicant in a hospital wanting to enroll in PACE and, HBU.

3.3.3.1.3. Skilled Nursing Facility to HCBS or CFC

3.3.3.1.3.1. Contractor conducts and documents the LOC Assessment within 5 Business Days of the LTSS LOC referral date or another referral requesting a LOC Assessment.

3.3.3.1.3.2. Contractor generates a LOC Eligibility Determination in the Department's prescribed system within 5 Business Days of the LTSS LOC referral or another referral requesting a LOC Assessment

3.3.3.1.3.3. Referral to LOC Eligibility Determination not to exceed 5 Business Days.

3.3.3.1.4. Skilled Nursing Facility Payer Source Change

3.3.3.1.4.1. Contractor conducts and documents the LOC Assessment within 5 Business Days of the LTSS LOC referral date or another referral requesting a LOC Assessment.

3.3.3.1.4.2. Contractor generates a LOC Eligibility Determinations in the Department's prescribed system within 5 Business Days of the LTSS LOC Referral or another referral requesting a LOC Assessment.

3.3.3.1.4.3. Referral to LOC Eligibility Determination not to exceed 5 Business Days.

3.3.3.1.5. HCBS or CFC to Skilled Nursing Facility

3.3.3.1.5.1. Contractor completes the LOC Assessment and PASRR Level I Screen within 10 Business Days of the LTSS LOC referral date or another referral requesting a LOC Assessment.

3.3.3.1.5.2. Contractor completes the nursing facility length of stay form to indicate the length of stay necessary to meet the applicant's needs.

3.3.3.1.5.3. LOC Eligibility Determination start date will be the date of referral on the LTSS LOC referral form or another referral requesting a LOC Assessment.

3.3.3.1.5.4. Contractor generates a LOC Eligibility Determination in the Department's prescribed system within 10 Business Days of the LTSS LOC referral or another referral requesting a LOC Assessment.

3.3.3.1.5.5. Referral to LOC Eligibility Determination not to exceed 10 Business Days.

3.3.3.1.6. HCBS or CFC Referral

3.3.3.1.6.1. Contractor completes the LOC Assessment within 10 Business Days of the LTSS LOC referral date or another referral requesting a LOC Assessment.

3.3.3.1.6.2. LOC Eligibility Determination start date for Assisted Care Facility may be the date of referral on the LTSS LOC referral form received by the Contractor.

3.3.3.1.6.3. Contractor generates a LOC Eligibility Determination in the Department's prescribed system within 10 Business Days of the LTSS LOC referral or another referral requesting a LOC Assessment.

3.3.3.1.6.4. Referral to LOC Eligibility Determination not to exceed 10 Business Days.

3.3.3.1.6.5. Contractor shall attempt to verify that a LTC Medicaid Application has been submitted after receiving a LTSS LOC referral but should not delay a LOC Assessment if the interview conducted to complete the CIST indicates that an applicant has not submitted a LTC Medicaid Application.

3.3.3.1.6.5.1. Hospital and Skilled Nursing Facility referrals do not require LTC Medicaid application verification.

3.3.3.2. Contractor shall consider a LOC Assessment to be complete when the following has been done: an in-person assessment is completed, the PMIP has been obtained and verified to be accurate by the Case Manager to determine target criteria, and the assessment has been entered in the Department's prescribed system.

3.3.3.3. A LOC Certification notice shall be provided to referring agencies such as PACE organizations, Nursing Facilities, or Hospitals upon obtaining written consent provided by the applicant that meets HIPAA standards.

3.3.3.3.1. **PERFORMANCE STANDARD:** Contractor shall ensure a Professional Medical Information Page (PMIP) is signed by a medical professional and dated no earlier than six months from the certification start date and of an Initial LOC Assessment.

3.3.3.4. Contractor shall conduct all Level of Care Assessments in accordance with regulations.

3.3.3.5. Contractor shall conduct an in-person Continued Stay Review Assessment annually, at least one but no more than three months before the current LOC certification end date for Members who are continually enrolled for in HCBS, CFC, PACE, Nursing Facilities, Hospital Back-Up, and ICF-IDD. Contractor shall enter the review into the Department's prescribed system within 10 Business Days of conducting the assessment.

3.3.3.5.1. **PERFORMANCE STANDARD:** Contractor shall ensure a Professional Medical Information Page (PMIP) is signed within 90 Calendar Days of the certification start date and before the certification end date for a Continued Stay Review (CSR) for all applicants and individuals currently receiving services through the Hospital Back-Up

Unit (HBU), Nursing Facility (NF), Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF-IDD), and Program for All-Inclusive Care for the Elderly (PACE).

3.3.3.6. Contractor shall enter and complete the Continued Stay Reviews within 10 Business Days after conducting the assessment.

3.3.4. Failure by Contractor to complete the annual Level of Care Assessment shall cause a break in payment authorization for waiver services for the individual or Member.

3.3.4.1. Contractor shall ensure that this break in payment authorization shall not affect the continued delivery of waiver services to the individual or Member. Service costs incurred during a break in payment authorization are non-allowable costs.

3.3.4.2. Contractor shall bear the sole financial responsibility for all costs incurred during this break in payment authorization and shall be responsible for reimbursing providers for any loss in funding as a result of the break in payment authorization.

3.3.4.3. Contractor shall notify all providers of the discontinuation of services no later than 11 Calendar Days prior to the certification end date that services shall not be authorized past the certification end date.

3.4. Level of Care Screen and Needs Assessment

3.4.1. Contractor shall perform all Initial and Annual Reassessment Level of Care Screens and Needs Assessments for the operation of a CMA in accordance with §25.5-6-104, C.R.S., 10 CCR 2505-10, Section 8.401, and 10 CCR 2505-10, Sections 8.7202.E et seq. and 8.7202.F et seq.

3.4.1.1. The Initial and Reassessment Level of Care Screen shall include and ensure, but not limited to, the following:

3.4.1.1.1. A verification of Long-Term Care (LTC) Medicaid Financial eligibility or LTC Medicaid application submission.

3.4.1.1.2. All Level of Care Screens are conducted in person with the individual or Member, at minimum, and in the place where the individual or Member resides.

3.4.1.1.3. Needs Assessments shall be conducted in person or virtually based on the Member's preference.

3.4.1.1.4. Contractor shall verify that a Member meets institutional level of care by receiving a PMIP signed by a medical professional and dated no earlier than six months from the certification start date and no later than 90 Calendar Days from the evaluation date of an Initial Level of Care Screen; and within 90 Calendar Days of the certification start date and before the certification end date for a Reassessment for all individuals and Members currently receiving services through Hospital Back-Up Unit (HBU), Nursing Facility (NF), Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF-IDD), and Program for All-Inclusive Care for the Elderly (PACE).

3.4.1.1.5. A review of all supportive information related to the Level of Care for the Member to include, but not limited to, documentation and interviews.

3.4.1.1.6. Communicating Level of Care Eligibility status to the appropriate eligibility site.

3.4.1.1.7. Representing the Department in all appeals relevant to a LTSS program eligibility.

3.4.1.1.8. A review of HCBS waiver Target Criteria for applicant or Member participation.

3.4.1.1.9. Determine individual or Member Level of Care Eligibility for enrollment in an HCBS Waiver, CFC, PACE, HBU, Nursing Facility admission, or ICF-IDD admission. Analyzing the information obtained to determine the most appropriate responses to the Level of Care Screen questions.

3.4.1.1.10. Providing notice of action to Members of all appealable actions related to their eligibility in a LTSS program.

3.4.1.1.11. Documenting and maintaining Level of Care Screens and Needs Assessments, including all relevant information, utilizing the Department's prescribed system within the timeframes established in 10 CCR 2505-10, Sections 8.7202.E and 8.7202.F et seq.

3.4.2. Level of Care Screen

3.4.2.1. The LOC Screen shall include the following event types:

3.4.2.1.1. Initial

3.4.2.1.2. Reassessment

3.4.2.1.3. Off-Cycle Review

3.4.2.1.4. Waiting List

3.4.2.2. Contractor shall conduct an Initial LOC Screen prior to enrolling in the following programs:

3.4.2.2.1. HCBS Waivers

3.4.2.2.2. CFC

3.4.2.2.3. PACE

3.4.2.2.4. Nursing Facilities

3.4.2.2.5. Hospital Back-Up

3.4.2.2.6. ICF-IDD

3.4.2.3. Contractor shall conduct an Initial LOC Screen in accordance with 10 CCR 2505-10 8.7202.E.:

3.4.2.3.1. Hospital to HCBS or CFC

3.4.2.3.1.1. Contractor conducts and documents the LOC Assessment within 2 business days of receiving a LTSS LOC referral or another referral requesting a LOC Assessment.

3.4.2.3.1.2. LOC Eligibility Determination start date for Assisted Care Facility may be the date of referral on the LTSS LOC referral form received by the CMA.

3.4.2.3.1.3. Contractor generates a LOC Eligibility Determination in the Department's prescribed system within 2 business days of the LTSS LOC referral or another referral requesting a LOC Assessment.

3.4.2.3.1.4. Referral to LOC Eligibility Determination not to exceed 2 Business Days.

3.4.2.3.2. Hospital to Skilled Nursing Facility

3.4.2.3.2.1. Contractor conducts and documents the LOC Assessment and PASRR Level 1 Screen within 2 business days of receiving a LTSS LOC referral another referral requesting a LOC Assessment.

3.4.2.3.2.2. Contractor completes and documents the Nursing Facility Length of Stay form to indicate the length of stay necessary to meet the applicant's needs.

3.4.2.3.2.3. LOC Eligibility Determination date may be the date of LTSS LOC referral form is received by the Contractor.

3.4.2.3.2.4. Contractor generates a LOC Eligibility Determination in the Department's prescribed system within 2 Business Days of the LTSS LOC Referral or another referral requesting a LOC assessment.

3.4.2.3.2.5. Referral to LOC Eligibility Determination not to exceed 2 Business Days.

3.4.2.3.2.6. Hospital timelines apply to any applicant in a hospital wanting to enroll in PACE and HBU.

3.4.2.3.3. Skilled Nursing Facility to HCBS or CFC

3.4.2.3.3.1. Contractor conducts and documents the LOC Assessment within 5 Business Days of the LTSS LOC referral date or another referral requesting a LOC Assessment.

3.4.2.3.3.2. Contractor generates a LOC Eligibility Determination in the Department's prescribed system within 5 Business Days of the LTSS LOC or another referral requesting a LOC Assessment.

3.4.2.3.3.3. Referral to LOC Eligibility Determination not to exceed 5 Business Days.

3.4.2.3.4. Skilled Nursing Facility payer source change

3.4.2.3.4.1. Contractor conducts and documents the LOC Assessment within 5 Business Days of the LTSS LOC referral date another referral requesting a LOC Assessment.

3.4.2.3.4.2. Contractor generates a LOC Eligibility Determinations in the Department's prescribed system within 5 Business Days of the LTSS LOC Referral or another referral requesting a LOC Assessment.

3.4.2.3.4.3. Referral to LOC Eligibility Determination not to exceed 5 Business Days.

3.4.2.3.5. HCBS or CFC to Skilled Nursing Facility

3.4.2.3.5.1. Contractor completes the LOC Assessment and PASRR Level 1 Screen within 10 Business Days of the LTSS LOC referral date or another referral requesting a LOC Assessment. Contractor completes the nursing facility length of stay form to indicate the length of stay necessary to meet the applicant's needs.

3.4.2.3.5.2. LOC Eligibility Determination start date will be the date of referral on the LTSS LOC referral form another referral requesting a LOC Assessment.

3.4.2.3.5.3. Contractor generates a LOC Eligibility Determination in the Department's prescribed system within 10 business days of the LTSS LOC referral or another referral requesting a LOC Assessment.

3.4.2.3.5.4. Referral to LOC Eligibility Determination not to exceed 10 Business Days.

3.4.2.3.6. HCBS or CFC Referral

3.4.2.3.6.1. Contractor completes the LOC Assessment within 10 Business Days of the LTSS LOC referral date another referral requesting a LOC Assessment.

3.4.2.3.6.2. LOC Eligibility Determination start date for Assisted Care Facility may be the date of referral on the LTSS LOC referral form received by the Contractor.

3.4.2.3.6.3. Contractor generates a LOC Eligibility Determination in the Department's prescribed system within 10 Business Days of the LTSS LOC referral or another referral requesting a LOC Assessment.

3.4.2.3.6.4. Referral to LOC Eligibility Determination not to exceed 10 Business Days.

3.4.2.3.7. CMAs shall attempt to verify that a LTC Medicaid Application has been submitted after receiving a LTSS LOC referral but should not delay a LOC Assessment if the interview conducted to complete the CIST indicates that an applicant has not submitted a LTC Medicaid Application.

3.4.2.3.8. Hospital and Skilled Nursing Facility referrals do not require LTC Medicaid application verification.

3.4.2.4. The Initial Level of Care Screen shall include, but is not limited to the following:

3.4.2.4.1. A review of financial eligibility information

3.4.2.4.2. A review of the Level of Care Screen information

3.4.2.4.3. A review of relevant medical, educational, social, or other assessment records or information when applicable.

3.4.2.4.4. A review of all community living information and options as an alternative to nursing facility/institutionalized care.

3.4.3. Annual Level of Care Screen Reassessment

3.4.3.1. Contractor shall conduct an Annual Reassessment Level of Care Screen no earlier than 90 Calendar Days prior to and no later than 30 Calendar Days prior to the current Level of Care Screen certification end date.

3.4.3.2. An Off-Cycle Review event type shall be utilized when a Level of Care Screen is needed outside of the Annual Reassessment cycle, due to a material change in the Member's condition that can reasonably be expected to result in a change in the Level of Care or Target Criteria eligibility.

3.4.3.2.1. In the event Contractor fails to conduct the Annual Reassessment Level of Care Screen for a Member enrolled in a HCBS waiver or CFC, Contractor shall be responsible for reimbursing any providers for services rendered during the gap in eligibility.

3.4.3.2.2. Contractor shall follow 10 C.C.R. 2505-10, Section 8.7202.M et seq. when transferring a Member from one county to another county or from one Defined Service Area to another Defined Service Area.

3.4.3.2.3. Contractor shall take action regarding Member Medicaid eligibility within one Business Day of receipt from the eligibility site.

3.4.3.2.4. In the event Contractor fails to discontinue waiver services for a Member found ineligible for a HCBS waiver or CFC, Contractor shall be responsible for reimbursing any providers for services rendered.

3.4.4. **PERFORMANCE STANDARD**: 100% of Initial Level of Care Screen and Annual Level of Care Screen assessments are conducted within required timelines at 10 CCR 2505-10, Sections 8.7202.E et seq. and 8.7202.F et seq. and are entered into the Department prescribed system. The Level of Care Screen must be entered into the Department's prescribed system following the timelines at 10 CCR 2505-10 Section 8.7202.E et seq.

3.4.4.1. Members shall be notified at the time of the eligibility decision that they have the right to appeal the actions of Contractor to 10 CCR 2505-10 Section 8.057 et seq. and 8.7202.R The notification shall include the right to request a fair hearing before an Administrative Law Judge.

3.4.5. Needs Assessment

3.4.5.1. Contractor shall conduct an Initial and Annual Needs Assessment for the following programs:

3.4.5.1.1. HCBS Waivers

3.4.5.1.2. Community First Choice

3.4.5.2. Contractor shall conduct a Needs Assessment (Initial) prior to enrollment into a HCBS waiver, annually (Reassessment), and as needed (off-cycle) by the Member due to a material change of situation or condition that may reasonably result in a change in the support needs of the Member. Members who are financially eligible, who choose to enroll in HCBS waiver services, and who meet the required Level of Care for LTSS and waiver Target Criteria for one of more HCBS waivers must have a Needs Assessment conducted.

3.4.5.2.1. Contractor shall conduct a Needs Assessment with Members to determine the level of support needed and identify personal preferences and goals.

3.4.5.2.2. Contractor shall explain to the Member the option to respond to required questions only or the choice to answer additional voluntary questions in the Needs Assessment.

3.4.5.3. Contractor shall conduct and document a Needs Assessment for Members in accordance with the following timelines:

3.4.5.3.1. Within 15 Business Days after determination of Level of Care and Financial eligibility for HCBS Waivers.

3.4.5.3.2. The Needs Assessment shall be administered prior to the Person-Centered Support Plan being developed with the Member; however, both the Needs Assessment and Person-Centered Support Planning may occur during a single session with the Member. However, they may also be completed over two or more sessions, if the Member needs or prefers to do so.

3.4.5.3.3. The Needs Assessment shall be conducted at time, modality, and location convenient for the Member and should include people of the Member's identified preference.

3.5. At-Risk Diversion

3.5.1. Contractor shall:

3.5.1.1. Outreach the identified At-Risk Diversion individuals in conjunction with timelines determined by the Department to ensure basic health and safety needs in the community are being met to avoid nursing facility placement.

3.5.1.2. Initial Outreach shall include any Member's first occurrence on the at-risk determination list as indicated by the Department.

3.5.1.2.1. At-Risk Diversion activities shall include, but are not limited to:

3.5.1.2.2. Assessing the effectiveness of current support and services to determine if there is a need for additional resources, supports, and/or services.

3.5.1.2.3. Support in assessing if the individual has become eligible for any other resources including community resources and other Medicaid resources.

3.5.1.2.4. Documenting all At-Risk Diversion activities in detail in the Department's prescribed system within 10 Business Days of the activity.

3.5.1.2.5. Maintaining all supporting documentation and make it available to the Department upon request.

3.5.1.2.5.1. **DELIVERABLE**: At-Risk Diversion Invoice

3.5.1.2.5.2. **DUE**: Monthly, by the 15th

3.6. Rapid Reintegration

3.6.1. Contractor shall initiate the Rapid Reintegration if applicable, during the LOC Assessment for Nursing Facility.

3.6.1.1. Contractor shall provide Members information about community-based services using the Member preference guide available on the Department's prescribed system and website.

3.6.1.2. Contractor shall complete the Rapid Reintegration within the Department's prescribed system if the Member expresses a desire to return to the community.

3.6.1.3. Contractor shall ensure the Rapid Reintegration includes the Rapid Reintegration barrier questions and either the Rapid Reintegration Plan or Rapid Referral as determined by the Department's prescribed system.

3.6.1.4. Contractor shall ensure that any referrals deemed necessary during the Rapid Reintegration process are completed within 2 Business Days of the LOC Assessment.

3.6.1.5. Contractor shall complete the post Rapid Reintegration satisfaction survey at the next scheduled contact with the Member or within 90 Calendar Days of the transition, whichever is earlier. The Rapid Reintegration survey shall be completed with any Member transitioning from a Nursing Facility to the community that received a Rapid Reintegration Plan or Rapid Referral.

3.6.1.6. **DELIVERABLE**: Rapid Reintegration Diversion Invoice

3.6.1.7. **DUE**: Monthly, by the 15th

3.7. Supports Intensity Scale-A Assessment

3.7.1. Contractor shall conduct a Supports Intensity Scale-A (SIS) assessment for all HCBS-DD and HCBS-SLS enrollments and reassessments when criteria set forth at 10 C.C.R. 2505-10 Section 8.612 et seq. are met. Contractor shall not be reimbursed for an SIS assessment prior

to the individual being determined eligible for a waiver through the Level of Care Screen and confirmation of financial eligibility. Contractor shall not be reimbursed for SIS reassessments without prior authorization from the Department to conduct the SIS reassessment.

3.7.2. Contractor shall conduct all initial SIS Assessments within 60 Calendar Days from the date of the Initial Level of Care Screen. Contractor shall conduct all SIS reassessments within 60 calendar days from the date of approval from the Department.

3.7.3. Contractor shall enter the SIS Assessment into SIS-A Online within 65 Calendar Days of completing the Level of Care Screen.

3.7.4. Contractor shall complete the SIS-A assessment and enter it into SIS-A Online prior to the Prior Authorization Review (PAR) Date.

3.8. Interim Support Level Assessment Pilot

3.8.1. Contractor shall establish one point of contact for Interim Support Level Assessment (ISLA) related processes and communications.

3.8.2. Contractor shall conduct an ISLA for all initial HCBS-DD and HCBS-SLS enrollments when the criteria set forth at 10 C.C.R. 2505-10 Section 8.7202.AA et seq. are met, and the enrollee has never had a SIS-A Assessment. Contractor shall not be reimbursed for an ISLA prior to the individual being determined eligible for a waiver through the Level of Care Assessment (ULTC 100.2) and confirmation of financial eligibility.

3.8.3. Contractor shall conduct all initial ISLAs within 60 Calendar days from the date of the Initial Level of Care Assessment (100.2).

3.8.4. Contractor shall upload the ISLA into the Department's prescribed system within 10 Business Days of the assessment date.

3.8.5. Contractor shall submit a list of all pilot ISLAs completed on an invoice template prescribed by the Department.

3.8.5.1. **DELIVERABLE**: Completed ISLA Invoice

3.8.5.2. **DUE**: Monthly, by the 15th

3.8.6. Contractor shall complete the ISLA prior to the Prior Authorization Request (PAR) Start Date.

3.9. HCBS-CES Applications

3.9.1. Contractor shall complete initial and CSR applications for persons applying for the HCBS-CES waiver as set forth by the Department's prescribed guidelines.

3.9.2. Initial HCBS-CES applications shall be submitted to the designated entity for review no more than 30 Calendar Days after the initial LOC is completed or no more than 30 Calendar Days after the Applicant/family has chosen enrollment onto the HCBS-CES waiver.

3.9.3. CSR HCBS-CES applications shall be submitted to the designated entity in accordance with timelines as set forth by the Department in order to prevent any break in services.

3.9.4. Contractor shall maintain all HCBS-CES applications and supporting documentation and make it available to the Department upon request.

3.10. HCBS-CHRP Support Need Level Assessment

3.10.1. Contractor shall conduct a Support Need Level Assessment for all HCBS-CHRP enrollments and re-assessments as set forth by the Department's prescribed guidelines.

3.10.2. Contractor shall conduct an initial Support Need Level Assessment within 45 Calendar Days from the date of the Initial Level of Care Assessment. Contractor shall conduct all reassessments as necessary when individual's needs change.

3.10.3. Contractor shall submit a list of all completed HCBS-CHRP Support Need Level Assessments on a template prescribed by the Department.

3.10.3.1. **DELIVERABLE**: Completed HCBS-CHRP Support Need Level Assessment List

3.10.3.2. **DUE**: Monthly, by the 15th

3.10.4. Contractor shall maintain all Support Need Level Assessments and supporting documentation and make it available to the Department upon request.

3.10.4.1. **PERFORMANCE STANDAND**: Support Need Level Assessment

3.10.4.2. **DUE**: Within 10 Business Days of the Department's request

4. STATE GENERAL FUND PROGRAM OBLIGATIONS

4.1. Service and Support Requirements

4.1.1. Contractor shall administer the three State General Fund Programs: State SLS, OBRA-SS, and FSSP and purchase services and supports for persons determined to be eligible under this Contract. If Contractor has been determined to be the only willing and qualified provider by the Department for the Defined Service Area, Contractor must administer the State Programs and purchase and/or provide services and supports for persons determined to be eligible under this Contract. Contractor shall not be responsible for guaranteeing services to eligible persons under this Contract if there are no Providers available to provide services and supports. Contractor must ensure separation of case management responsibilities and the provision of services for both State SLS and OBRA-SS.

4.1.2. Contractor shall ensure that written notifications are provided to individuals and Members informing them of their rights and the potential influence Contractor has on the Service Planning process, such as exercising free choice of providers.

4.1.3. Contractor shall provide the individual, Members, and/or guardian with written information about how to file a provider agency complaint as well as how to make a complaint against Contractor.

4.1.4. Contractor shall have procedures for a dispute resolution process, as described in 10 C.C.R. 2505-10, Section 8.7202.S et seq., when an action to terminate, change, reduce or deny services is initiated by the provider service agency.

4.2. State General Fund Service Expenditure Reporting

4.2.1. Contractor shall report all State SLS, FSSP, and OBRA-SS direct service expenditures on the template provided by the Department. All services must be reported and reimbursed within the fiscal year the service is provided.

4.2.1.1. **DELIVERABLE**: State General Fund Program Service Expenditure Reports

4.2.1.2. **DUE**: Monthly, by the 15th of each month or Fiscal Year end close date determined by the Department for the month of June.

4.2.2. Adjustments to direct service expenditures must be added to the next direct service expenditure report submitted by Contractor at the time of discovery. If the adjustment is identified after the close of the fiscal year the service is rendered, Contractor must report the adjustment to the Department within 10 Business Days of discovery and a check must be sent to the Department with the amount of the overpayment in addition to details about the overpayment to include member name, program, services, and dollar amount.

4.2.3. Contractor shall verify all services are supported with required documentation as required in 10 C.C.R. 2505-10 Sections 8.7560 et seq., 8.7561 et seq., and 8.7202.V et seq.

4.3. State Supported Living Services (State SLS)

4.3.1. General Requirements

4.3.1.1. Contractor shall operate the State SLS program pursuant to 10 C.C.R. 2505-10 Section 8.7560et seq.

4.3.1.2. Contractor shall not add surcharges to the purchase of covered services for State SLS.

4.3.1.3. Contractor shall provide a list of qualified providers for all services to Members and families, during the State SLS Individual Support Plan process, and to other interested parties upon request.

4.3.1.4. Contractor shall provide or coordinate with local service providers to provide community services to individuals enrolled in State SLS who meet the intellectual and developmental disabilities criteria and the eligibility requirements for the specific program required in 10 C.C.R. 2505-10 Section 8.7560 et seq.

4.3.1.5. The Department will notify Contractor of the target number of individuals that shall be served through State SLS prior to the start of each State Fiscal Year (SFY). Contractor may choose to enroll more individuals in State SLS than authorized, ensuring all individuals can be served within the funding allocated. Target caseload is calculated using the unique number of members that receive direct services during the contract period.

4.3.2. State SLS Eligibility

4.3.2.1. Contractor shall determine eligibility for the State SLS program pursuant to 10 C.R.S. 2505-10 Section 8.7560.B et seq.

4.3.2.2. Eligibility for the State SLS program does not guarantee the availability of services and supports.

4.3.3. State SLS Individual Support Plans

4.3.3.1. Pursuant to 10 C.R.S. 2505-10 Section 8.7560.D et seq. all State SLS Members must have a State SLS ISP.

4.3.3.2. Contractor shall develop a State SLS Individual Support Plan (State SLS ISP) within 10 Business Days after an initial Individual Support Plan (ISP) meeting for those individuals not established with Contractor and with a Developmental Disability determination at time of referral. Contractor shall have up to 10 Business Days to complete additional meetings and/or assessments that allow for the creation of the State SLS ISP during this time. Contractor shall ensure the State SLS ISP is signed by all required parties prior to implementation.

4.3.3.3. The State SLS ISP shall be developed through an in-person meeting that includes, at a minimum, the individual seeking services and Contractor.

4.3.3.4. Contractor shall utilize the ISP within the Department's prescribed system.

4.3.3.5. Contractor shall document and finalize all ISP information in the Department's prescribed system within 10 Business Days of the date of the initial ISP meeting.

4.3.3.5.1. **PERFORMANCE STANDARD**: Contractor shall ensure that 100% of the State SLS ISPs are developed within 10 Business Days of the individual's referral to a State General Fund program or after the initial ISP meeting.

4.3.3.6. The State SLS ISP shall be effective for no more than one year and reviewed by Contractor at least every six months in an in-person monitoring contact.

4.3.3.7. If an individual seeks additional supports or alleges a change in need, Contractor shall review and update the ISP prior to changing the authorized services and supports.

4.3.4. State SLS Ongoing Case Management

4.3.4.1. Contractor shall utilize appropriated funds to perform Case Management duties in accordance with 10 C.C.R. 2505-10 Section 8.7560.E et seq.:

4.3.4.1.1. Intake and referral.

4.3.4.1.2. Determining program eligibility.

4.3.4.1.3. Supporting individuals with learning and accessing other community resources.

4.3.4.1.4. Developing a State SLS Individual Support Plan.

4.3.4.1.5. Maintaining the determination of eligibility for services and supports.

4.3.4.1.6. Providing service and support authorization and coordination.

4.3.4.1.7. Program transition coordination.

4.3.4.1.8. Case Management, policy, and regulation training.

4.3.4.1.9. Service records maintenance.

4.3.4.1.10. Utilization review.

4.3.4.2. Contractor shall document all ongoing case management activities in detail in the Department's prescribed system within 10 Business Days of the activity.

4.3.4.3. The use of mass email communication, robotic and/or automatic voice messages cannot be used to replace Contractor's required individualized case management activities.

4.3.4.4. State SLS Monitoring

4.3.4.4.1. State SLS Monitoring shall be person centered and include at least one in person contact with the Member and three additional monitoring contacts per year using the individual's selected modality; in person or virtual and should be discussed and determined based on Member preference and need.

4.3.4.4.1.1. The Member's selected modality must be documented within the case notes for each monitoring contact within the Department's prescribed system.

4.3.4.4.2. State SLS Monitoring activities shall include, but not be limited to:

4.3.4.4.2.1. Monitoring all services and supports delivered pursuant to the State SLS Individual Support Plan.

4.3.4.4.2.2. Assessing the effectiveness of the State SLS supports and services.

4.3.4.4.2.3. Assessing if additional State SLS supports and services are needed.

4.3.4.4.2.4. Support in assessing if the individual has become eligible for any other resources including community resources and other Medicaid resources.

4.3.4.4.2.5. Reviewing health and safety concerns.

4.3.4.4.2.6. Reviewing any Critical Incidents.

4.3.4.4.3. Contractor shall document all monitoring activities in detail in the Department's prescribed system within 10 Business Days of the activity.

4.3.4.4.3.1. PERFORMANCE STANDARD: 100% of monitoring activities shall occur at the required quarterly interval.

4.3.4.5. State SLS Transfers

4.3.4.5.1. Contractor shall manage State SLS transfers in accordance with 10 C.R.S 2505-10 Section 8.7560.F et seq.

4.3.4.6. State SLS Direct Services

4.3.4.6.1. Contractor shall utilize appropriated funds to provide or subcontract with providers to provide services to support individuals with an intellectual and developmental disability living in the community in accordance with 10 C.C.R. 2505-10 Section 8.7560.H.

4.3.4.7. State SLS Records Maintenance

4.3.4.7.1. Contractor shall maintain supporting documentation capable of substantiating all expenditures and shall make it available to the Department upon request as required in 10 C.C.R. 2505-10 Section 8.7560.H et seq.

4.3.4.7.2. Receipts, invoices, and service logs must contain, at a minimum: Member name, service description, provider name, first and/or last date of service, service rate, and amount due or paid.

4.3.4.7.3. If Contractor does not maintain supporting documentation in the required format for all services rendered, the Department may recover these funds pursuant to 10 C.C.R. 2505-10 Section 8.076 et seq.

4.3.4.7.4. Through ongoing monitoring, Contractor shall ensure all services reimbursed by Contractor are rendered by service providers in accordance with the State SLS Individual Support Plan.

4.3.4.7.5. Contractor shall attempt to resolve any discrepancies with the service provider directly.

4.3.4.7.6. Contractor shall notify the Department of any instances of suspected fraud or waste, and any supporting documentation at the time of discovery.

4.3.4.7.7. Contractor shall notify all service providers that all records and supporting documentation related to services rendered through State SLS are subject to

inspection and recovery by the Department pursuant to 10 C.C.R. 2505-10 Section 8.076 et seq.

4.4. Omnibus Budget Reconciliation Act of 1987 Specialized Services (OBRA-SS)

4.4.1. Contractor shall provide or arrange for the provision of OBRA-SS to any individual where the Pre-Admission Screening and Resident Review (PASRR) Level II Evaluation identified the need for placement into a nursing facility and need for additional specialized services. Contractor shall ensure the OBRA-SS being provided are listed on the individual's Notice of Determination (NOD). Contractor shall ensure that OBRA-SS are related to the individual's intellectual or developmental disability or related condition and individualized to the resident's needs.

4.4.2. PASRR Level II Evaluation

4.4.2.1. Contractor will review the PASRR Level II Evaluations received from the Skilled Nursing Facility or State appointed vendor prior to developing an OBRA-SS Individual Support Plan or providing services.

4.4.3. Maintaining Eligibility and Enrollment

4.4.3.1. Contractor shall enroll individuals into OBRA-SS, if the individual resides in a nursing facility, demonstrates a need, and agrees to receive services.

4.4.3.2. Upon approval of the nursing facility admission by the State Intellectual Disability Authority and receipt of the Final Notice of Determination, Contractor shall send referrals to providers for OBRA-SS within 10 Business Days from the date the PASRR Notice of Determination is issued and/or received from the Skilled Nursing Facility or State appointed vendor.

4.4.3.3. Contractor shall maintain Member records within the Department prescribed system. All changes to OBRA-SS enrollments, shall be entered into the Department prescribed system within 10 Business Days of the change. The Department may adjust the number of authorized enrollments based on fluctuating enrollments. If the individual does not receive OBRA-SS within one calendar month Contractor shall inactivate the individual's record in the Department prescribed system.

4.4.4. OBRA-SS Individual Support Plans

4.4.4.1. Contractor shall develop an OBRA-SS Individual Support Plan (ISP) within 10 Business Days after an initial ISP meeting for those individuals not established with Contractor and with a Developmental Disability determination at time of referral. Contractor shall have up to 10 Business Days to complete additional meetings and/or assessments that allow for the creation of the OBRA-SS ISP during this time. Contractor shall ensure the OBRA-SS ISP is signed by all required parties prior to implementation.

4.4.4.2. The OBRA-SS ISP shall be developed through an in-person meeting that includes, at a minimum, the individual seeking services and Contractor.

4.4.4.3. Contractor shall utilize the ISP template within the Department's prescribed System.

4.4.4.4. Contractor shall document and finalize all ISP information in the Department's prescribed system within 10 Business Days of the date of the initial ISP meeting.

4.4.4.4.1. **PERFORMANCE STANDARD:** Contractor shall ensure that 100% of the OBRA-SS Individual Support Plans are developed within 10 Business Days of the individual's referral to a State General Fund program or after the initial ISP meeting.

4.4.4.5. The OBRA ISP shall be effective for no more than one year and reviewed by Contractor at least every six months in an in-person monitoring contact.

4.4.4.6. If a member seeks additional supports or alleges a change in need, Contractor shall review and update the ISP prior to changing the authorized services and supports.

4.4.4.7. Contractor shall maintain all OBRA-SS ISPs and supporting documentation and make them available to the Department upon request.

4.4.5. OBRA-SS Ongoing Case Management

4.4.5.1. Contractor shall utilize appropriated funds to perform Case Management duties to include:

4.4.5.1.1. Intake and referral.

4.4.5.1.2. Verifying a PASRR Level II Evaluation and Skilled Nursing Facility residency.

4.4.5.1.3. Developing an OBRA-SS Individual Support Plan.

4.4.5.1.4. Maintaining the determination of eligibility for services and supports.

4.4.5.1.5. Providing service and support authorization and coordination.

4.4.5.1.6. Ensuring there is not a duplication of authorized services with the services provided in the nursing facility.

4.4.5.1.7. Program transition coordination.

4.4.5.1.8. Service records maintenance.

4.4.5.1.9. Case Management, policy, and regulation training.

4.4.5.1.10. Utilization review.

4.4.5.2. Contractor shall document all ongoing case management activities in detail in the Department's prescribed system within 10 Business Days of the activity.

4.4.5.3. The use of mass email communication, robotic and/or automatic voice messages cannot be used to replace Contractor's required individualized case management activities.

4.4.6. OBRA-SS Monitoring

4.4.6.1.1. Monitoring shall be person centered and include at least one in person contact with the Member and three additional monitoring contacts per year using the individual's selected modality; in person or virtual and should be discussed and determined based on Member preference and need. The Member's selected modality must be documented within the narrative for each monitoring contact within the Department's prescribed system.

4.4.6.2. Monitoring activities shall include but not be limited to:

4.4.6.2.1. Monitoring all services and supports delivered pursuant to the OBRA-SS ISP.

4.4.6.2.2. Assessing the effectiveness of the supports and services.

4.4.6.2.3. Assessing if additional supports and services are needed.

4.4.6.2.4. Support in assessing if the individual has become eligible for any other resources including community resources or other Medicaid resources.

4.4.6.2.5. Reviewing health and safety concerns.

4.4.6.2.6. Reviewing any Critical Incidents.

4.4.6.3. Contractor shall document all monitoring activities in detail in the Department's prescribed system within 10 Business Days of the activity.

4.4.6.3.1. **PERFORMANCE STANDARD:** 100% of monitoring activities shall occur at the required quarterly interval.

4.4.7. OBRA-SS Direct Services

4.4.7.1. Contractor shall not utilize OBRA-SS funds to purchase mental health related services. Contractor shall seek provision of, or payment for, mental health services for those individuals through the Medicaid-funded mental health system or other local sources of funding.

4.4.7.2. Contractor shall not utilize or authorize OBRA-SS funds to provide or purchase services and supports that are covered and provided by the nursing facility.

4.4.7.3. Contractor shall utilize appropriated funds to provide services or coordinate with a provider to support individuals with intellectual and developmental disabilities living in a nursing facility. Contractor shall not utilize funding for services that are provided by the Nursing Facility through Medicaid reimbursement. Services eligible through OBRA include:

4.4.7.3.1. Assistive Technology

4.4.7.3.2. Behavioral Consultation

4.4.7.3.3. Behavioral Line Services

4.4.7.3.4. Behavioral Counseling

4.4.7.3.5. Behavioral Counseling Group

4.4.7.3.6. Behavioral Plan Assessment

4.4.7.3.7. Day Habilitation - Specialized Habilitation

4.4.7.3.8. Day Habilitation - Supported Community Connections

4.4.7.3.9. Dental – Basic

4.4.7.3.10. Dental – Major

4.4.7.3.11. Mileage

4.4.7.3.12. Other Public Conveyance

4.4.7.3.13. Prevocational Services

4.4.7.3.14. Recreational Facility Fees/Passes

4.4.7.3.15. Job Coaching – Individual

4.4.7.3.16. Job Coaching – Group

4.4.7.3.17. Job Development – Individual

4.4.7.3.18. Job Development – Group

4.4.7.3.19. Job Placement

4.4.7.3.20. Vision

4.4.7.4. Services must be provided in accordance with the service definitions found in 10 C.C.R. 2505-10 Section 8.7500 et seq.

4.4.8. OBRA-SS Records Maintenance

4.4.8.1. Contractor shall maintain supporting documentation capable of substantiating all expenditures and shall make it available to the Department upon request as required in 10 C.C.R. 2505-10 Section 8.130.2 et seq.

4.4.8.1.1. Receipts or invoices must contain, at a minimum: Member name, service description, provider name, first and/or last date of service, service rate, and amount due or paid.

4.4.8.2. If Contractor does not maintain supporting documentation in the required format for all services rendered, the Department may recover these funds pursuant to 10 C.C.R. 2505-10 Section 8.076 et seq.

4.4.8.3. Through ongoing monitoring, Contractor shall ensure all services reimbursed by Contractor are rendered by service providers in accordance with the OBRA-SS Individual Support Plan.

4.4.8.4. Contractor shall attempt to resolve any discrepancies with the service provider directly.

4.4.8.5. Contractor shall notify the Department of any instances of suspected fraud and any supporting documentation at the time of discovery.

4.4.8.6. Contractor shall notify all service providers that all records and supporting documentation related to services rendered through OBRA-SS are subject to inspection and recovery by the Department pursuant to 10 C.C.R. 2505-10 Section 8.076 et seq.

4.4.8.7. Mental Health Services Prohibited

4.4.8.7.1. Contractor shall not utilize state funds to purchase mental health related services for individuals with intellectual disabilities who are Medicaid eligible and who also have a Medicaid covered mental health diagnosis.

4.4.8.7.2. Contractor shall seek provision of, or payment for, mental health services for those individuals through the Medicaid funded mental health system or other local sources of funding.

4.5. Family Support Services Program (FSSP)

4.5.1. Contractor shall administer and provide or purchase Family Support Services pursuant to §25.5-10-305, C.R.S. and 10 C.C.R. 2505-10 Section 8.7561 et seq.

4.5.2. Eligibility, Needs Assessment, and Prioritization of Families

4.5.2.1. Contractor shall determine individual eligibility for the FSSP pursuant to 10 C.R.S 2505-10 Section 8.7561.C.

4.5.2.2. After FSSP eligibility has been determined, Contractor shall conduct an FSSP Needs Assessment prior to authorizing services. Contractor shall develop a Needs Assessment Tool that is, at a minimum, inclusive of all requirements outlined in 10 C.C.R 2505-10

Section 8.7561.F and have documented scoring criteria for the tool. The tool shall be included in Contractor's policies and procedures.

4.5.2.2.1. **DELIVERABLE**: Needs Assessment Tool Template and Scoring Criteria

4.5.2.2.2. **DUE**: Annually, by August 15th

4.5.2.3. Any revisions to the needs assessment tool template and scoring criteria must be submitted to the Department within 10 Business Days of the updated tool being implemented.

4.5.2.4. Contractor shall assess all families, both on the waiting list as "As Soon as Available" and currently receiving FSSP services, for level of need on an annual basis in accordance with 10 CCR 2505 Section 8.7561.F et seq.

4.5.2.5. Contractor shall document all completed FSSP Needs Assessments within the Department's prescribed system within 10 Business Days of completion of the assessment.

4.5.2.6. Contractor shall maintain all Needs Assessment documentation and make it available to the Department upon request.

4.5.2.7. The Department will notify Contractor of the target number of individuals that shall be served through FSSP prior to the start of each State Fiscal Year (SFY). Contractor may choose to enroll more individuals in FSSP than targeted, ensuring all individuals can be served within the funding allocated. Target caseload is calculated using the unique number of members that receive direct services during the contract period.

4.5.3. Family Support Plans (FSP)

4.5.3.1. Contractor shall ensure that individuals and families enrolled in the FSSP have an individualized Family Support Plan (FSP) which meets the requirements of an Individualized Plan, as defined in Section 25.5-10-202 et seq. and 25.5-10-211 C.R.S prior to receiving services.

4.5.3.2. Contractor shall develop the FSP within 10 Business Days after an initial Individualized Support Plan (ISP) meeting for those individuals not established with Contractor and with a Developmental Disability or Delay Determination at the time of referral. Contractor shall ensure the FSP is signed by all required parties prior to implementation.

4.5.3.3. The FSP shall be developed through by, at a minimum, a family representative, and Contractor.

4.5.3.3.1. Contractor shall ensure that FSPs are developed within 10 Business Days of the Most in Need Assessment being authorized.

4.5.3.4. The FSP shall be effective for no more than one year.

4.5.3.5. If the Member seeks additional supports or alleges a change in need, Contractor shall review and update the FSP prior to changing the authorized services and supports.

4.5.3.6. Contractor shall document and finalize all FSP information in the Department's prescribed system within 10 Business Days of the initial FSP meeting.

4.5.4. FSSP Ongoing Case Management

4.5.4.1. Pursuant to 10 C.R.S 2505-10 Section 8.7561.G Contractor shall provide case management for the FSSP, to include coordination of services provided for individuals with an IDD or Developmental Delay that consists of facilitating enrollment, assessing needs, locating, coordinating, and monitoring needed FSSP funded services, and monitoring the effective and efficient provision of services across multiple funding sources.

4.5.4.2. Contractor shall not charge families to provide direct services and case management for Family Support Services.

4.5.4.3. Contractor shall provide a list of qualified providers for appropriate services to applicants, Member(s), and families, during the individualized planning process, and to other interested parties upon request.

4.5.4.4. Contractor shall utilize appropriated funds to perform case management duties in accordance with 10 CCR 2505 8.7561.G et seq. to include:

4.5.4.4.1. Development, application assistance, and annual re-evaluation of the Family Support Plan (FSP) which shall be conducted at least once per year and include making changes to the FSP as indicated.

4.5.4.4.2. Providing service authorization and support coordination to include but not limited to assessing the effectiveness of FSSP supports and services.

4.5.4.4.3. Ensuring all services and supports are delivered in accordance with the FSP.

4.5.4.4.4. Coordinating with families to obtain required documentation for services.

4.5.4.4.5. Supporting the individual in assessing eligibility for other community and/or Medicaid resources.

4.5.4.4.6. Program transition coordination.

4.5.4.4.7. Service records maintenance.

4.5.4.4.8. Case Management, policy, and regulation training.

4.5.4.4.9. Utilization review.

4.5.4.5. Contractor shall document all ongoing case management activities in detail in the Department's prescribed system within 10 Business Days of the activity.

4.5.4.6. The use of mass email communication, robotic and/or automatic voice messages cannot be used to replace Contractor's required individualized case management activities.

4.5.5. FSSP Direct Services

4.5.5.1. Contractor shall utilize appropriated FSSP funds to purchase services and/or reimburse or advance funds to families for expenses that are incurred as a result of supporting the family and/or individual with an intellectual or developmental disability or delay living in the family home.

4.5.5.2. Contractor shall only authorize and advance or reimburse services that are needed as a result of the individual's Intellectual and Developmental Disability or Developmental Delay and shall not be approved if the need is a typical age-related need. The correlation between the need and the disability must be documented in the FSP.

4.5.5.3. Contractor shall ensure that all services are provided in the most cost-effective manner, meaning the least expensive manner to meet the need.

4.5.5.4. Contractor shall ensure that all services are authorized pursuant to the FSP.

4.5.5.5. Contractor shall utilize FSSP funds to provide funding to families for expenses referenced in §25.5-10-305(a-j), C.R.S and 10 C.R.S. 2505-10 Section 8.7561.D Contractor shall not authorize or provide any service that is not outlined in these regulations.

4.5.5.6. Contractor shall ensure the authorized services through FSSP are not duplicative of other resources the family has access to, including HCBS waivers, CFC, third party insurance, etc.

4.5.5.7. Contractor shall prioritize funding for the FSSP pursuant to 10 C.R.S 2505-10 Section 8.7561.F et seq.

4.5.6. Family Support Council

4.5.6.1. Contractor shall establish and maintain a Family Support Council (FSC) pursuant to §25.5-10-304 et seq., C.R.S. and 10 C.C.R. 2505-10 Section 8.7561.B et seq.

4.5.6.2. Contractor shall ensure that the FSC is comprised primarily of individuals in services, family members, and guardians of individuals enrolled in FSSP.

4.5.6.3. Contractor shall submit a list of FSC members annually.

4.5.6.3.1. **DELIVERABLE**: FSC Member List

4.5.6.3.2. **DUE**: Annually, by August 15th

4.5.6.4. Contractor shall notify the Department in writing of any changes to the FSC within 10 Business Days.

4.5.6.4.1. **DELIVERABLE**: FSC Member Updates

4.5.6.4.2. **DUE**: Within 10 Business Days of the date of change to the FSC members

4.5.6.5. Contractor shall provide orientation and training to all FSC members on the duties and responsibilities of the FSC. The training and orientation shall be documented with a record of the date of the training, who provided the training, training topic, and names of attendees. Contractor shall make the training and orientation materials available to the Department upon request.

4.5.6.6. Contractor shall ensure the FSC fulfills all duties outlined in 10 C.C.R. 2505-10 Section 8.7561.B et seq. Contractor shall document the meeting minutes and submit them to the Department. Contractor shall maintain all supporting documentation related to an FSC meeting and make it available to the Department upon request.

4.5.6.6.1. **DELIVERABLE**: FSC Meeting Minutes

4.5.6.6.2. **DUE**: Monthly, by the 15th of each month and by June 30th

4.5.7. FSSP Evaluation

4.5.7.1. In coordination with the FSC, Contractor shall be responsible for evaluating the effectiveness of the FSSP on an annual basis. Contractor shall ensure the annual program evaluation addresses all areas required in 10 CCR 2505-10 Section 8.7561.I et seq.

4.5.7.2. Contractor shall provide the Annual Evaluation Report to the Department for review and approval.

4.5.7.2.1. **DELIVERABLE**: Annual Evaluation Report

4.5.7.2.2. **DUE**: Annually, by June 1st

4.5.8. FSSP Annual Program Report

4.5.8.1. Contractor shall create and submit an FSSP Annual Program Report to the Department. The FSSP Program Report shall contain all requirements outlined in 10 CCR 2505-10 Section 8.7561.K et seq. Council member signatures approving the report must be submitted as a separate attachment to the Annual Program Report. Contractor must ensure the Annual Program Report does not contain Member PHI.

4.5.8.2. Contractor shall provide the FFS Program Report to the Department for review and approval.

4.5.8.2.1. **DELIVERABLE**: FSSP Annual Program Report and Council Signature Page

4.5.8.2.2. **DUE**: Annually, by October 1st

4.5.9. FSSP Records Maintenance

4.5.9.1. Contractor shall maintain supporting documentation capable of substantiating all expenditures and reimbursements made to providers, Members and/or families.

4.5.9.2. When Contractor purchases services or items directly for Members and/or families, Contractor shall:

4.5.9.2.1. Maintain receipts or invoices from the service provider and documentation demonstrating that the provider was paid by Contractor.

4.5.9.2.1.1. Receipts or invoices must contain, at a minimum: Member and/or family name, provider name, first and/or last date of service, item(s) or service(s) purchased, item(s) or service(s) cost and amount due or paid.

4.5.9.3. When Contractor reimburses Members and/or families for services or items, Contractor shall:

4.5.9.3.1. Ensure the Member and/or family provides Contractor with receipts or invoices prior to reimbursement.

4.5.9.3.1.1. Maintain receipts or invoices from the Member and/or family, and documentation demonstrating that the individual and/or family was reimbursed by Contractor.

4.5.9.3.2. Ensure all receipts or invoices provided by the Members and/or family contain, at a minimum: Member and/or family name, provider name, first and/or last date of service, item(s) or service(s) purchased, items(s) or service(s) cost, and amount paid.

4.5.9.4. When Contractor provides funding to Members and/or families for the purchase of services or items in advance, Contractor shall include, but is not limited to:

4.5.9.4.1. Establish policies and procedures outlining Contractor's processes for advancing funds, ensuring supporting documentation is received by the Member and/or family, and remedial action steps Contractor will take if supporting documentation is not received. The policies and procedures shall identify timelines and shall be made available to the Department upon request.

4.5.9.4.2. Notify the Member and/or family that they are required to submit invoices or receipts to Contractor of all purchases made prior to the close of the State Fiscal Year.

4.5.9.4.3. Ensure the Member and/or family provides Contractor with receipts or invoices.

4.5.9.4.4. Maintain receipts or invoices from the Members and/or family, and documentation demonstrating that the Members and/or family was provided with advanced funds by Contractor.

4.5.9.4.4.1. Ensure all receipts or invoices provided by the Members and/or family contain, at a minimum: Members and/or family name, provider name, first and/or last date of service, item(s) or service(s) purchased, items(s) or service(s) cost, and amount paid.

4.5.9.4.5. Contractor shall ensure the documentation received by the Member and/or family indicates that the amount was paid.

4.5.9.4.6. If a Member and/or family does not submit invoices or receipts, Contractor shall document all attempts to obtain receipts or paid invoices and any remedial action taken. Contractor shall make all supporting documentation available to the Department upon request.

4.5.9.4.7. If Contractor cannot provide supporting documentation as described in this section, the Department may recover any unsubstantiated expenditure from Contractor.

4.5.9.5. Contractor shall ensure supporting documentation is recorded for all FSSP dollars for multiple family services to include a detailed description of the service provided and the date(s) of service.

4.5.9.5.1. Contractor shall ensure all program expenses related to multiple family expenses can be substantiated through time tracking, wage costs, benefit costs, or any other supporting documentation to verify expenses related to proving the services.

5. DATA ENTRY, DATA MONITORING, AND OVERSIGHT

5.1. Individual/Member Records

5.1.1. Contractor shall:

5.1.1.1. Comply with all reporting and billing policies and procedures established by the Department, document individual and Member records within the Department's prescribed systems and adhere to the system requirements provided by the Department for these systems. Systems include, but are not limited to, the Colorado interChange Medicaid Management Information System (MMIS) and its subsystems: Bridge HCBS PAR subsystem and the Care and Case Management (CCM) System. Contractor shall have access to member eligibility, PAR, and claims data through reporting provided through a COGNOS data query application.

5.1.1.2. Maintain individual and Member records within the Department's prescribed systems for the purposes of individual and Member information management.

5.1.1.3. Maintain accurate and detailed documentation of all case management and State General Fund Program activities required through the Contract.

5.1.1.4. Maintain accurate and detailed supporting documentation of all activities required through this Contract to substantiate reimbursement and make all documentation

available to the Department upon request if not documented within the Department's prescribed systems.

5.1.1.5. Correct 100% of data errors discovered by the Department and confirm the accuracy of the data entered into the Department prescribed system within 10 Business Days of notification from the Department of an error.

5.1.1.5.1. **PERFORMANCE STANDARD:** 100% of data errors corrected within 10 Business Days of notification.

5.1.1.6. Develop and implement a plan to conduct, at minimum, an annual data integrity review. That includes, but is not limited to, the following:

5.1.1.6.1. Member program records completeness and accuracy as directed by the Department.

5.1.1.6.2. Member demographic information completeness and accuracy.

5.1.1.6.3. Member care team provider and team staff accuracy and completeness, as directed by the Department.

5.1.1.7. **DELIVERABLE**: Data Integrity and Data Quality Policies and Procedures

5.1.1.8. **DUE**: Annually, October 1st after the Contract Start Date or within 10 Business Days as revisions are made.

5.2. Systems Access and Training

5.2.1. Contractor shall develop and implement policies and procedures to internally oversee data integrity and data quality to include but not limited to how Contractor will:

5.2.1.1. Ensure all staff receive the required systems training as specified in this Contract.

5.2.1.2. Be responsible for management of user access and timely revocation for required systems to include the CCM, MMIS, Bridge, COGNOS, and PeakPro.

5.2.1.3. Ensure all provision forms are reviewed and submitted accurately and completely within at least 14 Calendar Days prior to needing access. Any forms submitted without all necessary information are subject to resubmission and delay.

5.2.1.4. Ensure all revocation forms are submitted immediately upon knowledge of license user's separation of employment.

5.2.1.5. Conduct an internal audit of all provisioned user licenses monthly or quarterly to ensure that the list of users is up to date, permissions are accurate, and revocation forms are submitted in a timely manner.

6. ACCOUNTING

6.1. Contractor's accounting methods shall conform to the standards of Generally Accepted Accounting Principles (GAAP), and any updates thereto, throughout the Term of the Contract.

6.2. Contractor shall establish and maintain internal control systems and standards that apply to the operation of the organization.

6.3. Contractor shall assure, all financial documents are filed in a systematic manner to facilitate audits, all prior years' expenditure documents are maintained for use in the budgeting process and for audits, and records and source documents are made available to the Department, its contracted representative, or an independent auditor for inspection, audit, or reproduction.

6.4. Contractor shall establish any necessary cost accounting systems to identify the application of funds and record the amounts spent.

6.5. Contractor shall document all transactions and funding sources, and this documentation shall be available for examination by the Department within 10 Business Days of the Department's request.

6.5.1. **DELIVERABLE**: Transaction and Funds Documentation

6.5.2. **DUE**: Within 10 Business Days of the Department's Request

7. SUBRECIPIENT STATUS AND REQUIREMENTS

7.1. Contractor has been determined to be a Subrecipient under 2 CFR Chapter I, Chapter II, Part 200 et al. Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (Uniform Guidance); Final Rule (the "Final Rule"), released December 26, 2013, and subsequently updated, and thus shall be required to follow all requirements and guidance contained in the Final Rule.

7.2. Single Audits

7.2.1. Under the Final Rule, all Non-Federal Entities, as defined in the Final Rule, expending $1,000,000.00 or more from all federal sources (direct or from pass-through entities) must have a single or program-specific audit conducted for that year in accordance with Subpart F of the Final Rule.

7.2.2. Contractor shall notify the State when expected or actual expenditures of federal assistance from all sources equal or exceed $1,000,000.00.

7.2.3. If the expected or actual expenditures of federal assistance from all sources do not equal or exceed $1,00,000.00 Contractor shall provide an attestation to the State that they do not qualify for a Single Audit.

7.2.4. Pursuant to the Final Rule §200.512 (a)(1) the Single Audit must be completed and submitted to the Department within the earlier of 30 Calendar Days after receipt of the auditor's report(s), or nine months after the end of the audit period. If the due date falls on a Saturday, Sunday, or federal holiday, the reporting package is due the next Business Day.

7.2.4.1. **DELIVERABLE**: Single Audit

7.2.4.2. **DUE**: Within the earlier of 30 Calendar Days after receipt of the auditor's report(s), or nine months after the end of the audit period

7.2.5. If Contractor did not receive enough federal funds to require a Single Audit, Contractor shall submit an attestation form stating a Single Audit was not required utilizing the Department's template.

7.2.5.1. **DELIVERABLE**: Attestation Form

7.2.5.2. **DUE**: Within the earlier of 30 Calendar Days after receipt of the auditor's report(s), or nine months after the end of the audit period

7.2.6. The audit period shall be Contractor's fiscal year.

7.3. Treatment of Funds

7.3.1. All funding identified as a subaward with matching federal dollars received through this Contract is subject to the requirements within Uniform Guidance.

7.3.1.1. All subawards must be used on allowable expenses associated with performing the activities outlined in this Contract and on allowable expenses per Uniform Guidance.

7.3.1.2. Any subawards not used on the activities outlined in this Contract is subject to recovery at the end of the Period of Performance as identified by the Department.

7.4. Subcontracting Subawards

7.4.1. Contractor shall ensure any Subcontractors performing activities outlined in this Contract on behalf of the Contractor fulfill all obligations outlined within this Contract and all obligations of a subrecipient.

8. FINANCIAL TRANSPARENCY

8.1. Contractor shall comply with all transparency requirements pursuant to C.R.S. Title 25.5-6-1708.

8.2. Contractor shall ensure all documents are available on Contractor's website in an easily accessible location and format. Board of Director or Governing Body Changes

8.2.1. Contractor shall notify the Department in writing of any changes to the Board of Directors or Governing Body within 10 Business Days.

8.2.1.1. **DELIVERABLE**: Written notification of changes to Board of Director or Governing Body membership

8.2.1.2. **DUE**: Within 10 Business Days of the effective date

9. COMPENSATION AND INVOICING

9.1. State General Fund Program Allocations

9.1.1. The Department will notify Contractor in writing of Contractor’s individual allocation for State SLS, OBRA-SS, and FSSP for each State Fiscal Year.

9.1.2. Reimbursement for activities and services performed by Contractor shall not exceed the maximum amount identified in Contractor’s individual allocation. Activities and services must be rendered during the State Fiscal Year.

9.1.3. The Department, in its sole discretion, may increase or decrease Contractor’s individual allocations under this Contract by notifying Contractor’s Representative. Increases or decreases in the amount of State funding during the term of this Contract may be made by written notice by the Department to Contractor or by amendment of the Contract. The circumstances may include but shall not be limited to:

9.1.3.1. If necessary to fully utilize program appropriations.

9.1.3.2. Adjustments to reflect prior year final contract utilization and current year expenditures.

9.1.3.3. Supplemental appropriation changes resulting in an increase or decrease in the amounts originally appropriated and available for the purposes of this program.

9.1.3.4. Closure of programs and/or termination of related contracts.

9.1.3.5. Delay or difficulty in implementing new programs or services.

9.1.3.6. Other special circumstances as deemed necessary by the Department.

9.1.3.7. Changes in Member utilization due to changing needs, new enrollments, terminations, and/or delays in services.

9.1.3.8. Target caseloads not being met.

9.2. State General Fund Program Target Caseloads

9.2.1. The Department will notify Contractor in writing of the target number of individuals that shall be served in State SLS, OBRA-SS, and FSSP prior to the start of each State Fiscal Year.

9.2.2. Contractor may choose to enroll more individuals in State SLS, OBRA-SS, and FSSP than authorized, ensuring all individuals can be served within the funding allocated.

9.2.3. Target caseload is calculated by the Department using the unique number of members that receive direct services during the contract period.

9.2.4. Contractor shall enroll members into OBRA-SS if the need for services is identified through the PASRR Level II and shall notify the Department if sufficient funding is not available in Contractor's individual allocation to support the individual's needs or to enroll a Member into the program.

9.2.5. Contractor shall redirect unallocated funding from one State General Fund program to another to fully utilize funding allocated and best serve member needs within the Defined Service Area. Contractor shall notify the Department if Contractor cannot use all of the funding allocated for State General Fund programs or if Contractor has additional funding needs that could support Members with unmet needs during the Fiscal Year.

9.3. State General Fund Program Compensation

9.3.1. The compensation under this Contract shall consist of rates-based reimbursement intended to cover the costs of all State General Fund activities provided through this Contract. The Department shall pay Contractor for the State SLS and OBRA-SS activities at the rates specified in Exhibit C, Rates. Direct services for State SLS and OBRA-SS shall be reimbursed at the rates posted and distributed on the Department's website on the Provider Rates and Fee Schedule. The Department shall pay Contractor for FSSP activities at the rates specified in Exhibit C, Rates. Direct services for FSSP shall be reimbursed at one dollar per unit.

9.3.2. The liability of the State, at any time, for such payment shall be limited to the unexpended amount remaining of such funds available to the Department.

9.3.3. Payments shall be made in accordance with rates as specified in Exhibit C, Rates of this Contract as determined by the Department and may be amended during the term of the contract using an Option Letter. When Contractor's maximum allocation of State funding has been paid to Contractor, no additional funds shall be provided under this Contract.

9.3.4. Payment pursuant to this Contract is contingent upon Contractor, or subcontractor(s), securing and properly maintaining all necessary licenses, certifications, approvals, etc., required to properly provide the services or goods covered by the contract.

9.3.5. The rates specified in Exhibit C; Rates are determined by the approved appropriation from the Colorado General Assembly. The Department, at its discretion, shall have the option to increase or decrease these rates as the Department determines is necessary based on its approved appropriation or to correct an administrative error in rate calculations. To exercise this option, the Department shall provide written notice to Contractor in a form substantially similar to the Sample Option Letter in the original Contract, and any new rates table or exhibit shall be effective as of the effective date of that notice unless the notice provides for a different date. The Department may modify the rates shown in this section based on the

Medicaid Provider rate increases or decreases authorized by the Colorado legislature or due to an administrative error. If the Department does modify these rates, the Department may modify them using an Option Letter.

9.3.6. The rates for State SLS and OBRA-SS direct services will be posted on the Department's website on the Provider Rates and Fee Schedule. Contractor shall bill all FSSP direct services at one dollar per unit.

9.4. Adjustments to Fund Disbursement Amounts

9.4.1. The Department reserves the right to adjust during the Contract period and post-period adjustment to disbursements following the end of the Contract period, or an adjustment to the Fiscal Year contract if:

9.4.2. Contractor does not achieve the Performance Standards identified for each program.

9.5. Case Management Agency Compensation

9.5.1. The compensation under this Contract shall consist of rates-based reimbursement intended to cover the costs of all activities provided through this Contract.

9.5.2. Contractor will receive payment as specified in Exhibit C, Rates.

9.5.2.1. The rates specified in Exhibit C are determined by the approved appropriation from the Colorado General Assembly. The Department, at its discretion, shall have the option to increase or decrease these rates as the Department determines necessary based on its approved appropriation or to correct an administrative error in rate calculations. To exercise this option, the Department shall provide written notice to Contractor in a form substantially similar to the Sample Option Letter in the original Contract, and any new rates table or exhibit shall be effective as of the effective date of that notice unless the notice provides for a different date. The Department may modify the rates shown in this section based on the Medicaid Provider rate increases or decreases authorized by the Colorado legislature or due to an administrative error. If the Department does modify these rates, the Department may modify them through the use of an Option Letter.

9.6. Rural or Urban Designation

9.6.1. The Department shall determine whether Contractor is a Rural and Frontier or an Urban agency.

9.7. Detailed Invoicing and Payment Procedures

9.7.1. Applications – HCBS-CES

9.7.1.1. Contractor shall submit all HCBS-CES applications to the Department's vendor for review and approval, as directed by the Department. The Department will pay for initial application per person applying for HCBS-CES per year, as well as CSR HCBS-CES application each year thereafter. The Department will not pay for initial or CSR applications that were denied due to being incomplete. Incomplete applications include any application that did not contain: a signature page, a completed Level of Care, DD or Delay Determination date, dates of service, or partial application (missing pages) which are required from Contractor necessary to process the application. An incomplete application denial is different than a denial for the client not meeting nighttime and/or daytime criteria. The Department will pay for HCBS-CES applications from reports

received by the Department's vendor on the 11th of the month for assessments from the previous month.

9.7.2. Appeal Packets and Hearing Attendance

9.7.2.1. Contractor shall ensure that all Appeal Packets and Hearing Attendance information is entered into the Department prescribed system within the required timeframe. The Department will pay for all Appeal Packets and Hearing Attendances from data pulled from the Department prescribed system on the 15th day of the month for Appeal Packets and Hearing Attendance from the previous month. Contractor shall maintain all supporting documentation and packets related to all Appeals.

9.7.3. At-Risk Diversion

9.7.3.1. Contractor shall complete all At-Risk Diversion activities as required by the Department and shall invoice the Department for all completed contacts by the 15th day of the month for all contacts completed in the previous month. The Department will pay for contacts once the invoice and supporting documentation is reviewed and accepted.

9.7.4. Case Management Training

9.7.4.1. Contractor shall submit the Case Management Training deliverable. Contractor will receive payment once the Department has reviewed and accepted the Deliverable. If the original submission is rejected by the Department, Contractor shall not receive payment until a revised deliverable has been received and accepted by the Department. If a case manager did not receive one or more of the required trainings prior to being assigned independent duties, Contractor shall not receive payment for the Deliverable until all trainings have been provided. Contractor shall have 30 Calendar Days to provide any outstanding trainings and resubmit the Deliverable.

9.7.5. Community Advisory Committee Updates

9.7.5.1. Contractor shall submit the Committee Updates Deliverable. Contractor shall receive payment once the Department has reviewed and accepted the Deliverable. If the Deliverable shows that no committee meeting updates have been included, Contractor shall not receive payment for the Deliverable.

9.7.6. Complaint Log and Trend Analysis

9.7.6.1. Contractor shall submit a quarterly Complaint Log and Trend Analysis deliverable. Contractor will receive payment once the Department has reviewed and accepted the Deliverable. If the original submission is rejected by the Department, Contractor shall not receive payment until a revised deliverable has been received and accepted by the Department.

9.7.7. Community First Choice Training

9.7.7.1. Contractor shall receive a one-time payment for completing Community First Choice trainings as directed by the Department. The payment will be based on an allocation calculated by the Department based on funding availability, the time required for training completion, and the average number of case managers participating.

9.7.8. Continuous Quality Improvement Plan

9.7.8.1. Contractor shall submit the Continuous Quality Improvement Plan deliverable and updates. Contractor shall receive payment once the Department has reviewed and

accepted the Deliverable. If the original submission is rejected by the Department, Contractor shall not receive payment until a revised deliverable has been received and accepted by the Department.

9.7.9. Critical Incident Quarterly Follow-Up Completion and Entry Performance Standard

9.7.9.1. Contractor is eligible to receive a quarterly performance-based payment for timely completion of the requested HCBS CIR follow-up action. To receive this quarterly performance-based payment, Contractor must have 90% of all CIRs assigned follow-up completed and entered into the Department's prescribed system within the timelines assigned by the Department and/or Department Quality Improvement Organization. The Department will calculate Contractor's performance at the close of each quarter to determine if Contractor will be awarded the performance-based payment. HCBS and SGF CIRs will be calculated and paid separately.

9.7.10. Critical Incident Reports and Critical Incident Report Administrative Review: HCBS IDD Waivers

9.7.10.1. Contractor shall ensure all CIRs have been entered in the Department prescribed system within the required timeframe. The Department will pay per Member enrolled each month based on actively enrolled Members pulled from the Department prescribed system on the 15th day of the month for HCBS-CES, HCBS-CHRP, HCBS-DD, and HCBS-SLS enrollments from the previous month.

9.7.11. Critical Incident Reports: HCBS LTSS Waivers

9.7.11.1. Contractor shall ensure all CIRs have been entered in the Department prescribed system within the required timeframe. The Department will pay per Member enrolled each month based on actively enrolled Members pulled from the Department prescribed system on the 15th day of the month for CHCBS, HCBS-BI, HCBS-CIH, HCBS-CLLI, HCBS-CMHS, and HCBS-EBD.

9.7.12. Critical Incident Reporting and Critical Incident Report Administrative Review State SLS, OBRA-SS, FSSP

9.7.12.1. Contractor shall ensure all CIRs have been entered in the Department prescribed system within the required timeframe. The Department will pay for all State SLS, OBRA-SS, and FSSP CIRs MANE and CIRs non-MANE based on data pulled from the Department's prescribed system on the 15th day of the month for CIRS from the previous month.

9.7.13. Developmental Disability and Delay Determinations

9.7.13.1. Contractor shall input all disability determinations into the Department prescribed system within the required timeframes. The Department will pay disability determinations, based on data pulled from the Department prescribed system on the 15th day of the month for determinations from the previous month.

9.7.14. Direct Services: State SLS, OBRA-SS, FSSP

9.7.14.1. Contractor shall submit the State General Fund program direct service expenditure report invoice for all direct service expenditures for State SLS, OBRA-SS, and FSSP by the 15th of each month. The Contract shall receive reimbursement for allowable direct services not to exceed maximum for State General Fund programs for all reimbursable activities for the fiscal year.

9.7.15. Testing for IDD Determinations

9.7.15.1. Contractor shall obtain prior approval from the Department for IDD Determination Testing funding by invoicing the Department each month for the costs of IDD Determination testing by the 15th day of the month. If approved, the Department will pay for the actual cost of testing once the request has been approved and the invoice has been reviewed and accepted. All invoices shall be submitted in the format prescribed by the Department.

9.7.16. Family Support Council Meetings

9.7.16.1. Contractor shall submit meeting minutes to the Department for FSC meetings attended by the 15th day of the month for meetings attended in the previous month, and by June 30th or the Fiscal Year end close date determined by the Department for all meetings attended in June. The Department will pay for up to six FSC meetings for the Designated Service Areas attended within the Fiscal Year once the invoice has been reviewed and accepted. Contractor shall maintain all supporting documentation related to an FSC meeting and make it available to the Department upon request.

9.7.17. FSSP Annual Report

9.7.17.1. Contractor shall submit an FSSP Report on an annual basis to the Department. Contractor shall receive payment for the Annual FSSP Report after it has been reviewed and accepted by the Department.

9.7.18. FSSP Evaluation Report

9.7.18.1. Contractor shall submit an FSSP Evaluation Report on an annual basis to the Department. Contractor shall receive payment for the FSSP Evaluation Report after it has been reviewed and accepted by the Department.

9.7.19. HCBS-DD Waiting List Enrollment Capacity Building

9.7.19.1. The Department will pay Contractor for each new member enrolled into the HCBS-DD waiver from the waiting list as authorized by the Department and as funding is appropriated and earmarked by the General Assembly. The Department will determine which HCBS-DD enrollments from the waiting list qualify for capacity building funding as defined in this Contract.

9.7.20. Human Rights Committee: HCBS IDD Waivers

9.7.20.1. Contractor shall create all HRC packets in accordance with Department requirements and timeframes. Contractor shall maintain all supporting documentation related to a Human Rights Committee meeting and make it available to the Department upon request. The Department will pay per member enrolled each month based on actively enrolled members pulled from the Department prescribed system on the 15th day of the month for HCBS-CES, HCBS-CHRP, HCBS-DD, and HCBS-SLS enrollments from the previous month.

9.7.21. Human Rights Committee Packet Creation: State SLS, OBRA-SS, FSSP

9.7.21.1. Contractor shall invoice the Department for all State SLS, OBRA-SS, and FSSP member packets created during a Human Rights Committee meeting by the 15th day of the month for all meetings held in the previous month. The Department will pay for each packet

created once the invoice has been reviewed and accepted. All invoices shall be submitted in the format prescribed by the Department.

9.7.22. Interim Support Level Assessments

9.7.22.1. Contractor shall maintain all supporting documentation related to the Interim Support Level Assessment and make it available to the Department upon request. Contractor shall invoice the Department by the 15th day of the month for all assessments completed in the previous month. The Department will pay for assessments once the invoice and supporting documentation are reviewed and accepted.

9.7.23. Level of Care Screen: Initial and Reassessments

9.7.23.1. Contractor shall conduct and enter all initial and reassessment Level of Care Screens into the Department's prescribed system within the required timeframes. The Department will pay for initial and reassessment Level of Care Screens based on data pulled from the Department's prescribed system on the 15th day of the month for Screens conducted in the previous month.

9.7.24. Long-Range Plan

9.7.24.1. Contractor shall submit a Long-Range Plan on an annual basis and present it to the Department. Contractor shall receive payment for the Long-Range Plan after it has been reviewed and accepted by the Department.

9.7.25. Monitoring Contacts: State SLS and OBRA-SS

9.7.25.1. Contractor shall conduct and enter all monitoring contacts for State SLS and OBRA-SS into the Department's prescribed system within the required timeframe. Contractor shall receive payment for the four required monitoring contacts per service plan year. The Department will pay for monitoring contacts based on data pulled from the Department's prescribed system on the 15th day of the month for contacts conducted in the previous month.

9.7.26. Most in Need Assessment: FSSP

9.7.26.1. Contractor shall conduct and enter all completed Needs Assessments into the Department's prescribed system within the required timeframe. Contractor shall receive payment for one Needs Assessment for members enrolled or on the FSSP ASAA waiting list per fiscal year. The Department will pay for Needs Assessments each month based on data pulled from the Department's prescribed system on the 15th day of the month for assessments conducted in the previous month.

9.7.27. Needs Assessment: Initial and Reassessment

9.7.27.1. Contractor shall conduct and enter all initial and reassessment Needs Assessments into the Department's prescribed system within the required timeframes. The Department will pay for initial and reassessment Needs Assessments based on data pulled from the Department's prescribed system on the 15th day of the month for assessments conducted in the previous month.

9.7.28. Ongoing Case Management: State SLS, OBRA-SS, FSSP

9.7.28.1. Contractor shall conduct and enter all ongoing case management activities for State SLS, OBRA-SS, and FSSP into the Department's prescribed system within the required timeframe. Contractor shall receive one ongoing case management payment each month

per member for allowable activities completed. The Department will pay for ongoing case management activities based on data pulled from the Department's prescribed system on the 15th day of the month for activities conducted in the previous month.

9.7.29. Operations Guide

9.7.29.1. Contractor shall develop an Operations Guide that meets all requirements outlined in this Contract for year one. Contractor shall receive payment for the Operations Guide once the deliverable has been reviewed and accepted by the Department.

9.7.30. Operations Guide Updates

9.7.30.1. Contractor shall review the Operations Guide for years two, three, four, and five of this Contract, and determine if any modifications are required. Updates shall include but not be limited to any changes in the Work, in the Department's processes and procedures, or in Contractor's processes and procedures. Contractor shall submit the Annual Operations Guide Update as well as a summary of all changes to the Department or an explanation demonstrating that the Operations Guide was reviewed, and Contractor determined that no edits were necessary. The Department shall review the Operations Guide Update and the summary to determine whether significant modifications were completed. Contractor shall receive payment for the updated Operations Guide only after the Department has determined that significant changes were made, and the Department has accepted the Deliverable. If minor changes or no changes were completed Contractor shall not receive payment for this deliverable. The Department does not consider changes such as updating dates, contact information or locations to be significant changes.

9.7.31. Rapid Reintegration

9.7.31.1. Contractor shall conduct and enter all Rapid Reintegration activities at the Level of Care Assessment into the Department's prescribed system within the required timeframes. The Department will pay for Rapid Reintegration based on an invoice template provided by the Department or data pulled from the Department's prescribed system on the 15th day of the month for Rapid Reintegration completed in the previous month. Rapid Reintegration shall include reimbursement for completing Rapid Reintegration barrier questions, assessment and support, and post survey questions.

9.7.32. Rural Travel Add-On for Rural and Frontier Counties

9.7.32.1. Contractor shall receive an additional payment for Rural Travel Add-On for Rural and Frontier Counties for the following activities only: initial and Reassessment Level of Care Screen, initial and Reassessment Needs Assessment, At-Risk Diversion, State SLS and OBRA-SS In-Person Monitoring, and State SLS and OBRA-SS In-Person Individualized Support Plans. Payment shall be based on approved invoices or data pulled from the Department prescribed system on the 15th day of the month for activities from the previous month.

9.7.33. SIS-A Assessments

9.7.33.1. Contractor shall enter all SIS assessments into SIS Online by the last day of the month. The Department will pay for all SIS-A Assessments from data pulled from the Department prescribed system on the 15th day of the month for assessments from the previous month. Reassessment requests must be reviewed and accepted by the Department prior to completion, entry, and payment.

9.7.34. Support Need Level Assessment - HCBS-CHRP

9.7.34.1. Contractor shall maintain all supporting documentation related to the Support Need Level Assessment and make it available to the Department upon request. Contractor shall invoice the Department for all completed assessments by the 15th day of the month for all assessments completed in the previous month. The Department will pay for assessments once the invoice and supporting documentation is reviewed and accepted.

9.7.35. Training on the Colorado Single Assessment, and Person-Centered Support Plan Instruments and Streamlined Eligibility

9.7.35.1. Contractor shall receive a one-time payment for the training and oversight of Contractor's staff in performing the Colorado Single Assessment, and Person-Centered Support Plan. Payment will be made calculated based on the average number of staff as specified by the Department. This funding is subject to recovery if the number of staff trained is below the average number of staff as specified by the Department. Waiting List Management

9.7.36. Contractor shall enter all waiting list management contacts with individuals and families into the Department prescribed system within the required timeframe. The Department will pay for required waiting list contacts from data pulled from the Department prescribed system on the 15th of the month for contacts from the previous month or using an invoice developed by the Department. The Department shall not pay for more than one contact per individual (18 and older) on the HCBS-DD ASAA, See Date and Safety Net waiting list and State SLS, OBRA-SS, or FSSP ASAA waiting list per year. Contractor shall only be reimbursed for one waiting list contact for the HCBS-DD, State SLS or FSSP waiting list when the event occurs during the same contact.

9.7.37. Year End Close Deadlines

9.7.37.1. The due dates identified in this section shall be adhered to, and information entered into the Department's prescribed systems and/or submitted to the Department by a date identified in this Contract. For the month of June, the Department will notify Contractor of the modified due date to account for year-end closing. Any submission past the assigned year end close date will not be reimbursed.

9.8. Payment and Billing Errors

9.8.1. Contractor shall review all payments made by the Department to ensure all activities are appropriately reimbursed.

9.8.2. Contractor shall notify the Department of any errors in billing or payment by the 15th of the month for the prior month's payment on the Department's prescribed template to ensure over and under payments are adjusted.

9.8.2.1. **DELIVERABLE**: Payment Correction Form

9.8.2.2. **DUE**: On the 15th of each month for corrections on the prior month's payment, with exception of June payments which must meet year-end close deadlines established by the Department. Contractor shall specify on the form if corrections have not been identified for the prior month's payment.

9.9. Unexpended Funds

9.9.1. Contractor shall remit any Subawards disbursed under this Contract that are not expended by the close of the Period of Performance.

9.10. Closeout Payments

9.10.1. Notwithstanding anything to the contrary in this Contract, all payments for the final month of this Contract shall be paid to Contractor no sooner than 10 Business Days after the Department has determined that Contractor has completed all the requirements of the Closeout Period.

EXHIBIT C-3, RATES

Case Management Agency (CMA) Subaward Rates Table				
Description	**Rate**	**Frequency**	**Payment Type**	**Funding Source**
Operations Guide	$7,905.56	Annually – Year 1 of the Contract	Deliverable	Federal/State Funded
Operations Guide Update	$1,424.14	Annually – Years 2+ of the Contract	Deliverable	Federal/State Funded
Long-Range Plan	$3,543.31	Annually	Deliverable	Federal/State Funded
Committee Updates	$1,071.73	Semi-Annually	Deliverable	Federal/State Funded
Continuous Quality Improvement Plan	$506.72	Annually	Deliverable	Federal/State Funded
Complaint Trend Analysis	$3,857.04	Quarterly	Deliverable	Federal/State Funded
Case Management Training	$648.75	Semi-Annually	Deliverable	Federal/State Funded
Creation of Packet - Appeals	$531.60	Per Packet	Report	Federal/State Funded
Attendance at Hearing - Appeals	$490.97	Per Hearing	Report	Federal/State Funded
IDD Critical Incident Reporting (HCBS – CES, HCBS – CHRP, HCBS – DD, HCBS – SLS)	$6.30	Monthly, Per Member Enrolled	Report	Federal/State Funded
LTSS Critical Incident Reporting (HCBS – BI, HCBS – CHCBS, CMHS, HCBS – EBD, HCBS – SCI, HCBS - CLLI)	$1.61	Monthly, Per Member Enrolled	Report	Federal/State Funded
HCBS Critical Incident Follow-Up Performance Standard	$3,457.07	Quarterly	Deliverable	Federal/State Funded
Human Rights Committee (HCBS – CES, HCBS – CHRP, HCBS – DD, HCBS – SLS)	$5.95	Monthly, Per Member Enrolled	Report	Federal/State Funded
Initial Level of Care Assessment (100.2)	$283.62	Per Assessment	Report	Federal/State Funded
CSR Level of Care Assessment (100.2)	$214.03	Per Assessment	Report	Federal/State Funded
Initial Level of Care Screen	$210.27	Per Screen	Report	Federal/State Funded

Annual Reassessment – Level of Care Screen	$195.63	Per Screen	Report	Federal/State Funded
Initial Needs Assessment – Required Questions Only	$265.49	Per Assessment	Report	Federal/State Funded
Annual Reassessment Needs Assessment – Required Questions Only	$249.20	Per Assessment	Report	Federal/State Funded
Initial Needs Assessment – Voluntary Questions Included	$331.87	Per Assessment	Report	Federal/State Funded
Annual Reassessment Needs Assessment – Voluntary Questions Included	$317.15	Per Assessment	Report	Federal/State Funded
Rapid Reintegration Barrier Questions	$48.54	Per Assessment	Invoice or Report	Federal/State Funded
Rapid Reintegration Assessment and Support	$107.73	Per Assessment	Invoice or Report	Federal/State Funded
Post Rapid Reintegration Survey Questions	$22.84	Per Survey	Invoice or Report	Federal/State Funded
SIS Assessment	$357.09	Per Assessment	Report	Federal/State Funded
Interim Support Level Assessment-Pilot	$294.17	Per Assessment	Report	Federal/State Funded
Initial At-Risk Diversion – In Person	$104.70	Monthly	Invoice or Report	Federal/State Funded
Initial At-Risk Diversion - Virtual	$87.45	Monthly	Invoice or Report	Federal/State Funded
HCBS-CHRP Support Level Needs Assessment	$165.26	Per Assessment	Invoice	Federal/State Funded
Initial HCBS-CES Application	$189.21	Per Application	Report	Federal/State Funded
CSR HCBS-CES Application	$142.76	Per Application	Report	Federal/State Funded
Medicaid Eligible IDD Determination	$458.81	Per Determination	Report	Federal/State Funded
Medicaid Eligible Delay Determination	$272.96	Per Determination	Report	Federal/State Funded
IDD Determination Testing	$481.10	Actual Costs up to Rate for Testing	Invoice	Federal/State Funded
Rural Travel Add-On	$37.46	Per Required in Person Contact for Rural and Frontier Agencies	Report	Federal/State Funded

Completed Training Plan for the Colorado Single Assessment and Person-Centered Support Plan	Calculated Allocation Based on Funding Availability	One-Time Payment	Deliverable	Federal/State Funded
Completed Training on Community First Choice	Calculated Based on Funding Availability	One-Time Payment	Deliverable	Federal/State Funded

Case Management Agency (CMA) State Only Rates Table				
Waiting List Management	$95.42	Per Contact	Report	State Funded
Non-Medicaid Eligible IDD Determination	$458.81	Per Determination	Report	State Funded
Non-Medicaid Eligible Delay Determination	$272.96	Per Determination	Report	State Funded
Non-Medicaid Eligible IDD Determination Testing	$481.10	Actual Costs up to Rate for Testing	Invoice	State Funded
State SLS, OBRA-SS, and FSSP Critical Incident Reporting & Investigation: MANE	$349.18	Per Incident	Report	State Funded
State SLS, OBRA-SS, and FSSP Critical Incident Reporting & Investigation: Non-MANE	$46.71	Per Incident	Report	State Funded
State SLS, OBRA-SS, and FSSP Human Rights Committee	$125.73	Per Member Reviewed	Invoice	State Funded
State SLS and OBRA-SS Complaints Trend Analysis	$220.69	Quarterly	Deliverable	State Funded
State SLS, OBRA-SS, and FSSP CIR Follow-Up Performance Standard	$51.81	Quarterly	Deliverable	State Funded
State SLS, OBRA-SS, and FSSP Ongoing Case Management	$91.67	Monthly, Per Activity	Report	State Funded
State SLS and OBRA-SS Monitoring – In Person	$104.70	Per Contact	Report	State Funded
State SLS and OBRA-SS Monitoring - Virtual	$87.45	Per Contact	Report	State Funded
State SLS Expenditure Report	$625.76	Monthly	Invoice	State Funded
OBRA-SS Expenditure Report	$369.56	Monthly	Invoice	State Funded

FSSP Needs Assessment	$33.25	Per Assessment	Report	State Funded
FSSP Expenditure Report	$556.57	Monthly	Invoice	State Funded
Family Support Council Meetings	$418.29	Per Meeting	Invoice	State Funded
FSSP Annual Report	$621.79	Annually	Deliverable	State Funded
FSSP Program Evaluation	$529.19	Annually	Deliverable	State Funded

EXHIBIT D-3, TERMINOLOGY

1. TERMINOLOGY

1.1. In addition to the terms defined in this Contract, the following list of terms shall be construed and interpreted as follows:

1.1.1. Adverse Action – A denial, reduction, termination, or suspension from a long-term service and support program or service.

1.1.2. Affiliated Entity – An organization that directly or indirectly controls another entity, has substantially similar ownership of another entity, and/or owns a substantial share of another entity.

1.1.3. Appeal – The process a case manager participates in when a Client or Member appeals an adverse action made by the case manager.

1.1.4. At Risk Diversion – is a Person-Centered process through which services are arranged or provided to enable a Member of an At-Risk Population to avoid admission to a nursing facility and live, instead, in a setting of their choice.

1.1.5. Behavioral Health Authorities (BHA) – The behavioral health administration established in Part 200 of Article 50 of Title 27, C.R.S.

1.1.6. Business Day – Any day in which the State is open and conducting business, but shall not include Saturday, Sunday, or any day which the State observes one of the holidays listed in C.R.S. §24–11–101(1).

1.1.7. Business Interruption – Any event that disrupts Contractor's ability to complete the Work for a period of time, and may include, but is not limited to a Disaster, power outage, strike, loss of necessary personnel or computer virus.

1.1.8. Care and Case Management System (CCM) – The Department's case management Information Technology (IT) platform.

1.1.9. Case Management – The assessment of a Member eligible to receive or receiving long-term services and supports, the development and implementation of a Support Plan for such Member, referral and related activities, the coordination and monitoring of long-term service and supports delivery, the evaluation of service effectiveness, and the periodic reassessment of such Member's needs.

1.1.10. Case Management Agency (CMA) – A public or private not-for-profit or for-profit organization contracted with the state of Colorado to provide case management services and activities pursuant to C.R.S. 25.5-6-1702.

1.1.11. Case Manager – A person who provides case management services and activities pursuant to Article 6 and Article 10 of C.R.S. Title 25.5 for members receiving long-term services and supports.

1.1.12. Child Health Plan Plus – Colorado's public low–cost health insurance for certain children and pregnant women. It is for people who earn too much to qualify for Health First Colorado, but not enough to pay for private health insurance.

1.1.13. Client – Any individual applying for or seeking information for LTSS.

1.1.14. Closeout Period – The period beginning on the earlier of 90 Calendar Days prior to the end of the last Extension Term or notice by the Department of its decision to not exercise its option for an Extension Term, and ending on the day that the Department has accepted the final deliverable for the Closeout Period, as determined in the Department–approved and updated Closeout Plan, and has determined that the closeout is complete.

1.1.15. Colorado Revised Statutes (C.R.S.) – The legal code of Colorado; the legal codified general and permanent statutes of the Colorado General Assembly.

1.1.16. Community Centered Board (CCB) – A private for-profit or not-for profit organization that is an administrator of locally generated funding pursuant to CRS 25.5-10-206(6) and acts as a resource for persons with an intellectual and developmental disability or a child with a developmental delay.

1.1.17. Community First Choice (CFC) - Services and supports authorized through the section 1915(k) of the Social Security Act and provided in community settings to an individual who requires an institutional level of care that would otherwise be provided in a Hospital, Nursing Facility, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID), an institution providing inpatient psychiatric services for individuals under age 21, or an institution for mental diseases for individuals age 65 or over.

1.1.18. Complaints – Any complaint received by Contractor as it relates to the services provided through this Contract to include, but not limited to general business functions, administration, State General Fund program functions, and case management functions. Excludes any complaints regarding activities outside the scope of this Contract.

1.1.19. Consumer-Directed Attendant Support Services (CDASS) – The service delivery option for services that assist an individual in accomplishing activities of daily living when included as a waiver benefit that may include health maintenance, personal care, and homemaker activities.

1.1.20. Contract – The agreement, including all attached Exhibits, all documents incorporated by reference, all referenced statutes, rules and cited authorities, and any future modifications thereto, that is entered into as a result of this solicitation.

1.1.21. Contract Funds – The funds that have been appropriated, designated, encumbered, or otherwise made available for payment by the State under the Contract resulting from this Solicitation.

1.1.22. Contractor – The individual or entity selected as a result of this solicitation to complete the Work contained in the Contract.

1.1.23. Contractor Pre–Existing Material – Material, code, methodology, concepts, process, systems, technique, trade or service marks, copyrights, or other intellectual property developed, licensed, or otherwise acquired by Contractor prior to the Effective Date of this Contract and independent of any services rendered under any other contract with the State.

1.1.24. Corrective Action Plan – A written plan, which includes the specific actions the agency shall take to correct non-compliance with regulations and contractual obligations, which stipulates the date by which each action shall be completed.

1.1.25. Critical Incident – An actual or alleged event that creates the risk of serious harm to the health or welfare of an individual receiving services; and it may endanger or negatively impact the mental and/or physical well-being of an individual.

1.1.26. Critical Incident Report (CIR) Mistreatment, Abuse, Neglect or Exploitation (MANE) – A Critical Incident Report entered into the Department prescribed system with a category of Mistreatment, Abuse, Neglect, or Exploitation.

1.1.27. Critical Incident Report (CIR) Non-MANE – A Critical Incident Report entered into the Department prescribed system with a category of criminal activity, damage to consumer's property/theft, death, injury/illness, medication management issues, missing persons, other high-risk issues, and unsafe housing/displacement.

1.1.28. Data – State Confidential Information and other State information resources transferred to Contractor for the purpose of completing a task or project assigned in the Statement of Work.

1.1.29. Deliverable – Any tangible or intangible object produced by Contractor as a result of the work that is intended to be delivered to the Department, regardless of whether the object is specifically described or called out as a "Deliverable" or not.

1.1.30. Department – The Colorado Department of Health Care Policy and Financing, a department of the government of the State of Colorado.

1.1.31. Designated Service Area – The geographical area determined by the State Department to be served by a Case Management Agency per C.R.S. 25.5-6-1702.

1.1.32. Disaster – An event that makes it impossible for Contractor to perform the Work out of its regular facility or facilities, and may include, but is not limited to, natural disasters, fire, or terrorist attacks.

1.1.33. Effective Date – The date on which the Contract resulting from this solicitation is approved and signed by the Colorado State Controller or designee, as shown on the Signature and Cover Page for the Contract.

1.1.34. Eligibility Determination – The eligibility of an individual for a Long-Term Services and Supports (LTSS) program is determined by meeting all the requirements of the program, including Level of Care Determination and financial eligibility.

1.1.35. Fraud – An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to that person or some other person and includes any act that constitutes fraud under any federal or state law.

1.1.36. Goods – Any movable material to be acquired, produced, or delivered by Contractor which shall include any movable material acquired, produced, or delivered by Contractor in connection with the Services.

1.1.37. Health First Colorado – Colorado's Medicaid program.

1.1.38. Health Insurance Portability and Accountability Act (HIPAA) – The Health Insurance Portability and Accountability Act of 1996, as amended.

1.1.39. Home and Community Based Services (HCBS) Waivers – Services and supports authorized through a 1915(c) waiver of the Social Security Act and provided in community settings to a client who requires an institutional level of care that would otherwise be provided in a Hospital, Nursing Facility, or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID). This includes: Children's Home and Community Based Services Waiver (CHCBS), Home and Community Based Services Waiver for Persons with Brain Injury (HCBS-BI), Home and Community Based Services Children's Extensive Services Waiver (HCBS-CES), Home and Community Based Services Children's Residential

Habilitation Program Waiver (HCBS-CHRP), Home and Community Based Services Waiver for Children with a Life Limiting Illness (HCBS-CLLI), Home and Community Based Services Community Mental Health Supports Waiver (HCBS-CMHS), Home and Community Based Services Waiver for Persons with Developmental Disabilities (HCBS-DD), Home and Community Based Services Waiver for Persons who are Elderly, Blind and Disabled (HCBS-EBD), Home and Community Based Services Supported Living Services Waiver (HCBS-SLS), and Home and Community Based Services Waiver for Persons with Spinal Cord Injury (HCBS-CIH).

1.1.40. Hospital Back-Up - A LTSS program for Members who have complex wound care and/or are ventilator-dependent or medically complex.

1.1.41. Incident – Any accidental or deliberate event that results in or constitutes an imminent threat of the unauthorized access or disclosure of State Confidential Information or of the unauthorized modification, disruption, or destruction of any State Records.

1.1.42. In-Home Services and Supports (IHSS) – Means services that are provided in the home and in the community by an Attendant under the direction of the client or client's Authorized Representative, including Health Maintenance Activities and support for activities of daily living or instrumental activities of daily living, Personal Care services and Homemaker services.

1.1.43. Intermediate Care Facility (ICF) - A residential facility that is certified by the Centers for Medicare and Medicaid (CMS) to provide habilitative, therapeutic and specialized support services to persons with intellectual and developmental disabilities. Intake, Screening and Referral – The initial contact between the individual and Contractor and shall include but is not limited to a preliminary screening in the following areas: a Client's need for long term services and supports; a Client's need for referral to other programs or services; a Client's eligibility for financial and program assistance; and the need for a Level of Care Screen and Needs Assessment of the Client seeking services.

1.1.44. Key Personnel – The position or positions that are specifically designated as such in the Contract.

1.1.45. Learning Management System (LMS) - An online software application for the administration, delivery and tracking of case management training programs and materials.

1.1.46. Level of Care – The level of assistance needed by an individual seeking services or a member to perform activities of daily living, to include mobility; bathing; dressing; eating; toileting; transferring; and need for supervision as determined by the Level of Care Screen.

1.1.47. Level of Care Determination – The eligibility determination of an individual for a Long-Term Services and Supports (LTSS) program by a Case Management Agency as determined by the requirements of the program, using the Department prescribed instrument.

1.1.48. Long Term Care notice of action – The form required to be sent to Clients by Contractor within 11 Business Days regarding their appeal rights in accordance with 10 CCR 2505-10 8.507 et seq.

1.1.49. Long Term Services and Supports (LTSS) – The services and supports used by Members of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities such as bathing, dressing, preparing meals, and administering medications.

1.1.50. Long Term Services and Supports (LTSS) Programs - Any of the following publicly funded programs: CHCBS, FSSP, HCBS-BI, HCBS-CES, HCBS-CHRP, HCBS-CLLI/CwCHN, HCBS-CMHS, HCBS-DD, HCBS-EBD, HCBS-CIH, HCBS-SLS, CFC, HBU, LTHH, Medicaid Nursing Facilities, OBRA-SS, PACE, State SLS.

1.1.51. Long Term Services and Supports Level of Care Eligibility Determination Screen (LOC Screen) – An evaluation conducted by the case manager with the individual seeking services and others chosen by the individual to participate (such as family members, friends, and/or caregivers), to determine an applicant or member's eligibility for long-term services and supports based on their need for institutional level of care as determined by utilizing the Department's prescribed instrument, with supporting diagnostic information from the Individual's medical providers, for the purpose of determining the Individual's level of functioning for admission or continued stay in Long-Term Services and Supports (LTSS) programs.

1.1.52. Medical Assistance (MA) Site - Designated sites allowed by statute or certified by the Department of Health Care Policy and Financing (Department) to process the State-authorized Medical Assistance application for the programs that are administered by the Department and determine eligibility for said programs.

1.1.53. Member – Any individual enrolled in the Colorado Medicaid program, State General Fund program, Colorado's CHP+ program or the Colorado Indigent Care Program, as determined by the Department.

1.1.54. National Core Indicators-Aging and Disabilities (NCI-AD) – Standard measures used across participating states to assess the quality of life and outcomes of seniors and adults with physical disabilities—including traumatic or acquired brain injury—who are accessing publicly-funded services through the Older Americans Act (OAA), Program of All-Inclusive Care for the Elderly (PACE), Medicaid, and/or state-funded programs. The project is coordinated by Advancing States and Human Services Research Institute (HSRI). NCI-AD data are gathered through yearly in-person Adult Consumer Surveys administered by state Aging, Disability, and Medicaid Agencies (or an Agency-contracted vendor) to a sample of at least 400 individuals in each participating state. NCI-AD data measures the performance of states' long-term services and supports (LTSS) systems and service recipient outcomes, helping states prioritize quality improvement initiatives, engage in thoughtful decision making, and conduct futures planning with valid and reliable LTSS data.

1.1.55. Needs Assessment - A comprehensive evaluation conducted by the case manager, using the Department prescribed instrument, with the individual seeking services or member and appropriate collaterals as requested and/or necessary (such as family members, advocates, friends and/or caregivers), and including supporting information from the individual's providers to determine the individual's service needs, goals, available resources, and potential funding resources.

1.1.56. Nursing Facility - A facility provider that meets the state nursing facility licensing standards established pursuant to C.R.S. §25-1.5-103 and is maintained primarily for the care and treatment of inpatients under the direction of a physician.

1.1.57. Offeror – Any individual or entity that submits a proposal, or intends to submit a proposal, in response to this solicitation.

1.1.58. Operational Start Date – When the Department authorizes Contractor to begin fulfilling its obligations under the Contract.

1.1.59. Organized Health Care Delivery System - A Case Management Agency that contracts with other qualified providers to furnish services authorized in the CHCBS, HCBS-BI, HCBS-CLLI, HCBS-CES, HCBS-CIH, HCBS-CHRP, HCBS-CMHS, HCBS-DD, HCBS-EBD, and HCBS-SLS waivers. CMAs are responsible for purchasing specific goods and services for members, authorized on the Person-Centered Support Plan, as set forth by the Department's prescribed guidelines for OHCDS.

1.1.60. Other Personnel – Individuals and Subcontractors, in addition to Key Personnel, assigned to positions to complete tasks associated with the Work.

1.1.61. Pandemic – Refers to an epidemic that has spread over several countries or continents, usually affecting a large number of people.

1.1.62. Period of Performance – Means the total estimated time interval between the start of an initial Federal award and the planned end date, which may include one or more funded portions, or budget periods. Identification of the period of performance in the Federal award per § 200.211(b)(5) does not commit the awarding agency to fund the award beyond the currently approved budget period.

1.1.63. Person-Centered Approach – Respecting and valuing individuals' and Members' preferences, strengths, and contributions.

1.1.64. Person-Centered Support Plan - A document, using the State-prescribed instrument, that identifies approved services, regardless of funding source, necessary to assist a member to remain safely in the community and develop in accordance with the Department rules. The plan includes the funding source, frequency, amount, and provider of each service and is developed with the member and people chosen by the member to identify goals, needed services, individual choices and preferences, and appropriate service providers based on the member's Assessment and knowledge of the individual and community resources and informs the member of their rights and responsibilities.

1.1.65. Person-Centered Support Planning – The process of working with the Member receiving services and people chosen by the Member to identify goals, needed services, individual choices and preferences, and appropriate service providers based on the Member seeking or receiving services, assessment, and knowledge of the Member and of community resources. Support planning informs the Member receiving services of his or her rights and responsibilities.

1.1.66. Personally Identifiable Information – Personally identifiable information including, without limitation, any information maintained by the State about an individual that can be used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, or biometric records; and any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information. PII includes, but is not limited to, all information defined as personally identifiable information in §24–72–501 C.R.S.

1.1.67. Pre-Admission Screening and Resident Review (PASRR) – The review that occurs for all Clients seeking admission to a Medicaid nursing facility to screen the Client for evidence of serious mental illness and/or intellectual and developmental disabilities or related conditions. The review determines whether the Client needs the level of services that a nursing facility

provides and whether Clients who need nursing facility services also need specialized services.

1.1.68. Professional Medical Information Page (PMIP) – The medical information document signed by a licensed medical professional used as a component of the Level of Care Screening and Assessment to determine the Client's or Member's need for an LTSS program.

1.1.69. Program – A publicly funded program including, but not limited to: Home and Community Based Services Waivers, CFC, Medicaid Nursing Facility, Hospital Back-Up, Program for All-Inclusive Care for the Elderly (PACE), Long Term Home Health (LTHH), and State General Funded (SGF) Programs.

1.1.70. Protected Health Information – Any protected health information, including, without limitation any information whether oral or recorded in any form or medium: **(i)** that relates to the past, present or future physical or mental condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and **(ii)** that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes, but is not limited to, any information defined as Individually Identifiable Health Information by the federal Health Insurance Portability and Accountability Act.

1.1.71. Provider – Any health care professional or entity that has been accepted as a provider in the Colorado Medicaid program, Colorado's CHP+ program or the Colorado Indigent Care Program, as determined by the Department.

1.1.72. Quality Improvement Strategy (QIS) – The Department's process to measure and improve its performance in meeting the HCBS waiver assurances annually as set forth in 42 CFR 441.301 and 441.302.

1.1.73. Quarter – Four (4) distinct time periods during the State Fiscal Year. Quarter one (1) begins on July 1 and ends September 30. Quarter two (2) begins on October 1 and ends December 31. Quarter three (3) begins on January 1 and ends March 31. Quarter four (4) begins on April 1 and ends June 30.

1.1.74. Rapid Referral – The Person-Centered process that occurs when a member, who is seeking admission to a nursing facility, does not oppose living in the Community, and is experiencing Unstable Housing, is rapidly referred to a Transition Coordinator to receive Transition Coordination Services.

1.1.75. Rapid Reintegration – the Person-Centered process that occurs when a member, who will be admitting into a nursing facility, does not oppose living in the Community, and is not experiencing Unstable Housing and receives services as described in the member's Rapid Reintegration Plan.

1.1.76. Rapid Reintegration Plan – a written Person-Centered plan developed for the purpose of rapidly transitioning a member(s) from a nursing facility and safely into the Community.

1.1.77. Regional Accountable Entity (RAE) – A single regional entity responsible for duties previously performed by Regional Care Collaborate Organizations and Behavioral Health Organizations (BHO).

1.1.78. Resource Development – The study, establishment and implementation of additional resources or services that extend the capabilities of community based LTSS systems to better

serve LTSS Clients and Members and those likely to need community based LTSS in the future.

1.1.79. Rural and Frontier – Defined Service Areas that are eligible for rural travel add-on reimbursement for required in-person activities reimbursed through this Contract.

1.1.80. Services – The services and activities to be performed by Contractor as set forth in this Contract and shall include any services and activities to be rendered by Contractor in connection with the Goods. Services identified through this Contract specifically exclude any Home and Community Based Services, State Plan Benefit Services, and other Medicaid services reimbursed through a Medicaid Provider Agreement.

1.1.81. Start–Up Period – The period starting on the Effective Date and ending on the Operational Start Date.

1.1.82. State – The State of Colorado, acting by and through any State agency.

1.1.83. State Fiscal Rules – The fiscal rules promulgated by the Colorado State Controller pursuant to C.R.S. §24–30–202(13)(a).

1.1.84. State Fiscal Year – The 12-month period beginning on July 1 of each calendar year and ending on June 30 of the following calendar year. If a single calendar year follows the term, then it means the State Fiscal Year ending in that calendar year.

1.1.85. State Intellectual Disability Authority (SIDA) – The person authorized by the Department to review PASRR Level II Evaluations and approve or deny a nursing facility admission for individuals with intellectual and developmental disabilities. SIDA issues the Letter of Determination to the nursing facility.

1.1.86. State General Fund Programs – Case management, services, and supports authorized by the General Assembly and provided in the family home, a community setting, or Nursing Facility using 100% General Fund dollars. Including, the Family Support Services Program (FSSP), State Supported Living Services Program (State SLS), and Omnibus Reconciliation Act of 1987 Specialized Services Program (OBRA-SS).

1.1.87. State Records – Any and all State data, information, and records, regardless of physical form, including, but not limited to, information subject to disclosure under CORA.

1.1.88. Subcontractor – Third parties, if any, engaged by Contractor to aid in performance of the Work.

1.1.89. Support Need Level Assessment - The standardized assessment tool to identify and measure the practical support requirements for HCBS-CHRP waiver participants.

1.1.90. Surcharge - Any additional amount added by Contractor, over and above the rate charged by the subcontractor to Contractor, which would be shown on an individual's service plan or on encounter data service rates submitted to the Department.

1.1.91. Target Criteria – Department defined criteria based on Member needs to access services under a HCBS waiver.

1.1.92. Targeted Case Management (TCM) – Required case management activities for Members enrolled in a HCBS waivers as defined in 10 CCR 2505-10 8.761.14 et seq. that are reimbursed as a State Plan benefit and through a Medicaid Provider Agreement. TCM activities are excluded from the Work within this Contract.

1.1.93. Waiting List - A list of otherwise eligible individuals established to manage selection of individuals' entrance into the waiver or State General Fund programs until approved capacity and funding become available.

1.1.94. Work – The delivery of the Goods and performance of the Services described in the Contract.

1.1.95. Work Product – The tangible and intangible results of the Work, whether finished or unfinished, including drafts. Work Product includes, but is not limited to, documents, text, software (including source code), research, reports, proposals, specifications, plans, notes, studies, data, images, photographs, negatives, pictures, drawings, designs, models, surveys, maps, materials, ideas, concepts, know–how, and any other results of the Work. "Work Product" does not include any material that was developed prior to the Effective Date that is used, without modification, in the performance of the Work.

2. ACRONYMS AND ABBREVIATIONS

2.1. The following list is provided to assist the reader in understanding certain acronyms and abbreviations used in this Contract:

2.1.1. CFC – Community First Choice

2.1.2. CFR – Code of Federal Regulations

2.1.3. CHP+ –Child Health Plan Plus

2.1.4. CORA – Colorado Open Records Act, C.R.S. §24–72–200.1, et. seq.

2.1.5. C.R.S. – Colorado Revised Statutes

2.1.6. CPI – Consumer Price Index

2.1.7. CPI-U – CPI for all urban consumers

2.1.8. HIPAA – Health Insurance Portability and Accountability Act of 1996, as amended.

2.1.9. MFCU – the Colorado Medicaid Fraud Control Unit in the Colorado Department of Law

2.1.10. PCI – Payment Card Information

2.1.11. PHI – Protected Health Information

2.1.12. PII – Personally Identifiable Information

2.1.13. SFY – State Fiscal Year

2.1.14. U.S.C. – United States Code

2.1.15. VARA – Visual Rights Act of 1990