Alliance State Forum

April 16, 2026

Questions from Alliance

CMA Guidance and Case Management Concerns

Continued guidance to remove Service Providers from the SP process is concerning, particularly when you have a CMA or CMA system that continues to do less for the IDD population. Some CMA functions/services provided to individuals with IDD are being eliminated.

- Members continue to have the choice of who is to be included at the Person-Centered Support Plan (PCSP) meeting (§8.7001.C.1(l)).

- CMA functions provided to members with IDD are not be eliminated.

It appears that the case management function for the IDD population is gradually being aligned with other disability populations, where CMAs provide fewer services and individuals may eventually be seen only once per year.

- CMAs continue to be required to conduct the Level of Care (LOC) Screen and one monitoring contact per certification period in person with the member. CMAs are required to conduct three additional monitoring contacts in person, using a virtual meeting platform, or by phone based on the member's preference (8.7100.A.30, 8.7202.K.2(c)(i)(5)(a), and 8.7202.K.2(c)(iv)(1)).
- CMAs continue to be required to conduct an Informed Consent Review Meeting with Members subject to Rights Modifications in person or using a virtual meeting platform based on the member's preference.
- When a member transfers from a CMA to another, the new CMA continues to be required to meet with the member in person within 10 days of transferring (8.7202.M.10).
- CMAs continue to be required to conduct the Support Level Assessment with the member in person or using a virtual meeting platform based on the member's preference (8.7202.AA.2(d)(iii)(6)).

CMA Guidance and Case Management Concerns (cont.)

Are various case management functions being eliminated?

- No, please see the Case Management Agency and Case Manager Roles and Responsibilities.

What is the overall plan for Case Management for individuals with IDD?

- The Department's expectation is that CMAs follow the policy and operational guidance outlined in rule, contract, memos, training, etc. to provide high quality case management to members with IDD.
- The Department is looking at ways that we can improve policies and processes that are person-centered while also relieving administrative burden to improve case management experience.

CMA Surveys

Will CMAs be surveyed by HCPF staff, and if so, how frequently?

- CMAs are surveyed by HCPF staff twice annually for quality and compliance.
  - Quality Improvement Strategy (QIS) reviews are conducted annually using a statewide statistically valid sample.
  - Performance and Quality Reviews (PQR) are conducted annually using a statistically valid sample for each CMA.
- Additionally, targeted reviews may be conducted at the Department’s discretion.
- National Core Indicators (NCI) are conducted every other year using a statistically valid sample of members with IDD.
- CMAs submit monthly reports on timeliness of activities to monitor stabilization.

Critical Incident Report Review

Provider agencies are required to complete their own investigations. My understanding is that CMAs should also complete their own investigations. Are CMAs relying on investigative work done by the Provider Agency? If so, that seems like a conflict.

CMA Roles and Responsibilities : Critical Incident Reporting

- CMAs shall ensure all employees receive Critical Incident Reporting training.
- Case Managers shall follow all applicable timelines set forth in regulation and contract for Critical Incident Reporting.
- Case Managers shall conduct all required follow-up within assigned timelines.
- Case Managers shall follow all mandatory reporting law requirements for allegation of mistreatment, abuse, neglect, and/or exploitation.
- CMAs shall report all allegations of mistreatment, abuse, neglect, and/or exploitation that as a complaint to CDPHE.

CMA Roles and Responsibilities: Administrative Review

- CMAs shall conduct requested activities as necessary, upon request and at the discretion of HCPF, for the purpose of a Critical Incident Administrative Review.

HCPF OM 25-038 Health, Safety, and Welfare: Roles and Responsibilities for Case Management Agencies, Provider Agencies, and Human Rights Comittees

Administrative Review - The investigation process for the expressed purpose to review the health, safety, and welfare protections taken by provider agencies of HCBS waiver Members in reference to a critical incident. Administrative Reviews will be requested at the Department of Health Care Policy and Financing's (HCPF's) discretion and completed by the Case Management Agency for incidents meeting the following criteria including, but not limited to: (1) allegations of mistreatment, abuse, neglect, and exploitation that are reported to be of suspected malicious intent; (2) root causes have not been determined through provider agency review; (3) other state or legal entity has not investigated.

Critical Incident Report Review (cont.)

Provider agencies are required to complete their own investigations. My understanding is that CMAs should also complete their own investigations. Are CMAs relying on investigative work done by the Provider Agency? If so, that seems like a conflict.

Provider Agency Roles and Responsibilities: Incident Reporting

- Provider Agencies shall ensure all employees and contractors receive Critical Incident Reporting training.
- Provider Agencies shall complete all reporting necessary for compliance with CDPHE and HCPF (§8.7411).
- Provider Agencies shall follow all incident reporting requirements for allegations of mistreatment, abuse, neglect, and/or exploitation (§8.7411.A.4 and §8.7408.A.4).
- Provider Agencies shall follow all regulatory requirements of timely Critical Incident Reporting to the Member's CMA (§8.7411.B-F).
- Provider Agencies shall conduct internal reviews of Incident Reports to determine root causes, determine appropriate and timely follow-up necessary to ensure the health, safety, and welfare of Members, determine immediate action taken by the provider to mitigate risk, and identify trends to prevent future incidents (§8.7408.A.4 and 8.7411.E).
- Provider Agencies shall ensure contingency plans are developed and followed to mitigate undue health, safety, and welfare risk for Members. Contingency plans shall outline the immediate action necessary to provide services in the event that approved services are not available (section 8.7408.A.10).
- Provider Agencies shall make Incident Reports and all reviews and follow-up available to the CMA, HCPF, and CDPHE upon request (§8.7411.D).

PCT Training Requirements

*Does this mean all caregivers must complete the person-centered training before an agency can revalidate? **{No.}** And that certificates for all caregivers must be attached for revalidation? **{No.}** For some providers, that would impact hundreds of caregivers.*

- The PCT training requirement is not new.
  - See 10 CCR 2505-10 8.7001.B.2.a.vi: "The Person-Centered Support Plan drives the services afforded to the individual, and the setting staff/Contractors are trained on this concept and person-centered practices, as well as the concept of dignity of risk." See also 8.7409.D.1.a.
- The available trainings to meet this requirement, including the one in COTrain, are not new.
- What's new per OM 26-017: the **fiscal agent (Gainwell)** will check for proof that **one person** per agency has taken the training.
  - As stated in memo: "it is sufficient for a provider enrollment/revalidation package to include proof that **a single person** within the provider agency completed each training (provided that the provider agency is **still employing the individual(s)** who took each required training)."
- The memo also reminds provider agencies of the existing, not new, possibility that **survey agencies like CDPHE and CDHS** may request proof that **all** staff covered by the rule have taken the training.

Non-Compliance with Base Wage Requirements

There appears to be potential false base wage violations due to a faulty HCPF algorithm. Members report that some caregivers did not work in Denver, but their wages were being compared against the Denver base wage for the applicable reporting period.

- The provider completes the BW attestation and identifies the county where the work is performed.
- There is not an algorithm that identifies this. If the Providers are incorrectly selecting Denver, they could be flagged for underpayment.
- All underpayments are flagged and reported to FCU and they prioritize them for a compliance review to follow up on the possible underpayment and any corrective actions that are needed.
- As an added measure, when we see Denver selected as the county and they have entered a rate less than the Denver Minimum Wage we can ask if the work is performed in the city/county of Denver as a first measure to allow them to correct their entry.

Budget Update: Two Percent Rate Cut

- Oct. 1, 2025: 1.6% rate increase rolled back; July 1, 2026: additional 2% rate reduction (updated from earlier 0.75% proposal).
- Applies to most Medicaid providers, including HCBS, case management, and CMA contract rates (State General Fund + Targeted Case Management).
- No anticipated changes to member services or access to care; direct care worker base wages remain protected by law.
- CDASS members may see reduced monthly/annual allocations (unless care needs change); further guidance will be shared.
- Supports state budget balancing (~$1B shortfall; ~$127M GF savings) while maintaining long-term Medicaid sustainability.

Budget Update: Weekly Caregiver Limit Phased Introduction

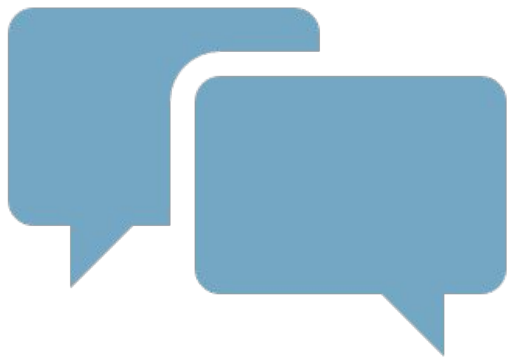
- This reduction will limit paid caregiving services for a member to a maximum of 56 hours per week (8 hours per day) for a single caregiver. The current 16-hour-per-day cap per caregiver will remain in place.
- This limit will impact Home Health Aide, Personal Care, Homemaker, HMA, & Nursing services.
  - Applies to all service delivery models (agency-based, CDASS, IHSS); services continue to be based on assessed need.
- Includes an exceptions process for higher or complex care needs or limited access to alternative caregivers.
- The weekly limit of 56 hours per caregiver for a single member will be implemented between July 1, 2026 and July 1, 2027. By July 1, 2027, all caregivers must not provide more than 56 hours of care for a single member per week for the services listed above unless an exception based on allowable criteria has been granted.
- Caregiver hours will be reduced in stages over a one-year period: reduction to 84 hours on July 1, 2026, 70 hours on January 1, 2027, and 56 hours on July 1, 2027.

Budget Update: Weekly Caregiver Limit Rules

- We are seeking stakeholder feedback on the proposed rule language. The proposed rules have been posted here for review. While the caregiver limits themselves cannot change, we are seeking targeted feedback pertaining to the exception process language, enforceability language, roles and responsibilities for Case Managers and provider agencies, and the structure of the changes. We invite you to comment via this feedback form.
- We also invite you to participate in a discussion on proposed rules related to the weekly limit of 56 hours per caregiver for a single member. We're hosting two meetings:

Thursday, April 30, 2026
From 11 a.m. to 12 p.m.
Register via Zoom

Friday, May 1, 2026
From 1 to 2 p.m.
Register via Zoom



Questions?