COLORADO
Department of Health Care Policy & Financing

OPERATIONAL MEMO

Title: Provider Agency Responsibilities

Audience: HCBS and Community First Choice (CFC) Provider Agencies, Home Health Agencies, Home Care Agencies, Case Management Agencies

Supersedes Number: N/A

Effective Date: Aug. 13, 2026

Expiration Date: Aug. 13, 2028

Topic: Provider Agency Operations

Sub-Topic: N/A

Division: Benefits and Services Management

Office: Office of Community Living

Program Area: HCBS Waivers, CFC, LTSS, and Long-Term Home Health

Key Words: Provider Agency Responsibilities, Provider Care Plans, Staffing Requirements, Contingency Planning, Service Continuity, Back-Up Staffing, Family Caregivers, Emergency Preparedness, Long-Term Services and Supports (LTSS)

Legal Authority: 10 CCR 2505-10, Sections 8.7402(T), 8.7408.A.10), , 8.7410(C) through (G),8.7528.H.1.c, 8.508.160.E.5 and 6 8.520.7.D.2.k and 8.520.7.E.12; 6 CCR 1011-1 Chapter 26 Part 5, Sections 5.2(C)(2), 5.4(A) through (B), and 5.14(A)(4) through (5)

Memo Author: Cassandra Keller

Operational Memo Number: HCPF OM 26-058

Issue Date: Aug. 13, 2026

Approved By: Bonnie Silva

HCPF Memo Series can be accessed online: https://www.colorado.gov/hcpf/memo-series

Purpose and Audience

The purpose of this Operational Memo is to clarify existing regulatory requirements and operational responsibilities for agencies that provide Medicaid home- and community-based services and long-term home health services. This memo does not establish new requirements. Rather, it summarizes existing requirements related to accepting Members for services, care planning, staffing, contingency planning, service continuity, and documentation. New weekly caregiver requirements effective July 1, 2026 have prompted the need to clarify and summarize provider requirements in one place.

This memo applies to:

- Home and Community-Based Services (HCBS) Provider Agencies;

- Community First Choice (CFC) Provider Agencies;
- Home Care Agencies licensed under 6 CCR 1011-1 Chapter 26; and
- Case Management Agencies to the extent they coordinate, authorize, or monitor services.

The responsibilities outlined in this memo apply regardless of the staffing model used by the Agency, including when services are delivered by employees, contracted workers, or paid family caregivers.

For purposes of this memo, the term **Agency** refers to any HCBS or CFC provider agency or licensed home care agency responsible for providing Medicaid-covered services.

Acceptance of Members and Care Planning

An Agency that accepts a Medicaid Member for services is responsible for providing those services in accordance with the applicable Provider Care Plan, care plan, service authorization, or documented service schedule. Before accepting a Member, an Agency must determine whether it can reasonably meet the Member's assessed needs. This includes having adequate staffing, supervision, scheduling, and operational support

Once services have been accepted, staffing shortages, employee absences, turnover, scheduling challenges, or other operational issues do not relieve the Agency of its responsibility to take appropriate steps to provide agreed-upon services, implement contingency plans, communicate with the Member and other appropriate parties, and document actions taken to address missed, delayed, or interrupted services.

For HCBS and CFC services, each Provider Agency identified in the Person-Centered Support Plan shall develop a Provider Care Plan for every Member receiving services. Although Provider Care Plans may vary by service or waiver, each plan must identify the services to be provided, corresponding goals and objectives, the Member's identified needs, anticipated benefit, and the scope, duration, and frequency of services.

At a minimum, the Provider Care Plan must identify:

- the service and care needs of the Member;
- the Provider Care Plan development date;
- the goals or objectives of the service;

- a plain-language description of the specific services, supports, methodologies, or interventions used to address the Member's identified needs;
- the Member's preferences;
- relevant medical information from medical and therapy providers, when applicable;
- the duration of the service, including how the duration corresponds to the Member's assessed needs and billing unit; and
- the frequency of the service according to the Member's needs and preferences in accordance with regulation, Direct Care Services Calculator (DCSC), and/or the physician order (PO).

It is the providers responsibility to follow the Provider Care Plan and/or update it to remain active. The Provider Care Plan must protect Member rights and be reviewed at least twice annually and whenever necessary to ensure that identified services remain appropriate to meet the Member's needs.

Home Health and Home Care Agencies licensed under 6 CCR 1011-1 Chapter 26 may accept a Member only when there is reasonable assurance that the Agency can adequately meet the Member's needs in the Member's home or place of residence. If ordered services cannot be provided at the time of referral, the Agency must notify the ordering physician or authorized provider, when applicable, and the Member or authorized representative. The Member may only be admitted to services when the ordering provider and the Member or the Member's authorized representative agree that the Member can safely receive the ordered services.

All Agencies must maintain documentation identifying the agreed-upon days and times services will be delivered and update this documentation whenever the Member's needs, authorization, or service schedule changes.

Applicable regulations: 10 CCR 2505 10-8.7410, 6 CCR 1011-1 Chapter 26 Part 5, Sections 5.2

Staffing Responsibility and Service Continuity

Acceptance of a Member carries with it responsibility for maintaining staffing sufficient to provide authorized services.

Agencies are responsible for maintaining the staffing, supervision, and operational support necessary to deliver services consistent with the applicable Provider Care

Plan, care plan, service authorization, or documented schedule in accordance with HCPF regulations around allowable staffing hours.

If scheduled staff become unavailable, Agencies must activate contingency plans, attempt to secure alternate coverage, communicate with the Member and other appropriate parties, and document the staffing issue, actions taken, communications, and any resulting service interruption.

For scheduled long-term home health services, calling emergency medical services is not an appropriate staffing contingency unless emergency medical intervention would have been necessary even if Agency staff had been present.

Applicable regulations: 10 CCR 2505 10-8.7408.A.10, 6 CCR 1011-1 Chapter 26 Part 5, Sections 5.10

Contingency Planning and Emergency Preparedness

Each Agency must maintain a documented contingency plan addressing how services will be provided when a caregiver or direct service provider is unavailable due to an emergency or unforeseen circumstance.

Contingency plans should describe how the Agency will:

- identify alternate staff;
- prioritize Members with urgent needs;
- communicate with Members, authorized representatives, and Case Management Agencies;
- document staffing events and service interruptions; and
- address missed or delayed services.

All Agencies must also maintain written emergency preparedness policies and procedures addressing emergencies that may endanger Members or staff or disrupt Agency operations, including medical emergencies, public health emergencies, fires, natural disasters, and other operational disruptions. Emergency plans should specifically address staffing shortages and continuity of service during emergency situations. Where required by regulation, including Day Habilitation services, emergency plans must be maintained regardless of service location.

Applicable regulations: 10 CCR 2505 10-8.7410, 6 CCR 1011-1 Chapter 26 Part 5, Sections 5.2

Family Caregivers and Agency Responsibility

Some Agencies employ or contract with approved family caregivers to provide authorized Medicaid services. Utilizing a family caregiver does not alter the Agency's regulatory responsibilities.

An Agency's responsibility for service delivery is established when the Agency accepts the Member for services and remains unchanged regardless of whether services are delivered by an employee or contractor, and the employee or contractor is an approved family caregiver.

If an employed or contracted family caregiver is unavailable due to illness, emergency, resignation, or any other circumstance, the Agency remains responsible for implementing its contingency plan, arranging alternate coverage as appropriate, communicating with the Member and Case Management Agency (when applicable), protecting the Member's health and safety, and documenting actions taken.

Agencies may not require, pressure, or condition ongoing service delivery upon unpaid assistance from a Member's family member, guardian, or other informal caregiver as the Agency's routine or primary back-up staffing plan. A contingency plan inclusive of unpaid family members of the Member is not sufficient or appropriate. The Agency must have a documented contingency plan that includes paid caregivers supplied by the Agency. While family members may voluntarily provide assistance when appropriate, voluntary assistance does not replace the Agency's obligation to provide accepted services.

Action To Be Taken

Agencies must immediately and on an ongoing basis:

1. **Confirm capacity before accepting services.** Agencies must only accept a Member when they can reasonably meet the person’s needs, including staffing, supervision, branch office support, and required service times on both an on-going basis and in the event back-up staffing coverage is required.
2. **Maintain required care planning documentation.** Agencies must develop, maintain, and update the applicable Provider Care Plan, care plan, or service schedule, including required information about services, goals, preferences, duration, frequency, days, and times.
3. **Maintain staffing and back-up coverage.** Agencies must ensure staffing schedules, provider assignments, supervision, and back-up plans are sufficient to deliver accepted services and meet all HCPF regulatory requirements for staffing hours, including but not limited to adherence to the applicable daily and weekly caregiver limits.

4. **Prepare for service disruptions.** Agencies must maintain contingency and emergency plans for staff absences, emergencies, public health events, natural disasters, and other disruptions.
5. **Respond when staff are unavailable.** Agencies must activate back-up or contingency plans, attempt to secure alternate coverage, protect the Member's health and safety, and document the steps taken. Agencies are expected to exhaust reasonable internal staffing and contingency options before relying on unpaid supports.
6. **Communicate and coordinate.** Agencies must provide advance notice of schedule changes when possible and coordinate with Members, authorized representatives, guardians, case management entities, providers, and other appropriate parties as needed.
7. **Protect Member choice and service rights.** Agencies must include Members in care planning, preserve choice among willing providers, and not condition HCBS, CFC, LTHH services on acceptance of other services.

Definitions

Provider Care Plan: The individualized documented approach the Provider Agency will use to provide services, including identified needs, services, goals, anticipated benefit, and the scope, duration, and frequency of authorized services.

Care Plan: For purposes of this memo, the documentation used by a Home Health or Home Care Agency describing the Member's needs, the services the Agency agrees to provide, the service schedule, and related supports. This is also known as the Plan of Care (POC) or the CMS-485 form.

Contingency Plan: The Agency's documented process for maintaining continuity of services when scheduled staff are unavailable due to emergencies or unforeseen circumstances.

Attachment(s):

None

HCPF Contact:

hcpf_hcbs_questions@state.co.us