Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waivers target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **Colorado** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:
Persons with Brain Injury (HCBS-BI)

C. Waiver Number:CO.0288
Original Base Waiver Number: CO.0288.

D. Amendment Number:

E. Proposed Effective Date: (mm/dd/yy)
07/01/24
Approved Effective Date of Waiver being Amended: 07/01/22

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

The purpose of this amendment is to:

- Remove Remote Supports from Personal Care and create a standalone Remote Supports Service that will include Remote Supports and Remote Supports Technology. With this change, the tasks available through the service will remain the same.
- Update the Organized Health Care Delivery System provider type due to Case Management Redesign and details outlined in IM 22-042. Waivers are being amended to clarify when the OHCDS can act as a provider for select services.
- Update language in Appendices D-1b and D-2b. The updates are to the Case Management Agency (CMA) rural exception process and to reflect that the state is no longer in conflict.
- Remove Hospice from the list of State Plan services that require Electronic Visit Verification (EVV) in appendix I-2d.
- Update HCPF's Rate Methodology description to include information on the locality, county, metropolitan area, and other types of regional boundaries for minimum wage increases and an allowance for HCPF to update these rates retroactively.
- Remove the reference to the number of Case Management Agencies that are contracted entities.
- Remove language that references "annual on-site monitoring" of the Case Management Agencies in Appendix F-1 and I-1, Participants Rights.
- Update the Cost Neutrality Demonstration in Appendix J with the new 372 data from State Fiscal Year (SFY) 2021-22.
- Update language to clarify the role and purpose of the Colorado State Long-Term Care Ombudsman program.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☒ **Waiver Application**	6I
☒ **Appendix A Waiver Administration and Operation**	3
☒ **Appendix B Participant Access and Eligibility**	3a
☒ **Appendix C Participant Services**	1a
☒ **Appendix D Participant Centered Service Planning and Delivery**	2d
☒ **Appendix E Participant Direction of Services**	1i
☒ **Appendix F Participant Rights**	1
☒ **Appendix G Participant Safeguards**	1b
☐ **Appendix H**	
☒ **Appendix I Financial Accountability**	1, 2a, 2d, 3g
☒ **Appendix J Cost-Neutrality Demonstration**	1, 2a, 2b, 2c, 2d

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

☐ **Modify target group(s)**

☐ **Modify Medicaid eligibility**

☐ **Add/delete services**

☐ **Revise service specifications**

☐ **Revise provider qualifications**

☐ **Increase/decrease number of participants**

☐ **Revise cost neutrality demonstration**

☐ **Add participant-direction of services**

☐ **Other**
Specify:

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **Colorado** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

Persons with Brain Injury (HCBS-BI)

C. Type of Request: amendment

Requested Approval Period:*(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Original Base Waiver Number: CO.0288
Draft ID: CO.007.06.05

D. Type of Waiver *(select only one):*

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/22
Approved Effective Date of Waiver being Amended: 07/01/22

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid state plan (*check each that applies*):

☒ **Hospital**

Select applicable level of care

◉ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☒ **Nursing Facility**

Select applicable level of care

◉ **Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☐ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates *(check each that applies):*

☐ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**
Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.
Check if applicable:

☒ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The Home and Community-Based Services waiver for persons with Brain Injury (HCBS-BI) provides assistance to individuals with brain injuries that require long term supports and services in order to remain in a community setting.

Brain injury has been defined as an injury to the brain of traumatic or acquired origin which results in residual physical, cognitive, emotional, and behavioral difficulties of a non-progressive nature.

Eligibility is limited to individuals aged 16 and older whose brain injury occurred prior to the individual's 65th birthday. Individuals must have been determined to have a significant functional impairment as identified by a comprehensive assessment using the Uniform Long Term Care (ULTC) assessment tool, and must require long term support services at a level comparable to services typically provided in a nursing facility or hospital.

The Department of Health Care Policy and Financing (the Department) has defined a range of community-based services designed to support individuals and their families. These services include:

Adult Day Heath
Behavioral Management and Education
Consumer Directed Attendant Supports and Services
Day Treatment
Home Modification
Independent Living Skills Training
Mental Health Counseling
Non-Medical Transportation
Personal Care
Personal Emergency Response Systems
Respite
Specialized Medical Equipment and Supplies/Assistive Devices
Substance Abuse Counseling
Supported Living Program
Transitional Living Program
Peer Mentorship
Home Delivered Meals
Transition Setup

In addition to these waiver services, participants also have access to all Medicaid State Plan benefits.

The Department contracts with local, non-state entities called Case Management Agencies (CMAs) to enable people with long term care needs to access appropriate supportive services. These agencies form a statewide network that provides case management and care coordination for BI waiver clients. Case management functions include: intake/screening/referral, assessment of client needs, functional eligibility determination, service plan development, ongoing case management, and monitoring to assure participant protections and quality assurance. The Department currently contracts with twenty-four (24) CMAs for the case management and utilization review of long term care waivers unrelated to developmental disabilities.

Through a client-centered service planning process, waiver clients assist the CMA case manager to identify services and community supports needed to prevent placement in a Nursing Facility. The waiver provides clients with a choice of service delivery options for the following services: personal care/assistance, homemaker, and health maintenance activities. Health Maintenance actives are routine and repetitive activities of daily living which require skilled assistance for health and normal bodily functioning, and which would be carried out by an individual with a disability if he or she were physically/cognitively able.

A client and/or authorized representative may choose to direct these services or choose to have the same services delivered by a traditional Medicaid agency provider. Clients who choose to self-direct personal care/assistance and/or homemaker services will receive support for these services through a Financial Management Services (FMS) organization. The FMS will be responsible for providing appropriate and timely fiscal management services to individuals and or authorized representatives who choose to self-direct these services.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the state provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the state requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ( ) **Not Applicable**
- (●) **No**
- ( ) **Yes**

C. Statewideness. Indicate whether the state requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- (●) **No**
- ( ) **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

- [ ] **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state.
  Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.
Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the state provides the following assurances to CMS:

A. Health & Welfare: The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide

individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the state secures public input into the development of the waiver:

The public comment period ran from 02/01/2024 through 03/01/2024:

The process is summarized as follows: The Department sent, via electronic mail, a summary of all proposed changes to all Office of Community Living (OCL) stakeholders. Stakeholders include clients, contractors, families, providers, advocates, and other interested parties. Non-Web-Based Notice: The Department posted notice in the newspaper of the widest circulation in each city with a population of 50,000 or more on 02/01/2024 and 02/15/2024. The Department employed each separate form of notice as described. The Department understands that, by engaging in both separate forms of notice, it will have met the regulatory requirements, CMS Technical Guidance, as well as the guidance given by the CMS Regional Office. The Department posted on its website the full waiver and a summary of any proposed changes to that waiver at https://hcpf.colorado.gov/hcbs-public-comment. The Department made available paper copies of the summary of proposed changes and paper copies of the full waiver. These paper copies were available at the request of individuals. The Department allowed at least 30 days for public comment. The Department complied with the requirements of Section 1902(a)(73) of the Social Security Act by following the Tribal Consultation Requirements outlined in Section 1.4 of its State Plan on 02/01/2024. The Department had the waiver amendment reviewed by the State Medical Care Advisory Committee (otherwise known as “Night MAC”) in accordance with 42 CFR 431.12 and Section 1.4 of the Department’s State Plan on 02/01/2024. In addition to the specific action steps described above, the Department also ensured that all waiver amendment documentation included instructions about obtaining a paper copy. All documentation contains language stating: “You may obtain a paper copy of the waiver and the proposed changes by calling (303) 866-3684 or by visiting the Department at 303 E 17th Avenue, Denver, Colorado 80203.”

Newspaper notices about the waiver amendment also included instructions on how to obtain an electronic or paper copy. At stakeholder meetings that announced the proposed waiver amendment, attendees were offered a paper copy, which was provided at the meeting or offered to be mailed to them after the meeting. Attendees both in person and on the telephone were also instructed that they may call or visit the Department for a paper copy. All relevant items confirming noticing will be provided upon request.

Summaries of all the comments and the Department’s responses are documented in a listening log that is posted to the Department’s website and submitted to CMS.

The Department followed all items identified in the letter addressed to the Regional Centers for Medicare and Medicaid Services Director from the Department’s legal counsel dated 6/15/15. A summary of this protocol is available upon request.

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Eggers

First Name: Lana

Title: Waiver Administration & Compliance Unit Supervisor

Agency: Colorado Department of Health Care Policy & Financing

Address: 1570 Grant Street

Address 2:

City: Denver

State: **Colorado**

Zip: 80203

Phone: (303) 866-2050 **Ext:** ☐ **TTY**

Fax: (303) 866-2786

E-mail: Lana.Eggers@state.co.us

B. If applicable, the state operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Colorado**

Zip:

Phone: **Ext:** ☐ **TTY**

Fax:

E-mail:

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under §1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

State Medicaid Director or Designee

Submission Date:

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name: Flores-Brennan

First Name: Adela

Title: Medicaid Director

Agency: Colorado Department of Health Care Policy & Financing

Address: 303 E 17th Ave

Address 2:

City: Denver

State: **Colorado**

Zip: 80203

Phone:

(303) 866-3060 **Ext:** ☐ **TTY**

Fax:

(303) 866-2786

E-mail:

Adela.Flores-Brennan@state.co.us

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The State assures that the settings transition plan included with this waiver amendment will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. The State will implement any required changes upon final approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal, or at another time if specified in the final Statewide Transition Plan and/or related milestones (which have received CMS approval).

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A-3: Waiver Administration and Operation-Use of Contracted Entities:

The Department contracts with an Administrative Services Organization (ASO) to provide oversight of the Non-Medical Transportation (NMT) benefit. The ASO is responsible for ensuring all provider agencies, vehicles, and drivers meet the regulatory and safety requirements set forth by the Department. The ASO will be responsible for coordination with the Regional Transportation District (RTD), verifying eligibility, processing the RTD special discount card, dissemination of transit fares, and production of outlined reports.

The Dept. contracts with the Dept. of Local Affairs – Division of Housing (DOH) to perform waiver operational and administrative functions on behalf of the Dept. The relationship between the Dept. and DOH is regulated by an IA, which requires the Dept. and DOH to meet no less than monthly to discuss continued program improvement. DOH's responsibilities include, but are not limited to, recruiting and enrolling providers, reviewing PARs, inspecting home modifications done by providers, creating standards to ensure a consistent quality of work statewide, managing the client and provider grievance processes, and making regular reports to the Dept. on the quality of the home modification benefit provided to clients.

Post-payment reviews of Medicaid paid services of individuals receiving benefits under the HCBS Waiver program will be mostly conducted by internal staff reviewers, however, the Department's existing Recovery Audit Contractor (RAC) will also be utilized to conduct post-payment claims reviews. All audits will continue to focus on claims submitted by providers for any service rendered, billed, and paid as a benefit under an HCBS Waiver. The Department will also issue notices of adverse action to providers to recover any identified overpayments. Retrospective audits occurring under the HCBS Waiver Post Payment Review contract focus on claims submitted by providers for any service rendered, billed, and paid as a benefit under an HCBS Waiver. The vendor is also required to issue notices of adverse action to providers to recover any identified overpayments.

The Dept. contracts with Fiscal Management Services (FMS) vendors that serve as the financial intermediaries for the Colorado Consumer-Directed Support Services (CDASS) program. In addition, the Dept. contracts with one training and operations vendor that trains participant-directed members, authorized representatives, IHSS provider agencies, and case management agencies. The FMS provides administrative and financial services to CDASS members and/or Authorized Representatives to complete employment-related functions for CDASS attendants and to record, monitor, and report on CDASS member allocations and utilization. The FMS vendor collects and processes attendant timesheets, conducts payroll functions, completes attendant enrollment with required background checks, and services customer complaints and questions. The FMS fulfills requirements to comply with Electronic Visit Verification (EVV) regulations, implement Americans with Disabilities Act accommodations and produce reports demonstrating contractual performance standards. Additionally, the FMS is required to implement necessary systems and services to fully administer newly mandated local, state, and federal laws impacting CDASS. The vendor provides technical assistance, records management, and payment processing for Colorado state employee Sick Time (SB 20-205) and Family and Medical Leave (Proposition 118). This model allows the client the most choice in directing and managing their services as they are the sole employer of the attendant.
Please refer to Appendix E for additional detail on the FMS responsibilities.

For out-of-state providers, the Department maintains an Interagency Agreement with the host state's Medicaid Agency/licensing agency to perform quality assurance and quality improvement activities. The Department may contract with out-of-state providers for the in-person monitoring requirements for case management.

Appendix A-QIS Discovery

A.26 The FMS reviews 100% of CDASS attendants eligible for hire assuring they meet the waiver requirements. The FMS reports this data to the Department through monthly and quarterly reports. The Department utilizes the monthly and quarterly reports to conduct a full audit of enrollment procedures and documentation of cases, chosen at random, to ensure the FMS is completing the mandatory CBI criminal history and Board of Nursing checks and following approved FMS enrollment policies and procedures.

Additional information for E-2-a-ii:

The Department will provide and require oversight for attendants who have been hired through the exception process. Oversight measures for granted exceptions will include in-person monitoring by the case manager including assessment that the attendant is meeting the member's needs; Department, FMS, Training and Operations vendor, and case manager monitoring of critical incidents; and reminding members and/or authorized representatives education about the state's processes for reporting critical incidents including mistreatment, abuse, neglect, and exploitation.

The CDASS attendant exception process will contain thorough oversight safeguards:

1. An outline of general attendant safety measures will be required for all newly enrolled CDASS members. It will be reviewed and approved by the case manager and Training and Operations Vendor before the member or authorized representative completes enrollment and services are rendered.
2. A formal safety plan will be required for all current CDASS members seeking an exception to hire an individual who was found ineligible. This plan will be created by the member/authorized representative and sent by them to the Department for review.
3. The member's safety plan must demonstrate that the member/authorized representative has considered and planned several defined safety elements related to the individual they are choosing to hire. If the plan does not have thorough responses for each of the elements, the exception will be denied and the individual will remain ineligible for hire as an attendant. The plan may be resubmitted.
4. The Department will notify the member/authorized representative upon approval of the exception and share the safety plan with the member's case manager, FMS, and the Training and Operations Vendor when an exception is processed.
5. Quarterly safety plan review and service assessment by the case manager.
6. Additional fraud, mistreatment, abuse, neglect, and exploitation (MANE) reporting tools developed by the Department and to be implemented by January 2023.
7. Robust educational and training resources for CDASS members/authorized representatives developed by the Training and Operations vendor and to be implemented by January 2023. Increased promotion of its current peer support services.
8. Continual stakeholder engagement will occur for ongoing policy and operational improvements where necessary.

Appendix I-1: Financial Integrity and Accountability
I-1 Financial Integrity and Accountability:
PICO Audits continued -
Regarding the audits performed by the PICO Section which are not randomly selected, below details how data samples and records are selected, communications to providers are made, how CAPs are issued, and how inappropriate claims are handled: Providers are selected based on their status as outliers in variables of interest. Members are then randomly selected from those providers, and all lines from those members are selected.

The provider is contacted prior to the start of the Audit via email and is asked to verify their contact. The Records Request is sent via certified mail and encrypted email. The results of the audit are communicated to the provider via a Notice Of Adverse Action Letter and Case Summary or a No Findings Letter. All audit results are sent electronically via encrypted email to the verified email address. If the provider requests a Review of Findings meeting in accordance with the timelines outlined in the Records Request Letter, we will meet with the provider over the phone or via video and go over the findings with them prior to issuing the Notice of Adverse Action.

The State does not require corrective action plans, however, corrective action plans (CAPs) are utilized by the PICO Section when deficiencies or breaches are identified within the RAC contract or any post-payment claims review contract. When the PICO Section identifies the need for a CAP, the State notifies the vendor in writing of the area of non-compliance and requests the vendor to create a CAP that outlines what efforts the vendor took to investigate the issue, the root cause of the issue, the outcome of the vendor's investigation and the proposed remediation actions the vendor would like to implement. The State will review the CAP and make any changes as needed to address and correct the area of non-compliance and then authorize the CAP. The State then monitors the CAP, including the milestones and steps outlined in the CAP, and makes the determination when the vendor is back in compliance with the contract. If the vendor fails the CAP, the State can move to terminate the contract.

When the State has received payment from a provider for an inappropriately billed claim found in a post-payment claims review, the State attaches claim information with that payment for processing to the accounting. The information includes calculations of FFP and the amount of recovery that should be recorded on the CMS-64 report by accounting staff and returned to the federal government.

Appendix I-2a: Rates, Billing, and Claims Rate Determination Methods:

The HCBS BI waiver utilizes a negotiated market price methodology for services in which reimbursement will differ by client, product, and by frequency of use. The services utilizing the negotiated market price methodology include:

- •Specialized Medical Equipment and Supplies/Assistive Technology
- •Home Modification
- •Non-Medical Transportation-Taxi
- •Personal Emergency Response System Install/Purchase
- •Personal Emergency Response System Monthly Service
- •Remote Supports Technology

For the above services case managers coordinate with providers and determine a market price that incorporates the client's needs, products required, and frequency of use. The Department's HCBS BI waiver administrator reviews and approves the market price determined and authorized by the case manager.

The Mobility Van, Wheelchair Van, and Taxi services are folded into one waiver service, Non-Medical Transportation (NMT). A weighted rate is calculated using the total NMT expenditure across all three components.

Home Modification services require two (2) competitive bids which are reviewed by the case manager and approved by the Department of Housing. Home Modification services are limited to $14,000 for a lifetime. All services are prior authorized and service reimbursement may not exceed prior authorized amounts.

The HCBS BI waiver utilizes a public pricing methodology for public services. Services with public pricing methodology are reimbursed at the price paid by the general public for the same service. The services utilizing the public pricing methodology include:

1. Non-Medical Transportation-Public Transit will be reimbursed at the RTD discounted rates applied to seniors 65+, individuals with disabilities, and Medicare recipients. The RTD rates can be found at the following link: https://www.rtd-denver.com/fares-passes/fares where the discounted rates reimbursed by Medicaid are denoted by a single *. RTD rates are updated annually in January. The Department updates the rates and fee schedules each January to align with annual changes.

After the implementation of the rate, only legislative increases or decreases are applied. These legislative rate changes are often annual and reflect inflationary increases or decreases. The rates for the HCBS BI waiver are reviewed for appropriateness every five years with the waiver renewal. Fee-for-service rates following the Department’s rate methodology were last reviewed in 2021-2022 for the BI waiver except for the Supported Living Program rates that were reviewed in 2019 as part of the change to the service’s rate methodology. The Department reviewed the rate-setting methodology in 2017.

The Department’s Waiver and Fee Schedule Rates Section is the responsible entity for rate determination. Oversight of the rate determination process is conducted internally by a review of the rates and methodology by internal staff in Policy, Budget, and members of leadership. The Department also hosts stakeholder feedback meetings in which the rates and rate determination factors are presented to external stakeholders such as providers, clients, and client advocacy groups to determine additional rate determination factors to be considered in the rate methodology which were not captured during the initial rate-setting process.

The state measures rate sufficiency and compliance with CMS regulations and measures efficiency, economy, quality of care, and sufficiency to enlist providers through analysis of paid claims which show both increases in service utilization and number of providers year over year. In conjunction with the Department’s rate methodology, these services are also reviewed through the Medicaid Provider Rate Review Advisory Committee which conducts geographic analyses related to waiver services and also includes measures of efficiency and economy to determine if rates are sufficient to enlist providers. This report includes a stakeholder feedback period which is also incorporated into the rate review and claims data analysis and future rate updates to ensure the methodology allows for all elements of service delivery and quality of care.

September 2017: The targeted increases for Non-Medical Transportation, Personal Care, and Homemaker services are to account for several factors including getting closer to the newly established rate methodology and associated budget neutrality factors. They also account for increases in the minimum wage in Colorado. Finally, the increases themselves are within a ten percent threshold.

The rates for Adult Day Health, Home Delivered Meals, Life Skills Training, Mental Health Counseling, and Respite were reviewed in the 2017 Medicaid Provider Rate Review Analysis Report, which found that they varied between 36.70% and 184.58% of their relevant benchmark comparisons. The Department recommended increasing rates for waiver services as

identified through the ongoing rate-setting process, with special attention to services that were identified by stakeholders through the rate review process and those that have the biggest gaps, or budget neutrality factor, between current rates and appropriate rates developed through the Department's rate-setting methodology. Additionally, upon implementation of Peer Mentorship and Home Delivered Meals in the waiver, the Department developed a documented rate methodology for Peer Mentorship and Home Delivered Meals and the budget neutrality factors were found to be more substantial than expected. The Department is closing the gap or reducing the budget neutrality factor, for these services in the HCBS waivers.

Rates are communicated via Departmental notice in provider bulletins, and tribal notices and are made available on the Department's external website to be accessed by stakeholders and providers at any time.

The state's process for soliciting public comment on rate determination methods involves a standardized and documented process consisting of the Presentation of Rate Setting Methodology to stakeholders before or during rate-setting and solicitation of feedback on methodology, a 30-day period to receive feedback from providers and community stakeholders, publishing of the rates as determined by the state's methodology in conjunction with a stakeholder presentation reviewing the methodology, providing guidance on documents that would be provided to stakeholders, stakeholder deliverable sent to providers following presentation included all services and the direct/indirect care hours, wage, BLS position, and capital equipment included and offered providers an extended (60 day) period to offer feedback. All feedback is reviewed and feedback that can be validated is incorporated into the rates. All information from the stakeholder process is posted on the Department's external website. Additional information on public input is located in Main 6-I.

The State will be utilizing funding from section 9817 of the American Rescue Act of 2021 for the Home Modification/Home Accessibility Adaptation budget enhancement of $10,000. The State will use 9817 ARP funds for the minimum wage rate increases through April of 2023 and then will utilize state general funds approved by legislation starting in April of 2023.

The State uses a blended rate of the different component services under CDASS: Homemaker, Personal Care, and Health Maintenance to calculate the overall CDASS rate.

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

   ◉ **The waiver is operated by the state Medicaid agency.**

   Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

   ◉ **The Medical Assistance Unit.**

   Specify the unit name:

   Office of Community Living, Benefits and Services Management Division

   (Do not complete item A-2)

   ○ **Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.**

   Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

   (Complete item A-2-a).

   ○ **The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.**

   Specify the division/unit name:

   In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available

through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

The Dept. maintains an Interagency Agreement (IA) with the Dept. of Public Health and Environment (CDPHE). This agreement allows CDPHE to survey and investigate complaints against the following HCBS providers: Personal Care, Homemaker, Adult Day Services, Day Treatment, Respite, ILST, Transition Setup, Peer Mentorship, Home Delivered Meals, SLPs, and TLPs. Once the CDPHE survey has been completed, the provider is referred to the Dept. to obtain Medicaid Certification

The Dept. contracts annually with Case Mgmt. Agencies serving 20 defined service areas throughout Colorado. CMAs consist of local/regional non-state public agencies, private agencies, and non-profit agencies. These governmental subdivisions are made up of County Depts. of Human and Social Services, County Depts. of Public Health, County Area Agencies on Aging or County, and District Nursing Services.

CMAs are contracted with the Dept. to provide case management services for HCBS participants including disability and delay determination, level of care screen, needs assessment, and critical incident reporting. CMAs also provide Targeted Case Management including case management, service planning, referral care coordination, utilization review, the prior authorization of waiver services, and service monitoring, reporting, and follow up services through a Medicaid Provider Participation Agreement. All CMAs are selected through a competitive bid process.

The Dept. contracts with a Fiscal Agent to maintain the Medicaid Mgmt. Information System (MMIS), process claims, assist in the provider enrollment/application process, prior authorization data entry, maintain a call center, respond to provider questions and complaints, maintain the Electronic Visit Verification (EVV) System, and produce reports.

The Quality Improvement Organization (QIO) is responsible for conducting assessments of the acuity level of individuals utilizing the SLP and TLP waiver services. The QIO is required to provide the Dept. with data from these assessments in order for appropriate rates to be set for these services.

The QIO is responsible for mgmt. of the Critical Incident Reports (CIR) for the HCBS-BI waiver. The QIO is responsible for assessing the appropriateness of both provider and CMA response to critical incidents, for gathering, aggregating, and analyzing CIR data, and ensuring that appropriate follow-up for each incident is completed.

The QIO also supports the Dept. in the analysis of CIR data, understanding the root cause of identified issues, and providing recommendations to changes in CIR and other waiver mgmt. protocols aimed at reducing/preventing the occurrence of future critical incidents.

The Dept. contracts with a QIO, to consolidate long-term care utilization mgmt. functions for waiver programs and Medicaid clients. For Service Accommodation request process the QIO reviews for duplication, medical orders, limits prescribed in rule and waiver, assessments outlining needs, and service plans to ensure all items are appropriate for the client. The QIO also manages appeals that arise from a Service Accommodation request review denial.

The Department contracts with a QIO to conduct reviews of skilled health maintenance activities (HMA) in participant-directed services for:

· duplication of state plan benefits,
· medical orders,
· limits prescribed in rule and waiver,
· assessments outlining needs, and
· service plans to ensure all items are appropriate for the client.

The QIO also testifies, when necessary, at appeals that arise from an HMA review denial.

Additional Information is located in Main B Optional.

○ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

○ **Not applicable**

◉ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

☒ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

The Department contracts with non-state public agencies to act as Case Management Agencies throughout the state of Colorado to perform HCBS waiver operational and administrative services, case management, utilization review, and prior authorization of waiver services for BI waiver recipients.

☒ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

The Department contracts with non-governmental, non-state agencies to act as Case Management Agencies throughout the state of Colorado to perform HCBS waiver operational and administrative services, case management, utilization review, and prior authorization of waiver services for BI waiver recipients. These agencies are selected through a competitive bid process.

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

Department of Health Care Policy and Financing, Office of Community Living, Benefits and Services Management Division

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

The Department provides on-going oversight of the Interagency Agreement with the Colorado Department of Public Health and Environment (CDPHE) through regular meetings and reports. Issues that impact the agreement, problems discovered at specific agencies, or widespread issues and solutions are discussed. In addition, the Department is provided with monthly and annual reports detailing the number of agencies that have been surveyed, the number of agencies that have deficiencies, the number of complaints received, complaints investigated, and complaints that have been substantiated. The Interagency Agreement contract between the Department and CDPHE requires that all complaints be investigated and reported to the Department. Should the investigation result in a CDPHE recommendation to decertify a provider agency, the Department terminates the provider agency and coordinates with the CMA to ensure the continuity of care and transition of clients to other provider agencies. By gathering this information, the Department is able to develop strategies to resolve issues that have been identified. Further information about the relationship between CDPHE and the Department is provided in Appendix G of the waiver application.

The Department oversees the Case Management Agency (CMA) system. As a part of the overall administrative and programmatic evaluation, the Department conducts annual monitoring for each CMA. The Department reviews compliance with regulations at 10 C.C.R. 2505-10 Sections 8.390 and 8.485.

The administrative evaluation is used to monitor compliance with agency operations and functions as outlined in waiver and department contract requirements. The Department will evaluate CMAs through the on-going tracking of administrative contract deliverables on a monthly, quarterly, semi-annually, and yearly frequency basis depending on the contract deliverable. These documents include: operations guide, personnel descriptions (to ensure the appropriateness of qualifications), complaint logs and procedures, case management training, appeal tracking, and critical incident trend analysis. The review also evaluates agency, community advisory activity, and provider and other community service coordination. Should the Department find that a CMA is not in compliance with policy or regulations, the agency is required to take corrective action. Technical assistance is provided to CMAs via phone, e-mail, and through meetings. The Department conducts follow-up monitoring to assure corrective action implementation and ongoing compliance. In addition, the contract with CMAs allows the Dept to withhold funding and terminate a contract due to noncompliance. If a compliance issue extends to multiple CMAs, the Department provides clarification through formal Policy Memos, formal training, or both. Technical assistance is provided to CMAs via phone and e-mail.

The programmatic evaluation consists of a desk audit in conjunction with the state's case management IT system to audit client files and assure that all components of the CMA contract have been performed according to necessary waiver requirements. The state's case management IT system is an electronic record used by each CMA to maintain client-specific data. Data includes client referrals, screening, level of care eligibility screen (LOC Screen), Person-Centered Support Plan, case notes, evaluation and reevaluation documentation, and all other case management activities. Additionally, the state's case management IT system is used to track and evaluate timelines for evaluations, reevaluations, and a notice of action requirements to assure that processes are completed according to Department prescribed schedules. The Department reviews a sample of client files to measure the accuracy of documentation and track appropriateness of services based upon the LOC determination. Additionally, the sample is used to evaluate compliance with the aforementioned case management functions. The contracted case management agency submits deliverables to the Department on an annual and quarterly basis for review and determination of approval. Case management agencies are evaluated through quality improvement strategy reviews annually which is completed by a quality improvement organization.

The contract for the Financial Management Services (FMS) vendors was established through a competitive bid process. It is monitored by the Department on an ongoing basis through monthly and quarterly reporting, monthly meetings, and ad hoc audits as needed. The Department has an established Participant-Directed Programs Policy Collaborative (PDPPC) that meets at least on a quarterly basis. The committee is comprised of clients, family members, Department staff, FMS staff, advocates, and other community stakeholders. The committee discusses a variety of issues that impact participant-directed services. Issues that require quick action are resolved through the use of workgroups comprised of volunteers from the committee. In addition, Department staff have monthly and ad hoc meetings with FMS contractors to resolve issues and maintain open and on-going communication. Additional information about CDASS operations is provided in Appendix E of the waiver application.

The Department has oversight of the fiscal agent, training vendor for CDASS training, Transportation ASO, and the QIO through different contractual requirements. Deliverable due dates include monthly, quarterly, and annual reports to ensure vendors are completing their respective delegated duties. The Department's Operations Division ensures that deliverables are given to the Department on time and in the correct format. Subject Matter Experts who work with the vendors review

deliverables for accuracy.

The Department has on-going oversight of the IA with DOH through regular meetings and reports. The Department requires DOH to provide detailed monthly and annual reports on issues that arise in the operation of the benefit, how funding is utilized under the benefit, and client and provider grievances. DOH will also report to the Department on provider recruitment and enrollment, home modification inspections, issues arising regarding local building code standards, and integration with the Single-Family Owner-Occupied (SFOO) program administered by DOH. The Department and DOH are working together to create standards specific to the home modification benefit, as well as standardized forms for use during the home modification process. The Department hosts a Home Modification Stakeholder Workgroup that meets periodically to provide input on the development of these standards. DOH will inspect home modifications for adherence to local building codes, adherence to the standards created for the home modification benefit, compliance with communication requirements between the provider and client, and quality of work performed by providers. DOH reports regularly to the Department with the results of these inspections. The Department retains oversight and authority over providers who are found to be out of compliance with the home modification benefit standards.

For any post-payment claims review work completed by the Department's Recovery Audit Contractor (RAC), all deliverables and work product will be reviewed and approved by the Department as outline in the Contract. The Department requires the Contractor to develop and implement an internal quality control process to ensure that all deliverables and work product—including audit work and issuance of findings to providers—are complete, accurate, easy to understand, and of high quality. The Department reviews and approves this process prior to the Contractor implementing its internal quality control process.

As part of the payment structure within the Contract, the Department calculates administrative payments to the RAC based on its audit work and quality of its audit findings. These payments are in addition to the base payment the RAC receives for conducting its claim audits. Under the Contract, administrative payments are granted when at least eighty-five (85%) of post-payment reviews, recommendations, and findings are sustained during informal reconsideration and formal appeal stages.

Also under the Contract, the Department has the ability to conduct performance reviews or evaluations of the RAC at the Department's discretion, including if work product has declined in quality or administrative payments are not being approved. The RAC is required to provide all information necessary for the Department to complete all performance reviews or evaluations. The Department may conduct these reviews or evaluations at any point during the term of the Contract, or after the termination of the Contract for any reason.

If there is a breach of the Contract or if the scope of work is not being performed by the RAC, the Department can also issue corrective action plans to the Contract to promptly correct any violations and return into compliance with the Contract.

The Department reviews and approves the RAC's internal quality control process at the onset of the Contract and monitors the Contract work product during the term of the Contract. The Department can request changes to this process as it sees fit to improve work performance, which the RAC is required to incorporate in its process.\

The Department evaluates, calculates, and approves administrative payments when the RAC invoices the Department work claims reviews completed. The Department reviews each claim associated with the invoice and determines if the Contractor met the administrative payment criteria for each claim. The Department only approves administrative payments for claims that meet the administrative payment criteria.

Reporting of assessment results follows the Program Integrity Contract Oversight Section clearance process, depending on the nature of the results and to what audience the results are being released to. All assessments are reviewed by the RAC Manager, the Audit Contract Management and Oversight Unit Supervisor, and the Program Integrity and Contract Oversight Section Manager. Clearance for certain reporting, including legislative requests for information, can also include the Compliance Division Director, the Medicaid Operations Office Director, and other areas of the Department.

Appendix A: Waiver Administration and Operation

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities

that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	☒	☒	☒
Waiver enrollment managed against approved limits	☒	☐	☐
Waiver expenditures managed against approved levels	☒	☒	☒
Level of care evaluation	☒	☒	☒
Review of Participant service plans	☒	☒	☒
Prior authorization of waiver services	☒	☒	☒
Utilization management	☒	☒	☒
Qualified provider enrollment	☒	☒	☐
Execution of Medicaid provider agreements	☒	☒	☐
Establishment of a statewide rate methodology	☒	☐	☐
Rules, policies, procedures and information development governing the waiver program	☒	☐	☐
Quality assurance and quality improvement activities	☒	☒	☐

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which

each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
A.2 # and % of reports submitted by CDPHE as required in the Interagency Agreement (IA) that are reviewed by Dept showing cert surveys are conducted ensuring providers meet Dept standards N: # of reports submitted by CDPHE per IA that are reviewed by Dept showing cert surveys are conducted ensuring providers meet Dept standards D: Total # of reports required to be submitted by DPHE as required

Data Source (Select one):
Other
If 'Other' is selected, specify:
Reports to State Medicaid Agency/Interagency Agreement with CDPHE

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: CDPHE	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
A.3 Number and percent of deliverables submitted to the Department by the Quality Improvement Organization (QIO) demonstrating performance of delegated functions N: # of deliverables submitted to the Department by the QIO demonstrating performance of delegated functions per the contract D: Total # of QIO deliverables mandated by the contract

Data Source (Select one):
Reports to State Medicaid Agency on delegated
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

QIO		
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
A.6 Number and Percent of Fiscal Intermediary service level agreements reviewed by the Dept demonstrating financial monitoring of the BI waiver N: # of Fiscal Intermediary service level agreements reviewed by the Dept demonstrating financial monitoring of the BI waiver D: Total # of service level agreements required from the fiscal intermediary as specified in their contract.

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: Fiscal Intermediary	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
A.10 # and % of data reports submitted by the FMS vendor as specified in the contract reviewed by the Dept showing CDASS services are paid in accordance with regs N: # of data reports submitted by FMS vendors as specified in contract reviewed by Dept showing CDASS services are paid in accordance with regs D: Total data reports required to be submitted by FMS vendors as specified in the contract

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: FMS Vendors	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
A.11 Number and percent of participant trainings completed by the CDASS Training Vendor within the timeframe designated by the Department N: Number of trainings completed by the CDASS Training vendor with the timeframe designated by the Department D: Total number of trainings required to be completed within the timeframe designated by the Department

Data Source (Select one):
Reports to State Medicaid Agency on delegated
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence

		Interval =
☒ **Other** Specify: Training Vendor	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
A.13 # and % of payments paid to legally responsible persons and family members by the FMS that do not exceed 40 hours of work per week reviewed by the Dept N: # of payments

paid to legally responsible persons and family members by the FMS that do not exceed 40 hours of work per week reviewed by the Dept D: Total # of payments paid to legally responsible persons and family members by the FMS

Data Source (Select one):
Reports to State Medicaid Agency on delegated
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: FMS Vendor	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
A.14 # and % of deliverables submitted by the Recovery Audit Contractor (RAC) vendor that are reviewed by the Department demonstrating performance of delegated functions. N: # of deliverables submitted by the RAC vendor that are reviewed by the Department demonstrating performance of delegated functions. D: Total # of deliverables for RAC reviews mandated by the contract

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: RAC Vendor	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
A.15 # and % of data reports submitted by DOLA-DOH as specified in the Interagency Agreement (IA) that ensure Home Mods meet Dept. reg. requirements N: # of data reports submitted by DOLA-DOH that are reviewed by the Department as specified in the IA ensuring Home Mods meet Dept. reg. requirements D: # of data reports required to be submitted by DOLA-DOH as specified in the IA

Data Source (Select one):
Reports to State Medicaid Agency on delegated
If 'Other' is selected, specify:
Reports to State Medicaid Agency/Interagency with DOLA-DOH

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid**	☐ **Weekly**	☒ **100% Review**

Agency		
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: DOLA-DOH	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Performance Measure:
A.16 Number and percent of quality inspections performed by DOLA-DOH during the performance review period N: Number of quality inspections completed for Home Modifications during the performance period D: Total number of inspections for Home Modification required to be completed during the performance period

Data Source (Select one):
Reports to State Medicaid Agency on delegated
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: DOLA-DOH	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
A.18 # and % of data reports submitted by the Transportation ASO that are reviewed by the Dept demonstrating services meet Dept regulation requirements N: # of data reports submitted by the Transportation ASO that are reviewed by the Dept demonstrating services meet Dept regulation requirements D: # of data reports required to be submitted by the Transportation ASO as specified in the contract

Data Source (Select one):
Reports to State Medicaid Agency on delegated
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

Transportation ASO Contractor		
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
A.20 Number and percent of deliverables submitted by the CMAs reviewed by the Dept. demonstrating performance of contractual requirements. N: Number of deliverables submitted by the CMAs reviewed by the Dept. demonstrating performance of contractual requirements D: Total number of CMA deliverables mandated by the contract

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data	**Frequency of data**	**Sampling Approach***(check*

collection/generation*(check each that applies):*	**collection/generation***(check each that applies):*	*each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
	☐ **Other** Specify:

Performance Measure:
A.26 # & % of background check requirements completed by the FMS vendor for newly enrolled CDASS attendants audited by the Dept who meet the requirements in the approved waiver N:# of bkgrnd chk requirements completed by the FMS for new CDASS attendants audited by the Dept who meet the requirements in the apvd wvr D:Total # of bkgrnd chk requirements completed by the FMS for new CDASS attendants

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	Frequency of data collection/generation*(check each that applies):*	Sampling Approach*(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with +/-5% margin of error
☒ **Other** Specify: FMS Vendor	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The Dept. maintains oversight of waiver contracts/interagency agreements through tracking contract deliverables on a monthly, quarterly, semi-annually, and yearly basis depending on requirements of the contract deliverable. The Dept. reviews all required reports, documentation and communications to ensure compliance with all contractual, regulatory, and statutory requirements.

A.2
The DPHE IA is to manage aspects of provider qualifications, surveys and complaints/critical incidents. The IA requires monthly/annual reports detailing: number and types of agencies surveyed, the number of agencies with deficiencies, types of deficiencies cited, date deficiencies were corrected, number of complaints received, investigated, and substantiated. Oversight is through monthly meetings and reports. Issues that impact the agreement, problems discovered at specific agencies or widespread issues and solutions are discussed.

A.3
QIO contractor oversight is through contractual requirements and deliverables. Dept. reviews monthly, quarterly, and annual reports to ensure the QIO is performing delegated duties. The Dept.'s Operations Division ensures that deliverables are provided timely and as specified in the contract. Subject Matter Experts review deliverables for accuracy.

A.6
The fiscal agent is required to submit weekly reports regarding performance standards as established in the contract. The reports include summary data on timely and accurate coding, claims submission, claims reimbursement, time frames for completion of data entry, processing claims PARs. The Dept. monitors the fiscal agent’s compliance with Service Level Agreements through reports submitted by the fiscal agent on customer service activities included provider enrollment, provider publication, and provider training. The Dept. requests ad hoc reports as needed to monitor any additional issues or concerns.

A.10, A.13, A.26
To assure oversight of FMS entities, the contractual deliverables are overseen by an administrator at the Dept. and performance is assessed quarterly. An on-site review is conducted at least annually.

A.10
FMS is required to monitor the client’s and/or authorized representative’s submittal of required timesheet information to determine that it is complete, accurate and timely; work with the case manager to address client performance problems; provide monthly reports to the client and/or authorized representative for the purpose of financial reconciliation; and monitoring the expenditure of the annual allocation. Monitoring consists of an internal evaluation of FMS procedures, review of reports, review of complaint logs, re-examination of program data, on-site review, formal audit examinations, and/or any other reasonable procedures.

A.11
The CDASS Training Vendor provides training to assure that case managers, clients and/or authorized representatives understand the philosophy and responsibilities of participant directed care. At minimum, this training includes: an overview of the program, client and/or authorized representative rights and responsibilities, planning and organizing attendant services, managing personnel issues, communication skills, recognizing and recruiting quality attendant support, managing health, allocation budgeting, accessing resources, safety and prevention strategies, managing emergencies, and working with the FMS.

A.13
The Dept. reviews FMS vendor reports to ensure that payments made to legally responsible persons and family members that do not exceed 40 hours or work per week.

A.14
The RAC vendor is contractually required to develop a quality control plan and process to ensure that retrospective reviews are conducted accurately and in accordance with the scope of work. The Dept. may conduct performance reviews or evaluations of the vendor. Performance standards within the contract are directly tied to contractor pay based on the quality of the vendor’s performance.

A.15, A.16
The Dept. maintains oversight of the DOH IA through regular meetings and reports specified in the IA. The Dept. reviews required detailed monthly and annual reports submitted by DOH on issues that arise in the operation of the benefit, how funding is utilized under the benefit, and client and provider grievances.

A.16
The Dept. reviews DOH reports regarding results of home modification inspections that ensure adherence to local building codes and standards created for the home modification benefit; compliance with communication requirements between the provider and client; and, quality of work performed by providers.

A.18
The Dept. contracts with an ASO to act as the Transportation Broker. The ASO is responsible for coordination with the RTD, verifying eligibility, processing the RTD special discount card, dissemination of transit fares, and production of reports that demonstrate services meet Dept. regulation requirements.

A.20
Monitoring of CMAs is completed through tracking administrative contract deliverables. Regular reporting is required to assure appropriate compliance with Dept. policies, procedures and contractual obligations. The Dept. audits CMAs for administrative functions including qualifications of individuals performing assessments and service planning; process regarding evaluation of need, service planning, participant monitoring, case reviews, complaint procedures, provision of participant choice, waiver expenditures, etc.

Additional discussion on Appendix A QIS Discovery may be found in Main B. Optional

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

A.2, A.3, A.6, A.10, A.11, A.13, A.14, A.15, A.16, A.18, A.20, A.26
Delegated responsibilities of contracted agencies/vendors are monitored, corrected and remediated by the Dept.'s Office of Community Living (OCL).

During routine annual evaluation or by notice of an occurrence, the Dept. works with sister agencies and/or contracted agencies to provide technical assistance or some other appropriate resolution based on the identified situation.

If remediation does not occur timely or appropriately, the Dept. issues a "Notice to Cure" the deficiency to the contracted agency. This requires the agency to take specific action within a designated timeframe to achieve compliance.

A.20
If problems are identified during a CMA audit, the Dept. communicates findings directly with the CMA administrator, and documents findings in the CMA's annual report of audit findings, and if needed, requires corrective action.
The Dept. conducts follow-up monitoring to assure corrective action implementation and ongoing compliance. In addition, the contract with CMAs allows the Dept. to withhold funding and terminate a contract due to noncompliance.If a compliance issue extends to multiple CMAs, the Dept. provides clarification through formal Policy Memos, formal training, or both. Technical assistance is provided to CMAs via phone and e-mail.

If issues arise at any other time, the Dept. works with the responsible parties (case manager, case management supervisor, CMA Administrator) to ensure appropriate remediation occurs.

A.14
If a deficiency is identified, the Dept. will issue a corrective action plan request to the vendor, in which the vendor must create a plan that addresses the deficiency and return to contractual compliance.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Addition to annual review of CMAs, continuous reviews occur with DPHE and the fiscal agent allowing the Dept. to gather data whenever there is a complaint or issue that requires immediate attention

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	**Included**	**Target SubGroup**	**Minimum Age**	**Maximum Age**	
				Maximum Age Limit	**No Maximum Age Limit**
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	Disabled (Physical)			
	☐	Disabled (Other)			
☒ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☒	Brain Injury	16		☒
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☐ Intellectual Disability or Developmental Disability, or Both					
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Intellectual Disability			☐
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

b. Additional Criteria. The state further specifies its target group(s) as follows:

Individuals must have been determined to have a significant functional impairment as identified by a Level of Care Eligibility Determination Screen (LOC Screen) using the state-prescribed LOC Screen instrument and must require long-term support services at a level comparable to services typically provided in a nursing facility or hospital. The individual's brain injury must have occurred prior to the individual's 65th birthday. If the injury has occurred prior to the age of 65, individuals are able to receive services for the remainder of their lifetime.

The Department defines brain injury as an injury to the brain of traumatic or acquired origin which results in residual physical, cognitive, emotional, and behavioral difficulties of a non-progressive nature and is limited to the current International Classification of Diseases found in the Code of Colorado Regulations (C.C.R) 10 2505-10, Section 8.515.3 General Definitions.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

◉ **Not applicable. There is no maximum age limit**

○ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- ○ **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ○ **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

  The limit specified by the state is *(select one)*

  - ○ **A level higher than 100% of the institutional average.**

    Specify the percentage:

  - ○ **Other**

    Specify:

- ◉ **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- ○ **Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

  Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

  The cost limit specified by the state is *(select one)*:

  - ○ **The following dollar amount:**

    Specify dollar amount:

    The dollar amount *(select one)*

    - ○ **Is adjusted each year that the waiver is in effect by applying the following formula:**

      Specify the formula:

    - ○ **May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.**
  - ○ **The following percentage that is less than 100% of the institutional average:**

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

Prior to entrance into the waiver, the client and case manager meet to develop a Person-Centered Support Plan (PCSP). If the case manager identifies that a client's needs are more extensive than the services offered in the waiver can support, the case manager informs the client that his/her health and safety cannot be assured in the community and provides the client with appeal rights. Please see Appendix F-I for more information on the client's appeal rights.

c. Participant Safeguards. When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☒ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

Upon a change in the client's condition, the case manager assesses the client to determine if the client's health and welfare can be assured in the community. If the case manager determines the client's health and welfare can be assured, the case manager is authorized by the Department to approve home health or health maintenance activities and HCBS waiver services up to the cost of the home health daily limit.

Should the combined costs for waiver services and/or long-term home health exceed the cost of the home health daily limit, the Department or its agent will review the request to determine if it is appropriate and justifiable based on the client's condition. While the Department is reviewing the request, the client's existing services remain intact until the request for additional services is approved or denied. In the event that the request is denied, the client is provided with appeal rights, as well as being offered additional options of having their needs met including, but not limited to, nursing facility placement.

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	823
Year 2	924
Year 3	1113
Year 4	1294
Year 5	1504

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: *(select one)* :

- (●) **The state does not limit the number of participants that it serves at any point in time during a waiver year.**
- ( ) **The state limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- (●) **Not applicable. The state does not reserve capacity.**
- ( ) **The state reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- (●) **The waiver is not subject to a phase-in or a phase-out schedule.**
- ( ) **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- (●) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

Individuals are enrolled based upon the date of the case manager's verification of Medicaid eligibility and certification that the individual meets the functional, level of care, and additional program criteria specified in this application.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. 1. State Classification. The state is a *(select one)*:

- (●) **§1634 State**
- ( ) **SSI Criteria State**
- ( ) **209(b) State**

2. Miller Trust State.

Indicate whether the state is a Miller Trust State *(select one)*:

- ( ) **No**
- (●) **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- [ ] **Low income families with children as provided in §1931 of the Act**

☒ **SSI recipients**

☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**

☒ **Optional state supplement recipients**

☐ **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

○ **100% of the Federal poverty level (FPL)**

○ **% of FPL, which is lower than 100% of FPL.**

Specify percentage:

☒ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**

☒ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**

☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**

☐ **Medically needy in 209(b) States (42 CFR §435.330)**

☐ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

○ **No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*

◉ **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

○ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**

◉ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

☒ **A special income level equal to:**

Select one:

◉ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

○ **A dollar amount which is lower than 300%.**

Specify dollar amount:

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**

☐ **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☒ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

◉ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the state elects to (*select one*):

◉ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

The state uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

◉ **The following standard included under the state plan**

Select one:

○ **SSI standard**
○ **Optional state supplement standard**
○ **Medically needy income standard**
◉ **The special income level for institutionalized persons**

(*select one*):

◉ **300% of the SSI Federal Benefit Rate (FBR)**
○ **A percentage of the FBR, which is less than 300%**

Specify the percentage:

○ **A dollar amount which is less than 300%.**

Specify dollar amount:

○ **A percentage of the Federal poverty level**

Specify percentage:

○ **Other standard included under the state Plan**

Specify:

○ **The following dollar amount**

Specify dollar amount: If this amount changes, this item will be revised.

○ **The following formula is used to determine the needs allowance:**

Specify:

○ **Other**

Specify:

ii. Allowance for the spouse only (*select one*):

◉ **Not Applicable**

○ **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (*select one*):

○ **SSI standard**

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (*select one*):

○ **Not Applicable (see instructions)**

◉ **AFDC need standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

○ **Other**

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

○ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

◉ **The state does not establish reasonable limits.**

○ **The state establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):

- ○ **SSI standard**
- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ◉ **The special income level for institutionalized persons**
- ○ **A percentage of the Federal poverty level**

  Specify percentage:
- ○ **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised
- ○ **The following formula is used to determine the needs allowance:**

  Specify formula:
- ○ **Other**

  Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- ◉ **Allowance is the same**
- ○ **Allowance is different.**

  Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

- ○ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- ◉ **The state does not establish reasonable limits.**
- ○ **The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. Frequency of services. The state requires (select one):

- (●) **The provision of waiver services at least monthly**
- ( ) **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- ○ **Directly by the Medicaid agency**
- ○ **By the operating agency specified in Appendix A**
- ◉ **By a government agency under contract with the Medicaid agency.**

Specify the entity:

Case Management Agencies (CMAs)

- ○ **Other**

Specify:

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

The minimum qualifications for HCBS Case Managers that conduct the person-centered service plan is:

1. A bachelor's degree; or
2. Five (5) years of experience in the field of LTSS, which includes Developmental Disabilities; or
3. Some combination of education and relevant experience appropriate to the requirements of the position.
4. Relevant experience is defined as:

a. Experience in one of the following areas: long-term care services and supports, gerontology, physical rehabilitation, disability services, children with special health care needs, behavioral science, special education, public health or non-profit administration, or health/medical services, including working directly with persons with physical, intellectual or developmental disabilities, mental illness, or other vulnerable populations as appropriate to the position being filled; and

b. Completed coursework and/or experience related to the type of administrative duties performed by case managers may qualify for up to two (2) years of required relevant experience.

Safeguards to assure the health and welfare of waiver participants, including response to critical events or incidents, remain unchanged.

Agency supervisor educational experience:

The agency's supervisor(s) shall meet minimum standards for education and/or experience and shall be able to demonstrate competency in pertinent case management knowledge and skills.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

The case manager completes the LOC Screen utilizing the state-prescribed LOC Screen instrument, to determine an individual's need for institutional level of care. The LOC Screen measures six defined Activities of Daily Living (ADL) and the need for supervision for behavioral or cognitive dysfunction. ADLs include bathing, dressing, toileting, mobility, transferring, and eating. To qualify for services, an individual must demonstrate deficits in two (2) of six (6) Activities of Daily Living (ADL) or require at least moderate assistance in Behaviors or Memory/Cognition under Supervision. For initial LOC eligibility determinations, the Professional Medical Information Page (PMIP) is also required to be completed by a treating medical professional who verifies the individual's need for institutional level of care.

Additional information is documented using the Instrumental Activities of Daily Living (IADL) information page. This supplemental assessment considers a client's independence level of activities such as money management, medication management, household maintenance, transportation, meal preparation, hygiene, shopping, and accessing resources.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- (●) **The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.**
- ( ) **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

Clients are referred to the CMA for an LTSS eligibility determination. The CMA screens the referrals to determine if a LOC Screen is appropriate.

Should the CMA determine that a LOC Screen is not appropriate, the CMA provides information and referral to other agencies as needed. The client is informed of the right to request a LOC Screen if the client disagrees with the CMAs determination.

Should the CMA determine that a LOC Screen is appropriate; or if the client requests, the CMA:

- Verifies the applicant's current financial eligibility status,
- Refers the applicant to the county Department of Human and Social services of the client's county of residence for application, or
- Provides the applicant with the financial eligibility application form(s) for submission, with required attachments, to the county department of social services for the county in which the individual resides, and document follow-up on the return of forms.

The determination of the applicant's financial eligibility is completed by the county department of social services for the county in which the applicant resides.

The eligibility site shall process an application for Medical Assistance Program benefits within the following deadlines:

- 90 days for persons who apply for the Medical Assistance Program and a disability determination is required.
- 45 days for all other Medical Assistance Program applicants.
- The above deadlines cover the period from the date of receipt of a complete application to the date the eligibility site mails a notice of its decision to the applicant.

In unusual circumstances, the eligibility site may delay its decision on the application beyond the applicable deadline at its discretion. Examples of such unusual circumstances are a delay or failure by the applicant or an examining physician to take a required action such as submitting required documentation, or an administrative or another emergency beyond the agency's control.

The eligibility site shall not use the above timeframes as a waiting period before determining eligibility or as a reason for denying eligibility.

Upon verification of the applicant's financial eligibility or verification that an application has been submitted, the CMA completes the assessment within the following time frames:

- For an individual who is not being discharged from a hospital or a nursing facility, the client's LOC Screen is completed within ten (10) working days.
- For a client who is being transferred from a nursing facility to an HCBS program, the LOC Screen is completed within five (5) working days.
- For a client who is being transferred from a hospital to an HCBS program, the LOC Screen is completed within two (2) working days.

The CMA is required to complete a reevaluation of clients within 12 months of the initial or previous evaluation. A reevaluation may be completed sooner if there is a significant change in the client's condition or if required by program criteria. At both evaluation and reevaluation, a CM performs the following activities:

1. Assess the client's functional status at a time and location convenient to the individual.
2. Review care plan, service agreements, and provider contracts or agreements;
3. Evaluate service effectiveness, quality of care, and appropriateness of services;
4. Verify continuing Medicaid eligibility, other financial and program eligibility;
5. Annually, or more often if indicated, complete new PCSP and service agreements;
6. Maintain appropriate documentation, including the type and frequency of long-term care services the client is receiving for certification of continued program eligibility if required by the program for a continued stay review.
7. Refer the client to community resources as needed and develop resources for the client if the resource is not available within the client's community;
8. Submit appropriate documentation for authorization of services, in accordance with program requirements; and
9. CMAs may use phone or telehealth to complete the LOC screen when there is a documented safety risk to the case

manager or client including public health emergencies as determined by state and federal government.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**

  Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

- ◉ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ○ **The qualifications are different.**

  Specify the qualifications:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the state employs to ensure timely reevaluations of level of care *(specify):*

Case Management Agencies (CMAs) are required to maintain a tracking system to assure that re-evaluations are completed on a timely basis. The Department monitors CMAs annually to ensure compliance through record reviews and reports electronically generated by the State's case management IT system. The State's case management IT system is utilized by every CMA and contains electronic client records and the timeframes for evaluation and re-evaluation. The annual program evaluation includes a review of a random sample to ensure LOC Screens are being completed correctly and with timeliness.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Case Management Agencies (CMAs) are required to keep documentation electronically in the State's case management IT system. The State's case management IT system database is located at the Department and the documentation is accessible electronically to monitoring staff and program administrators. CMAs are monitored annually for compliance with appropriate record maintenance.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
B.a.1 Number and percent of new waiver enrollees who received a level of care eligibility determination screen (LOC Screen) indicating a need for appropriate institutional LOC prior to the receipt of services N: # of new waiver enrollees who received LOC Screen indicating a need for appropriate institutional LOC prior to the receipt of services D: Total # of new waiver enrollees reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
State's case management IT system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☒ **Other** Specify: Proportionate consolidated representative sample of CO.0006, CO.0268, and CO.0288
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
B.c.2 Number and percent of new waiver participants whose eligibility was determined using the approved processes and instruments as described in the approved waiver Numerator: Number of new waiver participants whose eligibility was determined using the approved processes and instruments as described in the approved waiver Denominator: Total number of new waiver participants reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Program Review Tool

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

	☒ **Continuously and Ongoing**	☒ **Other** Specify: Proportionate consolidated representative sample of CO.0006, CO.0268, and CO.0288
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
B.c.3 Number and percent of new waiver participants for whom a PMIP was completed N: Number of new waiver participants for whom a PMIP was completed D: Total number of new waiver participants reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Program Review Tool/Super Aggregate Report

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with +/- 5% margin of error
☒ **Other** Specify: Case Management Agency	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: Proportionate consolidated representative sample of CO.0006, CO.0268, and CO.0288
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The Department utilizes the Super Aggregate Report as the primary data source for monitoring the Level of Care (LOC) assurance and performance measures. The Super Aggregate Report is a custom report consisting of two parts: data pulled directly from the state's case management system, the State's case management IT system, the Bridge, and data received from the annual program evaluations document, the QI Review Tool. Some performance measures use State's case management IT system-only data, some use QI Review Tool-only data, and some use a combination of both State's case management IT system and/or Bridge data and QI Review Tool data. The Super Aggregate Report provides initial compliance outcomes for performance measures in the LOC sub-assurances and performance measures.

The case manager completes the LOC Screen utilizing the state-prescribed LOC Screen instrument to determine an individual's need for institutional level of care. The LOC Screen measures six defined Activities of Daily Living (ADL) and the need for supervision for behavioral or cognitive dysfunction. ADLs include bathing, dressing, toileting, mobility, transferring, and eating. For initial evaluations, the Professional Medical Information Page (PMIP) is also required to be completed by a treating medical professional who verifies the individual's need for institutional level of care.

B.a.1
The LOC Screen must be conducted prior to the Long Term Care (LTC) start date; services cannot be received prior to the LTC start date; the LOC Screen must indicate a need for an institutional level of care. Discovery data for this performance measure is pulled directly from the State's case management IT system.

B.c.2
LOC Screen must comply with Department regulations and requirements. All level of care eligibility questions must be completed to determine the level of care. The Department uses the results of the QI Review Tool and the participant's State's case management IT system record to discover deficiencies for this performance measure.

B.c.3
Compliance with this performance measure requires assurance that each initial LOC Screen has an associated PMIP completed and signed by a licensed medical professional according to Department regulations which is prior to and within six months of the LTC start date. The Department uses the QI Review Tool results and the participant's state case management IT system record to discover deficiencies for this performance measure.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

B.a.1, B.c.2, B.c.3
The Department provides remediation training for CMAs annually to assist with improving compliance with the level of care performance measures and in completing assessments. The Department compiles and analyzes CMA CAPs to determine a statewide root cause for deficiencies. Based on the analysis, the Department identifies the need to provide policy clarifications, and/or technical assistance, design specific training, and determine the need for modifications to current processes to address statewide systemic issues.

The Department monitors the level of care CAP outcomes continually to determine if individual CMA technical assistance is required, what changes need to be made to training plans, or what additional training needs to be developed. The Department will analyze future QIS results to determine the effectiveness of the training delivered. Additional training, technical assistance, or systems changes will be implemented based on those results.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: Case Management Agency	☒ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: As warranted by nature of discovery and/or severity of incident.

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the state's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

During the initial Person-Centered Support Planning process, eligible individuals and/or legal representatives are informed of feasible service alternatives provided by the waiver and the choice of either institutional or home and community-based services. This information is also presented at the continued stay review(CSR).

The LOC Screen and the Person-Centered Support Planning process assist the case manager in identifying the client's needs and supports. Based on this assessment and discussion, a PSCP is developed. All forms completed through the Person-Centered Support Planning are available for signature through digital or wet signatures based on the member’s preference. Case managers complete a PSCP information and summary form that is reviewed with the client. Case managers also provide a choice of providers.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice

forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Both written and electronically retrievable facsimiles of freedom of choice documentation are maintained by the CMA and in the State's case management IT system.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

CMAs employ several methods to assure meaningful access to waiver services by Limited English Proficient persons. Documents include a written statement in Spanish instructing clients how to obtain assistance with translation. Documents are orally translated for clients who speak other languages by a language translator.

CMAs may employ case management staff to provide translation to clients. For languages in which there is not an available translator employed by the CMA, the case manager first attempts to have a family member translate. If family members are unavailable or unable to translate, the CMA may align with specific language or ethnic centers, and/or use a telephone translation service.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service		
Statutory Service	Adult Day Health		
Statutory Service	Day Treatment		
Statutory Service	Personal Care		
Statutory Service	Respite		
Other Service	Behavioral Management and Education		
Other Service	Consumer Directed Attendant Support Services		
Other Service	Home Delivered Meals		
Other Service	Home Modification		
Other Service	Independent Living Skills Training		
Other Service	Mental Health Counseling		
Other Service	Non-medical Transportation		
Other Service	Peer Mentorship		
Other Service	Personal Emergency Response Systems (PERS)		
Other Service	Remote Support		
Other Service	Specialized Medical Equipment and Supplies/Assistive Devices		
Other Service	Substance Abuse Counseling		
Other Service	Supported Living Program		
Other Service	Transition Setup		
Other Service	Transitional Living Program		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Adult Day Health service has 2 separate tiers

Tier 1 is a 15-minute unit to be provided:
- Up to 8 units or 2 hours/day
- 15-minute unit = minimum of 8 minutes
- Can be delivered virtually or in-person

Tier 1 can be provided via telehealth or in person for up to 2 hours a day for one or more days a week for members who may be vulnerable or at higher risk for contracting illness and do not want to be in a group setting or a facility site. This tier encompasses both health and social services to assure the optimal functioning of the individual. Outpatient settings include parks, churches, and office buildings. The requirement to provide lunch, meet other food safety requirements, and provide a place to shower are waived if services are not provided in person or over the lunch hour. Providers may utilize this tier to offer virtual classes, activities, and groups using telehealth to connect members to staff and other day program members.

Tier 2 is 1 unit of in-person to be provided:
- Unit = 2 or more hours
- Must be delivered in-person

Tier 2 can be provided for 2 hours or more on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a full nutritional regimen (3 meals per day). Physical, occupational and speech therapies indicated in the individual's plan of care would be furnished as component parts of this services if such services are not being provided in the participant's home.

A member shall have the choice in how they would like to receive Adult Day Health Services.

The purpose of the telehealth option in this service is to maintain and/or improve a participant's ability to support relationships while also encourage and promote their ability to participate in the community. The telehealth delivery option must meet the following requirements:

•Each provider of the telehealth service delivery option must demonstrate policies and procedures that include they have a HIPAA compliant platform. HIPAA compliance will be reviewed regularly through the Colorado Department of Public Health and Environment (CDPHE) survey and monitoring process. Each provider will sign an attestation that they are using a HIPAA compliant platform for the Telehealth service component. The provider requirements and assurances regarding HIPAA have been approved by the states HIPAA Compliance Officer.
•Privacy rights of individuals will be assured. Each participant will utilize their own equipment or equipment provided by the provider during the provision of telehealth services. The participant has full control of the device. The member can turn off the device and end services any time they wish.
•The participant's services may not be delivered virtually 100% of the time. The Adult Day service providers must maintain a physical location where in-person services are offered. There will always be an option for in-person services available.
•Participants must have an informed choice between in person and telehealth services;
•Providers must create a published schedule of virtual services participants can select from.
•The use of the telehealth option will not block, prohibit or discourage the use of in-person services or access to the community. Members may not be inclined to attend Adult Day programming every day in-person, but may still want to participate in games and activities, such as Bingo or entertainment programs, and engage with their community and their friends, when they choose or when they otherwise would not be able to do so due to illness, transportation issues, pandemics or other personal reasons.
•Members who require hands on assistance during the provision of Adult Day Services must receive services at the center. In order to ensure the health and safety of members, case managers and providers must assess the appropriateness of virtual services with member. If it is determined that hands-on assistance is required, virtual services may not be provided. This process will be outlined in each providers policies and procedures.
•Telehealth will not be used for the provider's convenience. The option must be used to support a participant to reach identified outcomes in the participant's Person-Centered Plan.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Adult Day Health services offered in this waiver are limited based on the client's assessed need for services, physician's orders and prior authorization by case managers up to the cost containment parameters.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Services Center

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Adult Day Health

Provider Category:

Agency

Provider Type:

Adult Day Services Center

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certification as a Medicaid provider of Adult Day Services. 10 C.C.R. 2505-10, Section 8.515.70

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Environment, Health Facilities and Emergency Medical Services Division

Frequency of Verification:

Providers are surveyed at a minimum every 36.9 months. Risk-based surveys may occur more often if a credible complaint is received by CDPHE. Credible complaints are ones that are validated; when investigated they have not been found to be fabricated allegations or misinterpreted impressions of something that did not occur. During the investigation of a complaint by CDPHE, findings are severe - i.e. a systemic failure, patient harm, etc. it may cause an investigation to be converted to a full survey at the time the investigation is underway. The findings of the investigation may be grounds for CDPHE to initiate a full recertification survey of the provider agency regardless of the date of the last survey.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Day Treatment

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Day Treatment is structured, nonresidential therapeutic treatment directed towards individuals who have a prognosis for continued functional improvement. Services are delivered according to a treatment plan coordinated by a comprehensive interdisciplinary team including the client and other appropriate collaterals to provide for consolidation of services in one location. Day Treatment encompasses intensive therapeutic services, directed at the ongoing development of community living skills. It includes: social skills training, sensory motor development, reduction/elimination of maladaptive behavior and services aimed at preparing the individual for community reintegration (reaching concepts such as compliance, attending, task completion, problem solving, safety, money management); behavioral programs, and professional services including occupational therapy, physical therapy, speech therapy, vocational counseling, nursing, and recreational therapy.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Services covered under Medicaid State Plan, EPSDT or by a third party source shall not be reimbursed.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Day Treatment Center

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Treatment

Provider Category:

Agency

Provider Type:

Day Treatment Center

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certification of Medicaid provider for Day Treatment services: 10 C.C.R. 2505-10, Section 8.515.80

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Environment - Health Facilities and Emergency Medical Services Division

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Personal care includes providing assistance with eating, bathing, dressing, personal hygiene, or other activities of daily living. Although these services may include assistance with meal preparation, this service will not include the cost of the meals themselves. When specified in the service plan, personal care may also include housekeeping chores such as bed making, dusting, and vacuuming. Housekeeping assistance must be incidental to the care furnished or essential to the health and welfare of the individual rather than for the benefit of the individual's family. Payment will not be made for services furnished to a minor if services are provided by the child's parent (or stepparent).

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Relatives, of the individual receiving services by virtue of blood, marriage, adoption, or Colorado common law, may be employed by a personal care/homemaker or home health agency to provide personal care services. Relatives employed by an agency shall meet the same experience and qualification standards required of all agency employees.

This waiver service is only provided to individuals age 21 and over. All medically necessary Personal care service for children under age 21 are covered in the state plan pursuant to the EPSDT

To prevent the duplication of other waiver services where personal care is a component of that service the following is completed for each client. The case manage completes an assessment and service plan with the client or client representative to determine the appropriate services to best meet the client’s needs. The case manager ensures no duplication of services when performing service authorization. Case management agencies complete internal auditing of services to ensure compliance. The Department also completes auditing to ensure no duplication of services.

Per 25.5-6-310, C.R.S., the number of Medicaid personal care units provided by relatives shall not exceed the equivalent of 444 hours per annual certification.

Clients that choose to have personal care services delivered by an agency shall have no duplication of these services by CDASS. There shall be no duplication of the light housekeeping chores that are incidental to personal care and the services are reimbursed under the homemaker benefit. This service can only be participant-directed if the client chooses to participate in Consumer Directed.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☒ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency
Agency	Personal Care / Homemaker Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Home Care Agency, Class A or B

Certificate *(specify):*

Certification as a Medicaid provider of Home and Community Based Services. 10 C.C.R. 2505-10, Section 8.489

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Environment, Health Facilities and Emergency Medical Services Division

Frequency of Verification:

Providers are surveyed every 9-15 months for the first three years of their Medicaid certification until eligibility for a Risk Based Survey can be established. Once a Risk Base is established providers survey schedules are modified to a 9 to 36 month risk based survey cycle. Providers that have deficiencies in areas of staff training/ supervision, or client care are surveyed every 9-15 months according to the number and severity of the deficiencies. Providers that have administrative deficiencies due to errors in paperwork are surveyed every 15 to 24 months. Providers that have no deficiencies are surveyed every 24 to 36 months. In addition, if DPHE receives a complaint involving client care, the findings of the investigation may be grounds for DPHE to initiate a full survey of the provider agency regardless of the date of the last survey.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:

Agency

Provider Type:

Personal Care / Homemaker Agency

Provider Qualifications

License *(specify):*

Home Care Agency, Class A or B

Certificate *(specify):*

Certification as a Medicaid provider of Home and Community Based Services. 26-4-601, C.R.S; 10 C.C.R. 2505-10, Section 8.489 and 8.490.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Environment - Health Facilities and Emergency Medical Services Division

Frequency of Verification:

Providers are surveyed every 9-15 months for the first three years of their Medicaid certification until eligibility for a Risk Based Survey can be established. Once a Risk Base is established providers survey schedules are modified to a 9 to 36 month risk based survey cycle. Providers that have deficiencies in areas of staff training/ supervision, or client care are surveyed every 9-15 months according to the number and severity of the deficiencies. Providers that have administrative deficiencies due to errors in paperwork are surveyed every 15 to 24 months. Providers that have no deficiencies are surveyed every 24 to 36 months. In addition, if DPHE receives a complaint involving client care, the findings of the investigation may be grounds for DPHE to initiate a full survey of the provider agency regardless of the date of the last survey.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.

Respite may be received in the individual's home, a Nursing Facility (NF), or in the community. An individual would be responsible for any prorated room and board costs for the time spent in an NF.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Relatives, other than a spouse, that are related to the individual receiving services by virtue of blood, marriage, adoption, or common law may be employed by a personal care/homemaker or home health agency to provide respite services. Relatives employed by an agency shall meet the same experience and qualification standards required of all agency employees.

Relatives shall be employed by an agency and shall not be the same persons normally providing care. There shall be no duplication of this service and the personal care or homemaker.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Nursing Facility
Agency	Home Health Agency
Agency	Personal Care / Homemaker Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Nursing Facility

Provider Qualifications

License *(specify):*

Long Term Care Facility

Certificate *(specify):*

Medicaid certified nursing facility. Certification as a Medicaid Nursing Facility. 10 C.C.R. 2505-10, Section 8.430

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Environment, Health Facilities and Emergency Medical Sergvices Division

Frequency of Verification:

Every nursing facility is surveyed by DPHE every 9-15 months.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Home Care Agency, Class A or B

Certificate *(specify):*

Medicaid certified Personal care provider. Certification as a Medicaid provider of Home and Community Based Services. 10 C.C.R. 2505-10, Sections 8.489 and 8.490.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Environment, Health Facilities and Emergency Medical Services Division

Frequency of Verification:

Providers are surveyed every 9-15 months for the first three years of their Medicaid certification until eligibility for a Risk Based Survey can be established. Once a Risk Base is established providers survey schedules are modified to a 9 to 36 month risk based survey cycle. Providers that have deficiencies in areas of staff training/ supervision, or client care are surveyed every 9-15 months according to the number and severity of the deficiencies. Providers that have administrative deficiencies due to errors in paperwork are surveyed every 15 to 24 months. Providers that have no deficiencies are surveyed every 24 to 36 months. In addition, if DPHE receives a complaint involving client care, the findings of the investigation may be grounds for DPHE to initiate a full survey of the provider agency regardless of the date of the last survey.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Personal Care / Homemaker Agency

Provider Qualifications

License *(specify):*

Home Care Agency, Class A or B

Certificate *(specify):*

Medicaid certified Personal care agency Certification as a Medicaid provider of Home and Community Based Services C.R.S; 10 C.C.R. 2505-10, Sections 8.489 and 8.490.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Environment, Health Facilities and Emergency Medical Services Division

Frequency of Verification:

Providers are surveyed every 9-15 months for the first three years of their Medicaid certification until eligibility for a Risk Based Survey can be established. Once a Risk Base is established providers survey schedules are modified to a 9 to 36 month risk based survey cycle. Providers that have deficiencies in areas of staff training/ supervision, or client care are surveyed every 9-15 months according to the number and severity of the deficiencies. Providers that have administrative deficiencies due to errors in paperwork are surveyed every 15 to 24 months. Providers that have no deficiencies are surveyed every 24 to 36 months. In addition, if DPHE receives a complaint involving client care, the findings of the investigation may be grounds for DPHE to initiate a full survey of the provider agency regardless of the date of the last survey.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Behavioral Management and Education

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10040 behavior support
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Behavioral Management and Education are services necessary for the treatment of a client's severe maladaptive behaviors when these services are not available under Medicaid State Plan benefits, other third party liability coverage or other federal or state funded programs, services or supports. Program includes comprehensive assessment of behaviors, development of a structured behavioral intervention plan with specific treatment goals, working one-on-one with the client to implement the intervention plan and determine its feasibility, training family and caregivers to reinforce behavioral programming methods and goals. Periodic reassessment of the individual plan is used to revise the plan, goals and outcomes according to client need.

Telehealth is an allowable mode for delivering this service. Telehealth use is by the choice of the client and policy requires assessment for use through the support planning process by the CMA. Policy requires the provider to maintain client consent and assessment for Telehealth use. The purpose of the telehealth option in this service is to maintain and/or improve a participant's ability to support relationships while also encourage and promote their ability to participate in the community. The telehealth delivery option must meet the following requirements:

- Each provider of the telehealth service delivery option must demonstrate policies and procedures that include they have a HIPAA compliant platform. HIPAA compliance will be reviewed regularly through the Colorado Department of Public Health and Environment (CDPHE) survey and monitoring process.
- Each provider will sign an attestation that they are using a HIPAA compliant platform for the Telehealth service component. The provider requirements and assurances regarding HIPAA have been approved by the states HIPAA Compliance Officer.
- Privacy rights of individuals will be assured. Each participant will utilize their own equipment or equipment provided by the provider during the provision of telehealth services. The participant has full control of the device. The member can turn off the device and end services any time they wish.
- The participant's services may not be delivered virtually 100% of the time. The service providers must maintain a physical location where in-person services are offered. There will always be an option for in-person services available.
- Participants must have an informed choice between in person and telehealth services;
- Providers must create a published schedule of virtual services participants can select from.
- The use of the telehealth option will not block, prohibit or discourage the use of in-person services or access to the community. Members may not be inclined to attend in-person, but may still want to participate in services, engage with their community and their friends, when they choose or when they otherwise would not be able to do so due to illness, transportation issues, pandemics or other personal reasons.
- Members who require hands on assistance during the provision of the service must receive services at the center. In order to ensure the health and safety of members, case managers and providers must assess the appropriateness of virtual services with member. If it is determined that hands-on assistance is required, virtual services may not be provided. This process will be outlined in each providers policies and procedures.
- Telehealth will not be used for the provider's convenience. The option must be used to support a participant to reach identified outcomes in the participant's Person-Centered Plan.
- Individuals who need assistance utilizing remote delivery of the service will be provided training initially and ongoing if needed on how to use the equipment, including how to turn it on/off.
- Video cameras/monitors are not permitted in bedrooms and bathrooms with the exception of members who are bedridden and request to allow the telehealth service delivery option.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is not duplicative of state plan behavioral health services.

Reimbursement for telehealth services is limited to enrolled Colorado Medicaid providers and excludes the purchasing or installation of telehealth equipment or technologies.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Behavioral Programming and Education Agency
Individual	Behavior Analyst

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavioral Management and Education

Provider Category:

Agency

Provider Type:

Behavioral Programming and Education Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified as a Medicaid provider of Behavioral Programming and Educational Services: 10 C.C.R. 2505-10, Section 8.516.40.C

Other Standard *(specify):*

Providers for the Telehealth service delivery option must demonstrate policies and procedures that include:
• HIPAA compliant platforms;
• Client support given when client needs include translation, or limited auditory or visual capacities are present;
• Have a contingency plan for provision of services if technology fails; and
• Professionals do not practice outside of their respective scope
For the Telehealth service delivery option, Case Management Agencies (CMA)s will be required to:
• Provide prior authorization for all services to be rendered using Telehealth; and
Indicate client choice to use telehealth and indicate in service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health Care Policy and Financing

Frequency of Verification:

Annually.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavioral Management and Education

Provider Category:

Individual

Provider Type:

Behavior Analyst

Provider Qualifications

License *(specify):*

Board Certified Behavior Analyst

Certificate *(specify):*

Certified as a Medicaid provider for Behavioral Services: 10 C.C.R. 2505-10, Section 8.516.40.C

Other Standard *(specify):*

Providers for the Telehealth service delivery option must demonstrate policies and procedures that include:
• HIPAA compliant platforms;
• Client support given when client needs include translation, or limited auditory or visual capacities are present;
• Have a contingency plan for provision of services if technology fails; and
• Professionals do not practice outside of their respective scope
For the Telehealth service delivery option, Case Management Agencies (CMA)s will be required to:
• Provide prior authorization for all services to be rendered using Telehealth; and
Indicate client choice to use telehealth and indicate in service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health Care Policy and Financing

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Consumer Directed Attendant Support Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Services that assist an individual to accomplish activities of daily living including health maintenance, personal care, and homemaker activities.

Health maintenance activities include routine and repetitive health-related tasks furnished to an eligible member in the community or in the member's home which is necessary for health and normal bodily functioning that a person with a disability is physically unable to carry out.

Personal Care services are furnished to an eligible member in the community or in the member's home to meet the member's physical, maintenance, and support needs.

Homemaker services are general household activities provided by an attendant in a member's home to maintain a healthy and safe environment for the member. Homemaker services shall be provided only in the primary living space of the member; multiple attendants may not be reimbursed for duplicating homemaker tasks. Tasks may include the provision of homemaker activities or teaching the member homemaker activities.

The client, or the authorized representative, is responsible for selecting, training, recruiting, setting wages, scheduling, and in other ways managing the attendant.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Consumer Directed Attendant Support Services offered in this waiver are limited based on the client's assessed need for services and prior authorization by case managers up to cost containment parameters. Services offered within CDASS will not be duplicative of State Plan services or other waivered services. Client's are also unable to receive personal care services in conjunction with CDASS services. Furthermore, individual attendants must be at least 16 years of age.

In addition, spouses, guardians, and family members are limited to providing CDASS under the guidelines described in Appendix C-2, d, and e.

Coverage is distinct under Consumer Directed Attendant Support Services (CDASS) due to the method of service delivery being materially different due to it being a participant-directed option unavailable under the State Plan.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☐ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☒ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	The program participant or representative is the common law employer of workers hired, trained and managed by the participant or representative.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Consumer Directed Attendant Support Services

Provider Category:

Individual

Provider Type:

The program participant or representative is the common law employer of workers hired, trained and managed by the participant or representative.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The Department contracts with Financial Management Service Vendors to review the hiring agreements between the client and their selected CDASS attendant to ensure all forms are complete and follow employment qualifications established by the federal and state government. At a minimum, attendants must be at least 16 years of age, trained to perform appropriate tasks to meet the client's needs, and demonstrate the ability to provide support to the client and/or the authorized representative as defined in the client's Attendant Support Management Plan and Hiring Agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management Service Organization and the Department of Health Care Policy and Financing, Office of Community Living

Frequency of Verification:

The FMS vendor shall ensure all employment paperwork required by the federal and state government is complete and filed prior to the attendant being hired and eligible to perform services.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home Delivered Meals

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Home Delivered Meals services offer nutritional counseling and meal planning, preparation, and delivery to support a client.

Services do not include the provision of items outside of the nutritional meals identified in the meal planning, such as additional food items or cooking appliances.

To access Home Delivered Meals, a client must participate in a needs assessment through which they demonstrate a need for the service based on the following:

- The client demonstrates a need for nutritional counseling, meal planning, and preparation;
- The client shows documented special dietary restrictions or specific nutritional needs;
- The client cannot prepare meals with the type of nutrition vital to meeting their special dietary restrictions or special nutritional needs;
- The client has limited or no outside assistance, services, or resources through which they can access meals with the type of nutrition vital to meeting their special dietary restrictions or special nutritional needs; and
- The client's need demonstrates a risk to health, safety, or institutionalization; and
- The client demonstrates that, within 365 days, they have the ability to acquire skills, other services, or other resources to access meals.

To access Home Delivered Meals for individuals who are discharged from the hospital, a client must meet the following requirements:

- Has been admitted to the hospital or Emergency Department for at least one (1) day;
- Screened by a physician, registered dietician or nutrition professional, or clinical social worker to receive meals through the program.
- Demonstrates a risk to health, safety, institutionalization, or readmission to the hospital;
- Demonstrates a need for nutritional counseling, meal planning, and preparation;
- Has a documented special dietary restrictions or specific nutritional needs;
- Cannot prepare meals with the type of nutrition vital to meeting their special dietary restrictions or special nutritional needs;
- Does not reside in a provider-owned or controlled setting; and
- Has limited or no outside assistance, services, or resources through which they can access meals with the type of nutrition vital to meeting their special dietary restrictions or special nutritional needs.

The assessed need is documented in the Service Plan as part of the client's acquisition process, which includes gradually becoming capable of preparing his/her own meals or establishing the resources to obtain needed meals.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Home Delivered Meal services are available over a period of 365 days following the first day the service is provided.

The unit designation for Home Delivered Meal services is per meal. Meals are limited to two meals per day or 14 meals delivered one day per week. Home Delivered Meals is not available when the person resides in a provider owned or controlled setting.

Home Delivered Meals services post hospital discharge are available for 30 calendar days following discharge from a hospital stay up to two (2) times per service plan certification year. Meals are limited to two meals per day or 14 meals delivered one day per week.

Exceptions will be granted based on extraordinary circumstances.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Delivered Meals Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Home Delivered Meals Provider

Provider Qualifications

License *(specify):*

The provider must be a legally constituted entity or foreign entity (outside of Colorado) registered with the Colorado Secretary of State Colorado with a Certificate of Good Standing to do business in Colorado.

The provider shall have all licensures required by the State of Colorado Department of public health and Environment (CDPHE) for the performance of the service or support being provided, including necessary Retail Food License and Food Handling License for Staff; or be approved by Medicaid as a home delivered meals provider in their home state.

Certificate *(specify):*

The provider must meet the certification standards in §8.487.20 (10 CCR 2505-10.

The provider must have an on-staff or contracted certified Registered Dietitian (RD) or Registered Dietitian Nutritionist (RDN).

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health Care Policy and Financing and the Department of Public Health and Environment.

Frequency of Verification:

Initially and at submission of renewed license upon expiration of each required license. In addition, if CDPHE receives a complaint involving client care, the findings of the investigation may be grounds for CDPHE to initiate a full survey of the provider agency regardless of the date of their last survey.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home Modification

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Those physical adaptations to the home, required by the individual's plan of care, which are necessary to assure the health, welfare, and safety of the individual, or which enable the individual to function with greater independence in the home, and without which the individual would require institutionalization.

Excluded are those adaptations or improvements to the home which are of general utility and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, or covered under the Durable Medical Equipment benefit within the state plan. Adaptations that add to the total square footage of the home are excluded from this benefit. Home modifications are reviewed with the case manager and outlined in the person centered service plan to confirm the participant will meet the assessed need prior to approval and completion of work. All services shall be provided in accordance with applicable State and local building codes.

It may be necessary to make home modifications to an individual’s place of residence before they transition from an institution to the community. Such modifications may be made while the person is institutionalized if the individual is in the process of transitioning. Home modifications, included in the individual’s plan of care, may be furnished up to 180 consecutive days prior to the individual’s discharge from an institution. However, such modifications will not be considered complete until the date the individual leaves the institution and is enrolled in the waiver. Home modifications made under this circumstance may not be billed to the HCBS waiver authority until the date the individual leaves the institution and enters the HCBS waiver.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Home modifications are limited based on the client's assessed need for services. The total cost of home modification shall not exceed $14,000 over the life of the waiver except that, on a case-by-case basis, a higher amount may be approved, if there is an immediate risk of the client being institutionalized or a significant change in the member's needs since a previous home modification.

During the Public Health Emergency (PHE), some individuals on the waiver will have exceeded the lifetime cap as there is a temporary $10,000 increase, $24,000 total, to the service limit to help members continue to live in their home and the community. This increase will continue through December 31, 2024 to ensure continuity of operations and assurance of client health, safety, and welfare within waiver benefits due to the COVID-19 pandemic. Beginning January 1, 2025, the waiver life cycle cap will begin at $14,000 per individual.

Criteria for consideration above the $14,000 to ensure client health and welfare include: 1) a change in the client's condition and needs since the previous home modification, if applicable; 2) length of time since previous home modification, if applicable; and 3) amount requested over the cap. On occasion, the health, safety, and welfare of the client may still not be assured by exceeding the lifetime cap. In these limited situations, the Department would evaluate the client for eligibility for other programs, supports, and services that would ensure the client's health and welfare. This could include removing the client from the waiver.

Home modifications shall not be made to provider-owned housing. All medically necessary Home Modifications that are covered under the Durable Medical Equipment benefit within the state plan shall be accessed first. The Home Modification service under this waiver is limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives of avoiding institutionalization.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☒ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Licensed Building Contractor
Agency	Contractor Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Modification

Provider Category:

Individual

Provider Type:

Licensed Building Contractor

Provider Qualifications

License *(specify):*

As required by State and local laws

Certificate *(specify):*

Certification as a Medicaid Home Modification Provider 10 C.C.R. 2505-10 Section 8.493.12. Meets Uniform Building Codes as adopted by the State of Colorado, and meets local building codes.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health Care Policy and Financing

Frequency of Verification:

The Department currently reviews the provider qualifications at the time of initial application and every five years through provider re-validation.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Modification

Provider Category:

Agency

Provider Type:

Contractor Agency

Provider Qualifications

License *(specify):*

As required by State and local law.

Certificate *(specify):*

Certification as a Medicaid Home Modification Provider 10 C.C.R. 2505-10 Section 8.493.12. Meets Uniform Building Codes as adopted by the State of Colorado, and meets local building codes.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health Care Policy and Financing

Frequency of Verification:

The Department currently reviews the provider qualifications at the time of initial application and every five years through provider re-validation.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Independent Living Skills Training

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Independent Living Skills Training (ILST) is designed and directed at the development and maintenance of the waiver participant's ability to be self-sustaining physically, emotionally, socially and economically in the community. Skills training may include assessment, training and supervision or assistance to an individual with self-care and the activities of daily living as well as medication supervision, task completion, communication skill building, interpersonal skill development, socialization training, community mobility training, reduction or elimination of maladaptive behaviors, problem solving, benefits coordination, resource coordination, financial management and household management. ILST shall be delivered according to client's service plan and need for rehabilitation maintenance.

Telehealth is an allowable mode for delivering this service. Telehealth use is by the choice of the client and policy requires assessment for use through the support planning process by the CMA. Policy requires the provider to maintain client consent and assessment for Telehealth use. The purpose of the telehealth option in this service is to maintain and/or improve a participant's ability to support relationships while also encourage and promote their ability to participate in the community. The telehealth delivery option must meet the following requirements:

•Each provider of the telehealth service delivery option must demonstrate policies and procedures that include they have a HIPAA compliant platform. HIPAA compliance will be reviewed regularly through the Colorado Department of Public Health and Environment (CDPHE) survey and monitoring process. Each provider will sign an attestation that they are using a HIPAA compliant platform for the Telehealth service component. The provider requirements and assurances regarding HIPAA have been approved by the states HIPAA Compliance Officer.
•Privacy rights of individuals will be assured. Each participant will utilize their own equipment or equipment provided by the provider during the provision of telehealth services. The participant has full control of the device. The member can turn off the device and end services any time they wish.
•The participant's services may not be delivered virtually 100% of the time. The service providers must maintain a physical location where in-person services are offered. There will always be an option for in-person services available.
•Participants must have an informed choice between in person and telehealth services;
•Providers must create a published schedule of virtual services participants can select from.
•The use of the telehealth option will not block, prohibit or discourage the use of in-person services or access to the community. Members may not be inclined to attend in-person, but may still want to participate in services, engage with their community and their friends, when they choose or when they otherwise would not be able to do so due to illness, transportation issues, pandemics or other personal reasons.
•Members who require hands on assistance during the provision of the service must receive services at the center. In order to ensure the health and safety of members, case managers and providers must assess the appropriateness of virtual services with member. If it is determined that hands-on assistance is required, virtual services may not be provided. This process will be outlined in each providers policies and procedures.
•Telehealth will not be used for the provider's convenience. The option must be used to support a participant to reach identified outcomes in the participant's Person-Centered Plan.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

ILST is billed in 15 minute unit increments. Intensive ILST delivered for rehabilitation shall be no more than 40 hours per week and shall not exceed five years in duration. After five years, ILST shall be delivered according to a maintenance level, not to exceed 28 hours per week. This service is available to clients determined eligible for specialized nursing facility level of care by the SEP agency. Maintenance includes cueing, reminding and prompting of previously delivered skills training to keep the client from regressing. Maintenance also includes working with the client and the client's Personal Care Provider to achieve an integrated care plan that will reinforce skills training.

Reimbursement for Telehealth services is limited to enrolled Colorado Medicaid providers and excludes the purchasing or installation of telehealth equipment or technologies.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Independent Living Skills Training Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Independent Living Skills Training

Provider Category:

Agency

Provider Type:

Independent Living Skills Training Provider

Provider Qualifications

License *(specify):*

Home Care Agency Class A or B license

Certificate *(specify):*

Certified as a Medicaid provider of Independent Living Skills Training: 10 C.C.R. 2505-10, Section 8.516.10.C.

Other Standard *(specify):*

Providers for the Telehealth service delivery option must demonstrate policies and procedures that include:

•HIPAA compliant platforms;

•Client support given when client needs include: accessibility, translation, or limited auditory or visual capacities are present;

•Have a contingency plan for provision of services if technology fails;

•Professionals do not practice outside of their respective scope; and

•Assessment of clients and caregivers that identifies a client's ability to participate in and outlines any accommodations needed while utilizing Telehealth.

For the Telehealth service delivery option, Case Management Agencies (CMA)s will be required to:

•Provide prior authorization for all services to be rendered using Telehealth; and

Indicate client choice to use telehealth and indicate in service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Environment.

Frequency of Verification:

Initially and every three years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Mental Health Counseling

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10060 counseling
Category 2:	**Sub-Category 2:**
10 Other Mental Health and Behavioral Services	10090 other mental health and behavioral services
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Mental Health Counseling services are designed to assist the client in managing and overcoming as effectively as possible the difficulties and stresses confronted after brain injury. As a benefit of the HCBS-BI Waiver, Mental Health Counseling expands mental health services offered under the Medicaid State Plan by serving a brain-injury specific population with individuals trained to work with that disability. Further, it is not limited to the diagnosis or treatment of a covered mental health disorder and by allowing more than 35 visits per state fiscal year. If a client requires traditional counseling services those would be sought under the state plan. Counseling includes services for families of individuals served by this waiver. For purposes of this service "family" is defined as persons who live with or provide care to a recipient of waiver services, and may include a parent, spouse, child, relative, foster family or in-laws. "Family" does not include individuals who are employed to care for recipient except where a family member may be providing personal care and receiving compensation. All individual, group and family counseling shall be included in the individual's written plan of care.

Telehealth is an allowable mode for delivering this service. Telehealth use is by the choice of the client and policy requires assessment for use through the support planning process by the CMA. Policy requires the provider to maintain client consent and assessment for Telehealth use. The purpose of the telehealth option in this service is to maintain and/or improve a participant's ability to support relationships while also encourage and promote their ability to participate in the community. The telehealth delivery option must meet the following requirements:

•Each provider of the telehealth service delivery option must demonstrate policies and procedures that include they have a HIPAA compliant platform. HIPAA compliance will be reviewed regularly through the Colorado Department of Public Health and Environment (CDPHE) survey and monitoring process. Each provider will sign an attestation that they are using a HIPAA compliant platform for the Telehealth service component. The provider requirements and assurances regarding HIPAA have been approved by the states HIPAA Compliance Officer.
•Privacy rights of individuals will be assured. Each participant will utilize their own equipment or equipment provided by the provider during the provision of telehealth services. The participant has full control of the device. The member can turn off the device and end services any time they wish.
•The participant's services may not be delivered virtually 100% of the time. The service providers must maintain a physical location where in-person services are offered. There will always be an option for in-person services available.
•Participants must have an informed choice between in person and telehealth services;
•Providers must create a published schedule of virtual services participants can select from.
•The use of the telehealth option will not block, prohibit or discourage the use of in-person services or access to the community. Members may not be inclined to attend in-person, but may still want to participate in services, engage with their community and their friends, when they choose or when they otherwise would not be able to do so due to illness, transportation issues, pandemics or other personal reasons.
•Members who require hands on assistance during the provision of the service must receive services in-person. In order to ensure the health and safety of members, case managers and providers must assess the appropriateness of virtual services with member. If it is determined that hands-on assistance is required, virtual services may not be provided. This process will be outlined in each providers policies and procedures.
•Telehealth will not be used for the provider's convenience. The option must be used to support a participant to reach identified outcomes in the participant's Person-Centered Plan.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Reimbursement for Telehealth services is limited to enrolled Colorado Medicaid providers and excludes the purchasing or installation of telehealth equipment or technologies.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Licensed Professional

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Mental Health Counseling

Provider Category:

Individual

Provider Type:

Licensed Professional

Provider Qualifications

License *(specify):*

Professional license, as required by federal and state law.

Certificate *(specify):*

Certification of Medicaid provider for Mental Health Counseling: 10 C.C.R. 2505-10, Section 8.516.50.D

Other Standard *(specify):*

Providers for the Telehealth service delivery option must demonstrate policies and procedures that include:

• HIPAA compliant platforms;

• Client support given when client needs include: accessibility, translation, or limited auditory or visual capacities are present;

• Have a contingency plan for provision of services if technology fails;

• Professionals do not practice outside of their respective scope; and

•Assessment of clients and caregivers that identifies a client's ability to participate in and outlines any accommodations needed while utilizing Telehealth.

For the Telehealth service delivery option, Case Management Agencies (CMA)s will be required to:

• Provide prior authorization for all services to be rendered using Telehealth; and

Indicate client choice to use telehealth and indicate in service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy and Financing.

Frequency of Verification:

Annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through

the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Non-medical Transportation

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Service offered in order to enable individuals served on the waiver to gain access to waiver and other community services, activities and resources, specified by the service plan. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State Plan, defined at 42 CFR 440.170 (a) (if applicable), and shall not replace them. Transportation services under the waiver shall be offered in accordance with the individuals service plan. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge will be utilized.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Non-medical transportation services offered in this waiver are limited based on the clients assessed need for services, physicians orders and prior authorization by case managers up to the cost containment parameters. Clients may utilize a combination of NMT services up to the Department prescribed limit.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Organized Health Care Delivery System (OHCDS)
Individual	Non-medical Transportation Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Non-medical Transportation

Provider Category:

Agency

Provider Type:

Organized Health Care Delivery System (OHCDS)

Provider Qualifications

License *(specify):*

Colorado Drivers License or Commercial Drivers License, or C.R.S. 40-10-101 et.seq.

Certificate *(specify):*

Other Standard *(specify):*

Rules: 10 CCR 2505-10 § 8.611 Transportation.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy & Financing

Frequency of Verification:

Verification of provider qualification is completed upon initial Medicaid enrollment and every five years through provider revalidation.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Non-medical Transportation

Provider Category:

Individual

Provider Type:

Non-medical Transportation Provider

Provider Qualifications

License *(specify):*

As required by state law.

Certificate *(specify):*

Medicaid certified. Certification as a Medicaid provider of Non-medical transportation provider 10 C.C.R. 2505-10, Section 8.494: All drivers shall possess a valid Colorado drivers license, shall be free of physical or mental impairment that would adversely affect driving performance, and have not had two or more convictions or chargeable accidents within the past two years. And All vehicles and related auxiliary equipment shall meet all applicable federal, state and local safety inspection and maintenance requirements, and shall be in compliance with state automobile insurance requirements.

Other Standard *(specify):*

The contracted Administrative Services Organization (ASO) must be engaged in a provider agreement with the Department, and comply with all regulations in C.R.S 10 C.C.R 2505-10, Section 8.00 and 8.100.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health Care Policy and Financing.

Frequency of Verification:

The Department currently reviews the provider qualifications at the time of initial application and on an annual basis.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Peer Mentorship

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition (Scope):

Peer Mentorship is provided by a peer who draws from common experience to support a client with acclimating to community living. The peer supports a client with advice, guidance, and encouragement on matters of community living, including through describing real-world experiences, encouraging the client's self-advocacy and independent living goals, and modeling strategies, skills, and problem-solving.

Peer Mentorship does not include services or activities that are solely diversional or recreational in nature.

To access Peer Mentorship, a client must participate in a needs assessment through which they demonstrate a need for the service based on the following:

- The client demonstrates a need for a peer to mentor the client in acclimating to community living; and
- The client's need demonstrates health, safety, or institutional risk; and
- There are no other services or resources available to meet the need; and
- The client demonstrates that, within 365 days, they have ability to acquire these skills or establish other services or resources necessary to their need.

Telehealth is an allowable mode for delivering this service. Telehealth use is by the choice of the client and policy requires assessment for use through the support planning process by the CMA. Policy requires the provider to maintain client consent and assessment for Telehealth use. The purpose of the telehealth option in this service is to maintain and/or improve a participant's ability to support relationships while also encourage and promote their ability to participate in the community. The telehealth delivery option must meet the following requirements:

- Each provider of the telehealth service delivery option must demonstrate policies and procedures that include they have a HIPAA compliant platform. HIPAA compliance will be reviewed regularly through the Colorado Department of Public Health and Environment (CDPHE) survey and monitoring process. Each provider will sign an attestation that they are using a HIPAA compliant platform for the Telehealth service component. The provider requirements and assurances regarding HIPAA have been approved by the states HIPAA Compliance Officer.
- Privacy rights of individuals will be assured. Each participant will utilize their own equipment or equipment provided by the provider during the provision of telehealth services. The participant has full control of the device. The member can turn off the device and end services any time they wish.
- The participant's services may not be delivered virtually 100% of the time. The service providers must maintain a physical location where in-person services are offered. There will always be an option for in-person services available.
- Participants must have an informed choice between in person and telehealth services;
- Providers must create a published schedule of virtual services participants can select from.
- The use of the telehealth option will not block, prohibit or discourage the use of in-person services or access to the community. Members may not be inclined to attend in-person, but may still want to participate in services, engage with their community and their friends, when they choose or when they otherwise would not be able to do so due to illness, transportation issues, pandemics or other personal reasons.
- Members who require hands on assistance during the provision of the service must receive services in-person. In order to ensure the health and safety of members, case managers and providers must assess the appropriateness of virtual services with member. If it is determined that hands-on assistance is required, virtual services may not be provided. This process will be outlined in each providers policies and procedures.
- Telehealth will not be used for the provider's convenience. The option must be used to support a participant to reach identified outcomes in the participant's Person-Centered Plan.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Clients may utilize Peer Mentorship services over a period of 365 days.

Peer Mentorship is billed in 15-minute units. Clients may utilize Peer Mentorship up to 24 units (six hours) a day, and up to 365 days upon initial service provision.
Exceptions will be granted based on extraordinary circumstances.

Reimbursement for Telehealth services is limited to enrolled Colorado Medicaid providers and excludes the purchasing or installation of telehealth equipment or technologies.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Peer Mentorship Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Peer Mentorship

Provider Category:

Agency

Provider Type:

Peer Mentorship Provider

Provider Qualifications

License *(specify):*

The provider agency must be licensed under a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all applicable local, state, and federal requirements, laws, and regulations.

Certificate *(specify):*

The provider agency must be a legally constituted entity or foreign entity (outside of Colorado) registered with the Colorado Secretary of State Colorado with a Certificate of Good Standing to do business in Colorado.

The provider must meet the standards for a Certified Medicaid provider under 10 C.C.R. 2505-10 Section 8.515.6.C

Other Standard *(specify):*

The provider must ensure services are delivered by a peer mentor staff who:

•Has lived experience transferable to support a client in acclimating to community living through providing them client advice, guidance, and encouragement on matters of community living, including through describing real-world experiences, encouraging the client's self-advocacy and independent living goals, and modeling strategies, skills, and problem-solving;
•Is qualified in the customized needs of the client as described in the Service Plan.
•Has completed the provider agency's peer mentor training, which is to be consistent with core competencies as defined by the Department.

Providers for the Telehealth service delivery option must demonstrate policies and procedures that include:
•HIPAA compliant platform
•Client support given when client needs include: accessibility, translation, or limited auditory or visual capacities are present;
•Have a contingency plan for provision of services if technology fails;
•Professionals do not practice outside of their respective scope; and
•Assessment of clients and caregivers that identifies a client's ability to participate in and outlines any accommodations needed while utilizing Telehealth.

For the Telehealth service delivery option, Case Management Agencies (CMA)s will be required to:
•Provide prior authorization for all services to be rendered using Telehealth; and
Indicate client choice to use telehealth and indicate in service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Environment.

Frequency of Verification:

Initially and every 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Personal Emergency Response Systems (PERS)

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

PERS is an electronic device, which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. Monitoring of the device is included in the PERS service. The response center is staffed by trained professionals.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time and who would otherwise require routine supervision.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Alert Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response Systems (PERS)

Provider Category:

Agency

Provider Type:

Personal Alert Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certification as a Medicaid provider of Electronic Monitoring services. C.R.S (2005); 10 C.C.R. 2505-10, Section 8.488

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health Care Policy and Financing

Frequency of Verification:

The Department currently reviews the provider qualifications at the time of initial application and on an annual basis.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Remote Support

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Remote Support includes live two-way support from a remote location that increases the HCBS member's independence and integration into the community. Remote Support is available to the member if needs are identified through the person-centered planning process that can be met through remote coaching, prompts, supervision, or consultation rather than with in-person assistance.

The goal of Remote Support is to increase autonomy by providing the member an opportunity to build life skills through independent learning via cueing, coaching, and on-call support. The member engages with their remote support in the setting they choose. This support not only allows the member to be more independent and have increased autonomy, but directly supports community integration, rather than institutionalization, since the member receives their needed supports in their chosen community and in a person-centered way.

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

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

Member Consent and Privacy:

Members will acknowledge the risks of using technology in any setting. When remote support is added to a member's home where there is family living (and not providing informal support), every member of the household must consent to the use of the Remote Support Technology devices during the person-centered planning process. The member can choose an area within the home to video call or video chat their Remote Support provider for privacy.

The member's interaction with support staff may be scheduled, on-demand, or in response to an alert from a device in the technology integrated system. The type of technology and where it is placed will depend upon the needs and preferences of the member. When a member elects to receive remote support, the person-centered support plan will reflect how many hours/days per week a member will receive this support.

Video and audio devices may not be mounted in a bathroom or bedroom. The Department will not allow the use of passive video or audio monitoring technology without a documented need identified in the member's Person-Centered Support Plan prior to use and consented to by every member of the household during the person-centered planning process.

Additionally, Remote Support Providers will have written policies and procedures regarding the safeguarding of member privacy.

Remote Support Plan and Backup Support Person(s):

Department policy requires the Remote Support Provider to provide documentation in the form of a Remote Support Plan that details when and where the Remote Support provider will be expected to provide support, what the support is for (coaching for Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs), reminders, check ins, etc), what Remote Support Technology will be used, and a list of backup persons or agency to contact in the case of emergency or when in-person support is needed for a specific task.

Department policy will direct case managers to ensure a completed remote support plan with a list of backup support is in place in the member's person-centered support plan before authorizing services.

The Remote Supports Plan with the back up support list must be kept by the provider and be up to date.

Remote Support Technology

Remote Support Technology means any item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used for Remote Supports and maintained by an enrolled Remote

Supports Provider to increase, maintain, or improve functional capabilities of members. Remote Support Technology does not include the cost of cell phones, internet access, landline telephone lines, cellular phone voice, and/or data plans necessary for the provision of services.

Remote Support Technology will enhance/increase the member's independence by providing real-time support with tasks that do not require hands-on assistance and that would otherwise require an in-home visit by a provider.

Remote Support Technology will help members increase opportunities to fully integrate into the community and participate in community activities by allowing members to connect with Remote Support providers and their community at times when inclement weather or a health condition would confine them to their homes.

The provision of all necessary equipment to deliver Remote Supports is the responsibility of the Remote Supports provider and the cost for this equipment is built into a separate line-item dollar for dollar rate within the Remote Supports service. The Remote Supports provider will be responsible for the installation, maintenance, and removal of all Remote Support Technology. Need for Remote Support technology is based on the person-centered planning process.

The Remote Support methodology is accepted by the state's HIPAA Compliance Officer.

The Remote Support Provider will have a backup power system (such as battery power and/or generator) in place at the monitoring base in the event of electrical power outages.

Case managers will also be responsible for ensuring equipment is functioning and that the member has the training and ability to use the equipment during regular monitoring visits.

Assurances:

The well-developed person-centered support plan will document the member's specific health and welfare needs and how each support selected by the member contributes to meeting their needs and does not duplicate services or supports.

Policy requires providers to work collaboratively with the member, and case manager at a minimum, for selecting Remote Supports and identifying goals and desired outcomes in the member's Person-Centered Support Plan.

Remote Supports cannot be billed for any support that could be provided via telehealth from other services. These include all services authorized to deliver telehealth at 10 C.C.R. 2505-10 Section 8.7559

Each provider of Remote Supports must demonstrate policies and procedures that include the use of a HIPAA compliant platform. Each provider will sign an attestation that they are using a HIPAA compliant platform for the technology/devices used. The provider requirements and assurances regarding HIPAA have been approved by the state's HIPAA Compliance Officer.

The privacy rights of a member will be assured by the Remote Supports provider and Case Manager. The member has full control of any device. The Remote Supports provider will ensure that the member can turn off devices and technology being used and end services any time they choose. All individuals in the household of the member receiving Remote Supports shall give their consent for Remote Supports during the person-centered support planning process.

Policy requires providers to maintain emergency contact protocols in the event the member requests in-person assistance.

Policy requires the provider to maintain contact with the member until the responsible backup person arrives or in the event of an emergency until emergency services personnel arrive.

Members must have an informed choice between Remote Supports and other in-person services.

Remote Support service must be used in conjunction with Remote Support Technology for an integrated support approach.

The member’s Home and Community-Based Services may not be delivered remotely 100% of the time. There will always be an option for in-person services available.

The use of the remote supports option will not block, prohibit or discourage the use of in-person services or access to the community.

If it is determined that hands-on assistance is required, remote support may not be provided. This process will be outlined in each provider's policies and procedures.

Remote support technology will not be used for the provider's convenience. The option must be used to support a member to reach identified outcomes in the member’s Person-Centered Support Plan.

Members will be fully trained initially and ongoing, if needed, by the Remote Support Provider on the use of equipment and remote support service, including how to turn it on/off.

Members will maintain the right to revoke consent and discontinue the use of Remote Supports at any time.

The case manager is required to work with the member and their family/guardian to ensure member choice and appropriateness in selecting any home and community-based service, including Remote Support. These discussions and decisions will be documented by the case manager in the Person-Centered Support Plan.

Case managers will be responsible for ensuring the health and safety of members utilizing remote support during regular monitoring visits.

The member’s Home and Community-Based Services may not be delivered remotely 100% of the time. There will always be an option for in-person services available.

The use of the remote supports option will not block, prohibit or discourage the use of in-person services or access to the community.

If it is determined that hands-on assistance is required, remote support may not be provided. This process will be outlined in each provider's policies and procedures.

Remote support technology will not be used for the provider's convenience. The option must be used to support a member to reach identified outcomes in the member’s Person-Centered Support Plan.

Members will be fully trained initially and ongoing, if needed, by the Remote Support Provider on the use of equipment and remote support service, including how to turn it on/off.

Members will maintain the right to revoke consent and discontinue the use of Remote Supports at any time.

The case manager is required to work with the member and their family/guardian to ensure member choice and appropriateness in selecting any home and community-based service, including Remote Support. These discussions and decisions will be documented by the case manager in the Person-Centered Support Plan.

Case managers will be responsible for ensuring the health and safety of members utilizing remote support during regular monitoring visits.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Remote Support is limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Remote Support must replace an identified need for in-person support and not be duplicative of any other waiver service.

Remote Supports must never be used to restrict a person from their home, community, or body autonomy.

Remote Supports cannot be provided for any service or support that is authorized for telehealth.

Remote Support Technology must be provided in conjunction with Remote Support service.

Remote Support is provider managed and must be provided by a Remote Support enrolled Medicaid Provider.

Remote Supports service may NOT be provided by:
• Legally Responsible Person
• Relative
• Legal Guardian

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Remote Supports Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Remote Support

Provider Category:

Agency

Provider Type:

Remote Supports Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

The provider must meet the standards for a Certified Remote Supports Medicaid provider under 10 C.C.R. 2505-10 Section 8.488 and must receive the Department Remote Support Provider Training Completion Certificate.

Other Standard *(specify):*

• Must be at least 18 years of age

• Have the ability to communicate effectively, complete required forms and reports, and follow verbal and written instructions

• Have the ability to provide services in accordance with a Service Plan

• Have competed minimum training based on State training guidelines

• Have necessary ability to perform the required job tasks

• Have the interpersonal skills needed to effectively interact with members receiving waiver services

Verification of Provider Qualifications

Entity Responsible for Verification:

Colorado Department of Health Care Policy & Financing

Frequency of Verification:

The Department currently reviews the provider qualifications at the time of initial application and every 5 years at recertification.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Specialized Medical Equipment and Supplies/Assistive Devices

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Specialized medical equipment and supplies includes devices, controls or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate wih the environment in which they live.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items and durable/non-durable medical equipment not available under the Medicaid State Plan.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State Plan and shall exclude items which are not of direct medical or remedial benefit to the individual. The service under this waiver is limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives of avoiding institutionalizationAll items shall meet applicable standards of manufacture, design and installation.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Medical Equipment Suppliers
Agency	Organized Health Care Delivery System (OHCDS)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies/Assistive Devices

Provider Category:

Individual

Provider Type:

Medical Equipment Suppliers

Provider Qualifications

License *(specify):*

As required by state, county and local laws.

Certificate *(specify):*

Certified as a Medicaid provider of Specialized Medical Equipment and Supplies: 10 C.C.R. 2505-10, Section 8.515.50.C.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy and Financing.

Frequency of Verification:

Annually.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies/Assistive Devices

Provider Category:

Agency

Provider Type:

Organized Health Care Delivery System (OHCDS)

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

Other Standard *(specify):*

The product or service to be delivered shall meet all applicable manufacturer specifications, state and local building codes, and Uniform Federal Accessibility Standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy & Financing

Frequency of Verification:

Verification of provider qualification is completed upon initial Medicaid enrollment and every five years through provider revalidation.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Substance Abuse Counseling

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10090 other mental health and behavioral services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Substance Abuse Counseling is designed to assist the client in reducing or eliminating the use of alcohol and/or drugs which, if not effectively addressed, may interfere with the person's ability to remain integrated in the community. These services are provided under the HCBS-BI Waiver because they are integral to the rehabilitation and maintenance of brain injured persons in a community setting. Clients will seek substance abuse counseling through the State Plan before utilizing waiver services. Substance abuse services are provided in a non-residential setting and shall include assessment, development of an intervention plan, implementation of the plan and ongoing education and training for the client, family and/or caregivers. When appropriate, periodic reassessment and education regarding appropriate use of prescription medication will be made available. Substance abuse counseling is provided in individual, group and family settings.

The service under the waiver is distinct from the State plan coverage as it requires providers be specialized in training on how to work with individuals with a brain injury. This requirement stipulates requirements and specialization for counselors beyond what is necessary on the state plan. Given the unique nature of the disability and the high level of co-occurrence with substance use disorder, this particular service is needed on the waiver in order to specialize coverage for this population, making provider types materially different than what is available on the state plan.

Telehealth is an allowable mode for delivering this service. Telehealth use is by the choice of the client and policy requires assessment for use through the support planning process by the CMA. Policy requires the provider to maintain client consent and assessment for Telehealth use. The purpose of the telehealth option in this service is to maintain and/or improve a participant's ability to support relationships while also encourage and promote their ability to participate in the community. The telehealth delivery option must meet the following requirements:

• Each provider of the telehealth service delivery option must demonstrate policies and procedures that include they have a HIPAA compliant platform. HIPAA compliance will be reviewed regularly through the Colorado Department of Public Health and Environment (CDPHE) survey and monitoring process. Each provider will sign an attestation that they are using a HIPAA compliant platform for the Telehealth service component. The provider requirements and assurances regarding HIPAA have been approved by the states HIPAA Compliance Officer.

• Privacy rights of individuals will be assured. Each participant will utilize their own equipment or equipment provided by the provider during the provision of telehealth services. The participant has full control of the device. The member can turn off the device and end services any time they wish.

• The participant's services may not be delivered virtually 100% of the time. The service providers must maintain a physical location where in-person services are offered. There will always be an option for in-person services available.

• Participants must have an informed choice between in person and telehealth services;

• Providers must create a published schedule of virtual services participants can select from.

• The use of the telehealth option will not block, prohibit or discourage the use of in-person services or access to the community. Members may not be inclined to attend in-person, but may still want to participate in services, engage with their community and their friends, when they choose or when they otherwise would not be able to do so due to illness, transportation issues, pandemics or other personal reasons.

• Members who require hands on assistance during the provision of the service must receive services in-person. In order to ensure the health and safety of members, case managers and providers must assess the appropriateness of virtual services with member. If it is determined that hands-on assistance is required, virtual services may not be provided. This process will be outlined in each providers policies and procedures.

• Telehealth will not be used for the provider's convenience. The option must be used to support a participant to reach identified outcomes in the participant's Person-Centered Plan.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Counseling in the context of family shall be defined in Section 8.515.3.G.3.

Reimbursement for Telehealth services is limited to enrolled Colorado Medicaid providers and excludes the purchasing or installation of telehealth equipment or technologies.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Licensed Professional

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Substance Abuse Counseling

Provider Category:

Individual

Provider Type:

Licensed Professional

Provider Qualifications

License *(specify):*

Professional license, as required by federal and state law.

Certificate *(specify):*

Certified Medicaid provider: 10 C.C.R. 2505-10 Section 8.516.50.D

Other Standard *(specify):*

Providers for the Telehealth service delivery option must demonstrate policies and procedures that include:

•HIPAA compliant platforms;

•Client support given when client needs include: accessibility, translation, or limited auditory or visual capacities are present;

•Have a contingency plan for provision of services if technology fails;

•Professionals do not practice outside of their respective scope;

•Assessment of clients and caregivers that identifies a client's ability to participate in and outlines any accommodations needed while utilizing Telehealth.

For the Telehealth service delivery option, Case Management Agencies (CMA)s will be required to:

•Provide prior authorization for all services to be rendered using Telehealth; and

Indicate client choice to use telehealth and indicate in service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health Care Policy and Financing

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Supported Living Program

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Supported Living Program services encompass training and supervision of activities of daily living and protective oversight, supervision, behavioral management, cognitive supports, interpersonal and social skills development, management of medical needs, financial management, household management, individual activity plans, and recreational and social activities on and off the campus. Services include transportation between therapeutic tasks in the community, individual person-centered planning, recreational outings, and activities of daily living.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

SLP services provided in an out-of-state setting are only allowed when there is not a service provider within Colorado that is able to meet the waiver participant's needs due to specific, individualized health and safety concerns. The need for out-of-state services and out-of-state providers must be approved by HCPF. When services are provided out-of-state, the standard waiver requirements will continue to be met per the Olmstead Letter #3 State Medicaid Directors on July 25, 2000. These requirements include:

• There must be a written plan of care with the services. The plan of care must identify the services to be provided, the amount and type of each service, and the type of provider.
• Services must be furnished by a qualified provider. The provider must meet the standards for service provision that are set forth by the state where services are being provided. The host state in which services are received must have an equivalent licensure or certification as a Colorado provider for SLP.
• Colorado remains responsible for the assurance of the health and welfare of the waiver member. Oversight is performed directly by the case management agency via telehealth options and by the host state in which services are received.
• The provider of out-of-state SLP must be chosen just as freely as the provider of in-state services by the waiver member.
• The out-of-state provider must have a provider agreement with HCPF per section 1902(a)(27) of the Act and payment must be made directly to the provider per section 1902(a)32 of the Act.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**
☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**
☐ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supported Living Program

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Supported Living Program

Provider Category:

Agency

Provider Type:

Supported Living Program

Provider Qualifications

License *(specify):*

Assisted Living Residence and/or Home Care Agency Class A

Certificate *(specify):*

Certified as a Medicaid Supported Living Program provider 10 C.C.R. 2505-10 Section 8.515

Other Standard *(specify):*

SLP services provided in an out-of-state setting are only allowed when there is not a service provider within Colorado that is able to meet the waiver participant's needs due to specific, individualized health and safety concerns. The need for out-of-state services and out-of-state providers must be approved by HCPF. When services are provided out-of-state, the standard waiver requirements will continue to be met per the Olmstead Letter #3 State Medicaid Directors on July 25, 2000. These requirements include:

• There must be a written plan of care with the services. The plan of care must identify the services to be provided, the amount and type of each service, and the type of provider.
• Services must be furnished by a qualified provider. The provider must meet the standards for service provision that are set forth by the state where services are being provided. The host state in which services are received must have an equivalent licensure or certification as a Colorado provider for SLP.
• Colorado remains responsible for the assurance of the health and welfare of the waiver member. Oversight is performed directly by the case management agency via telehealth options and by the host state in which services are received.
• The provider of out-of-state SLP must be chosen just as freely as the provider of in-state services by the waiver member.
• The out-of-state provider must have a provider agreement with HCPF per section 1902(a)(27) of the Act and payment must be made directly to the provider per section 1902(a)32 of the Act.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Environment, Health Facilities and Emergency Medical Services Division

Frequency of Verification:

A third of the total SLPs are inspected every fiscal year by CDPHE. The CDPHE fiscal year runs from July 1 to June 30th. During inspections, the health team inspects each facility for compliance with Chapter VII operating licensing, Chapter 24 medication administration regulations and Volume 8 - SLP regulations. Therefore, two deficiency lists are generated if there are citations under each regulation set. The Health inspections focus on resident care and treatment, resident rights and the delivery of services, including medication administration, etc. In between survey cycles, should CDPHE receive a complaint, this will be investigated as well. Should a SLP demonstrate a pattern of non-compliance or be issued an outcome level deficiency, CDPHE will consider enforcement action in the form of intermediate conditions. Any issues or concerns regarding Life Safety Code found during an inspection are forwarded to Colorado Department Fire Prevention and Control (DFPC).

DFPC conducts Life Safety Code Inspections of SLPs on a three-year cycle. DFPC inspects the physical environment, according to the Life Safety Code standards set forth in the National Fire Protection Association. A SLP shall not occupy or use a Health Facility for the provision of services until a completed Certificate of Compliance (COC) has been issued by DFPC. Any violations must be corrected before a COC is issued. DFPC sends the COC to CDPHE, which is needed for the SLP licensure.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Transition Setup

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	**Sub-Category 4:**

Transition Setup includes coordination and purchase of one-time, non-recurring expenses necessary for a client to establish a basic household upon transitioning from an institutional setting to a community living arrangement.

Allowable setup expenses include:

1. Security deposits that are required to obtain a lease on an apartment or home.
2. Setup fees or deposits to access basic utilities or services (telephone, electricity, heat, and water).
3. Services necessary for the individual's health and safety such as pest eradication or one-time cleaning prior to occupancy.
4. Essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, or bed or bath linens.
5. Expenses incurred directly from the moving, transport, provision, or assembly of household furnishings to the residence.
6. Fees associated with obtaining legal and/or identification documents necessary for a housing application such as a birth certificate, state issued ID, or criminal background check.

Setup expenses do not include rental or mortgage expenses, ongoing food costs, regular utility charges, or items that are intended for purely diversional, recreational, or entertainment purposes. Setup expenses do not include the furnishing of living arrangements that are owned or leased by a waiver provider where the provision of these items and services are inherent to the service they are already providing. Setup expenses do not include payment for room and board.

To access Transition Setup, a client must be transitioning from an institutional to a community living arrangement and participate in a needs assessment through which they demonstrate a need for the service based on the following:

- The client demonstrates a need for the coordination and purchase of one-time, non-recurring expenses necessary for a client to establish a basic household in the community;
- The need demonstrates health, safety, or institutional risk; and
- Other services/resources to meet the need are not available.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Transition Setup coordination is billed in 15 minute unit increments. The coordination must not exceed 40 units per eligible client. Transition Setup is not available when the person resides in a provider owned or controlled setting.

Transition Setup expenses must not exceed a total of $2,000 per eligible client, unless otherwise authorized by the Department. The Department may authorize additional funds above the $2,000 unit limit, not to exceed a total value of $2,500, when it is demonstrated as a necessary expense to ensure the health, safety, and welfare of the client.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Transition Setup Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transition Setup

Provider Category:

Agency

Provider Type:

Transition Setup Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

The provider must be a legally constituted entity or foreign entity (outside of Colorado) registered with the Colorado Secretary of State Colorado with a Certificate of Good Standing to do business in Colorado.

The provider must meet the standards for a Certified Medicaid provider under 10 C.C.R. 2505-10 Section 8.515.6.C

Other Standard *(specify):*

In accord with 42 CFR 441.301(c)(1)(vi), the Transition Setup provider, or those who have an interest in or are employed by the provider, must not be of the same provider or agency that provides case management to the client.

The product or service to be delivered shall meet all applicable manufacturer specifications, state and local building codes, and Uniform Federal Accessibility Standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Environment.

Frequency of Verification:

Initially and every three years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Transitional Living Program

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

The Transitional Living Program provides 24-hour support, supervision and therapeutic services. It is designed to facilitate independent living while transitioning clients into the community. Transitional Living provides assessment, training and supervision of self-care, medication management, sensory and motor skill development, communication skills, interpersonal skills training, socialization training, money management, household maintenance skills, various therapies (including physical therapy, occupational therapy, cognitive behavioral therapy, and speech therapy), and management of medical needs. The program is offered to clients who require assistance in a milieu setting for safety, supervision and comprehensive treatment. Room and board are not included in Medicaid reimbursement. After receiving services in the Transitional Living Program, the client can access other benefits of the HCBS-BI Waiver in order to remain in the community.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Transitional Living Program services are not duplicative of Supportive Living Program Services.
Therapies in the Transitional Living Program are intended to serve individuals in the post-acute stage of recovery. This includes more intensive services and therapies that are needed during the critical stage of recovery. A client may not receive services through a Transitional Living Program and a Supportive Living Program concurrently.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Transitional Living Program Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transitional Living Program

Provider Category:

Agency

Provider Type:

Transitional Living Program Provider

Provider Qualifications

License *(specify):*

Assisted Living Residence and/or Home Care Agency Class A

Certificate *(specify):*

Certification as a Medicaid provider for Transitional Living Program services: C.R.S; 10 C.C.R. 2505-10, Section 8.516.30

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Environment, Health Facilities and Emergency Medical Services Division

Frequency of Verification:

A third of the total TLPs are inspected every fiscal year by CDPHE. The CDPHE fiscal year runs from July 1 to June 30th. During inspections, the health team inspects each facility for compliance with Chapter VII operating licensing, Chapter 24 medication administration regulations and Volume 8 - TLP regulations. Therefore, two deficiency lists are generated if there are citations under each regulation set. The Health inspections focus on resident care and treatment, resident rights and the delivery of services, including medication administration, etc. In between survey cycles, should CDPHE receive a complaint, this will be investigated as well. Should a TLP demonstrate a pattern of non-compliance or be issued an outcome level deficiency, CDPHE will consider enforcement action in the form of intermediate conditions. Any issues or concerns regarding Life Safety Code found during an inspection are forwarded to Colorado Department Fire Prevention and Control (DFPC).

DFPC conducts Life Safety Code Inspections of TLPs on a three-year cycle. DFPC inspects the physical environment, according to the Life Safety Code standards set forth in the National Fire Protection Association. A TLP shall not occupy or use a Health Facility for the provision of services until a completed Certificate of Compliance (COC) has been issued by DFPC. Any violations must be corrected before a COC is issued. DFPC sends the COC to CDPHE, which is needed for the TLP licensure.

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

  Check each that applies:

  - ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
  - ☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
  - ☒ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
  - ☒ **As an administrative activity.** *Complete item C-1-c.*
  - ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

The Department contracts through competitive procurement with Case Management Agencies serving 20 defined service areas throughout Colorado to perform Home and Community-Based Services waiver operational and administrative services, case management, utilization review, and prior authorization of waiver services.

TCM includes the following case management functions: service planning meetings, dissemination of service plan, LTHH PAR review, person-centered support planning, internal case consultation, case administration, PAR development, monitoring of long-term service delivery, coordination of care, intake screening, referral, and CDASS coordination.

Administrative contractual activities include Level of Care Screens, Need Assessments, Human Rights Committee, Critical Incidents, appeals, developmental disability and delay determinations, Support Intensity Scale Assessments, and specific contract deliverables.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Home Care Agencies (HCA) certified to provide Personal Care and facilities certified to provide Supported Living Services (SLP) and Transitional Living Services (TLP) are licensed annually by the Department of Public Health and Environment (CDPHE). This licensure requires that any individual seeking employment with the agency submit to a Colorado Bureau of Investigation (CBI) criminal history record check. The criminal history record check must be conducted not more than 90 days prior to the employment of the individual. To ensure that the individual does not pose a risk to the health, safety, and welfare of the consumer, HCAs must develop and implement policies and procedures regarding the employment of any individual who is convicted of a felony or misdemeanor.

CDPHE will not issue a license or recommend certification until the agency conforms to all applicable statutes and regulations. Should it be found that an agency has not performed the criminal background investigations as required by licensure or regulatory standards, CDPHE requires the agency to submit a plan of correction within 30 days. CDPHE has the discretion to approve, impose, modify, or reject a plan of correction. Only after the plan of correction has been accepted will a license or recommendation for certification be issued. CDPHE sends the survey and licensing information to the Department for review. Agencies denied licensure or recommendation for certification by CDPHE are not approved as Medicaid providers.

HCBS-BI clients may utilize Nursing Facilities (NF) for respite services. Owners and administrators along with any staff or volunteers that have personal contact with residents at these facilities are required to submit to a CBI criminal history check. When making an employment decision, it is the responsibility of an NF to determine whether prospective staff or volunteers have been convicted of a felony or misdemeanor that could pose a risk to the health, safety, and welfare of the residents. During regular surveys, CDPHE reviews employment records to ensure NFs are completing required criminal background checks.

State-approved educational programs for Certified Nurse Aides also require CBI criminal history checks upon admission to the education program.

For clients who choose CDASS, the FMS performs Colorado Bureau of Investigation (CBI) criminal history checks on all prospective attendants. The Department maintains a list of high risk crimes that initially prohibit a potential attendant from employment. After over two years of engagement, stakeholders voted to implement an exception process that enables a member and/or authorized representative to make the final hiring decision for certain individuals found initially ineligible for employment. The exception process requires that the Department receive from the member/AR a written acknowledgement that: the Colorado Criminal Background Check report was received and reviewed, that the reason for initial ineligibility is understood, that the member and/or authorized representative chooses to hire this person, and that a safety plan is in place. Support resources and education are available to members and/or authorized representatives to learn more about best practices regarding hiring employees with criminal backgrounds and what protective resources are available if the member becomes unsafe. Ongoing oversight of the safety plan and quality of care occurs quarterly by the case manager. Employment decisions are made at the discretion of the client and/or authorized representative.

In addition, all prospective attendants for CDASS and IHSS are subject to a Board of Nursing and certified nurse aide background check, and Office of Inspector General (OIG) check. Any person who has had their license as a nurse or certification as a nurse aid suspended or revoked or their application for such license or certification denied shall be denied employment as an attendant. Any person who has failed the OIG check shall be denied employment as an attendant.

The Department audits the employment records of the FMS annually to ensure they are completing the mandatory Board of Nursing and certified nurse aide background checks.

Adult day service providers are not licensed in the State of Colorado. CDPHE surveys these providers on a risk-based survey schedule to ensure compliance with the certification standards detailed in program regulation. Currently, this regulation does not require criminal background investigations though many providers complete the investigations voluntarily. The adult day services regulation is currently under review, and the Department will consider adding criminal background investigations as a requirement.

Background checks are not required on any other HCBS-BI waiver service providers, though many providers complete the checks on staff voluntarily. The Department does not require an abuse registry screening, because the State does not have such a registry.

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

○ **No. The state does not conduct abuse registry screening.**

◉ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Statute 26-3.1-111(6)(a)(I) and State regulation, 12 CCR 2518-1 30.960 state that employees providing direct care to at-risk adults must submit to a Colorado Adult Protective Services (CAPS) check. The Colorado Department of Human Services is the operating agency, ensuring screening takes place and processing the CAPS checks. Employers are required to complete a Colorado Adult Protective Services (CAPS) check prior to hiring a new employee who will provide direct care to an at-risk adult. Employers must register prior to requesting a CAPS check to allow for verification of the employer's legal authority to request the check. The Employer then obtains written authorization and any required identifying information from the new employee prior to requesting the CAPS check and submits the request using an online or hard copy to the Department of Human Services (DHS). DHS completes the CAPS check and will respond to the request as soon as possible, but no later than 5 business days from the receipt of the request. The CAPS check will include: Whether or not there is a substantiated finding for the new employee, purpose for which the information in CAPS may be made available, consequences for improper release of information in CAPS, and for CAPS checks in which there is a substantiated finding, the CAPS check results will include the date(s) of the report, county department(s) that completed the investigation(s), and the type(s) of severity level(s) of the mistreatment.

Out-of-state providers must meet comparable requirements for abuse registry screening in their state.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

Note: Required information from this page (Appendix C-2-c) is contained in response to C-5.

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

○ **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**

◉ **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar*

services for which payment may be made to legally responsible individuals under the state policies specified here.

A spouse may be paid to furnish extraordinary care through Consumer Directed Attendant Support Services (CDASS) and relative personal care service delivery options. Extraordinary care is determined by assessing whether an individual who is the same age without a disability needs the requested level of care, the activity is one that a spouse would not normally provide as part of a normal household routine, and the activity is one that a relative or family member is not legally responsible to provide and is necessary to assure the health and welfare of the participant and avoid institutionalization.

A spouse may not provide more than 40 hours of CDASS in a seven-day period. The CDASS FMS vendors have systems in place to maintain and enforce established program limits.

A client/authorized representative must complete an Attendant Support Management Plan outlining a plan for attendant schedules and tasks to be performed prior to starting CDASS.

Allowing a client to receive Personal Care Services or similar services from a legally responsible individual provides an opportunity for the client to receive consistent services from a caregiver who is uniquely familiar with the client's needs. This practice ensures the health and welfare of the individual and aids in avoiding institutionalization.

An individual must be offered a choice of providers. If clients or his/her authorized representative choose a spouse as a care provider, it must be documented in the Attendant Support Management Plan. In addition to case management monitoring and reporting activities required for all waiver services, the following additional requirements are employed when a spouse is paid as a care provider:
a. At least quarterly reviews of expenditures, and health, safety, and welfare status of the client by the case manager.
b. Monthly reviews by the fiscal agent of hours billed for spouse-provided care.
c. A spouse who is a client's authorized representative may not also be paid to be the client's attendant.

A spouse may not provide more than 37 hours of Relative Personal Care in a one month period.

Electronic Visit Verification (EVV) is used for verification of payment for Personal Care service providers.

In the authorization of services, the case manager works directly with the member to identify needs. The member is asked if they know someone who may be willing and able to provide the necessary services; that person may or may not be related or a legally responsible individual. Services are then referred to the members' agency of choice, at which point the agency works to interview, hire, and train the identified individuals. The agency and case manager conduct quarterly contacts to ensure member satisfaction with services and adherence to the care plan.

☒ **Self-directed**

☒ **Agency-operated**

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

○ **The state does not make payment to relatives/legal guardians for furnishing waiver services.**

◉ **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

For the purpose of this section relatives/legal guardians shall be defined as all persons related to the client by virtue of blood, marriage, adoption, or Colorado common law. Extraordinary Care is an activity that relatives/guardians would not normally provide as part of a normal household routine.

The Department contracts with case management agencies to authorize Personal Care or similar services as appropriate to a client's needs and to coordinate with provider agencies to review the Personal Care services received.

Family members may be employed to provide Personal Care or CDASS based on the limitations described below:

Family members may also be employed by the program participant or representative to provide CDASS subject to the conditions below:
1. The family member providing CDASS shall meet the following requirements for employment:
a. Being employed and supervised by the program participant or representative.
b. A family member who is an individual's authorized representative may not be reimbursed for the provision of CDASS.
2. The family member employed by the program participant or representative may provide up to 40 hours of CDASS in a seven-day period.
3. Client and/or authorized representative must provide a planned work schedule to the FMS two weeks in advance of beginning CDASS, and variations to the schedule must be noted and supplied to the fiscal agent when billing.
4. Clients and/or authorized representatives who choose to hire a family member as a care provider in CDASS must document their choice on the Attendant Support Management Plan.

Allowing a client to receive Personal Care Services from a relative/guardian provides an opportunity for the client to receive consistent services from a caregiver who is uniquely familiar with the client's needs. Traditional agency-based personal care services can be provided by a relative. Services are limited to 8.5 hours per week.

The case manager utilizes an assessment tool and service planning process to determine the client's needs and the available services to best meet their identified support needs. Support needs may be met by utilizing natural supports, non-Medicaid resources, state plan benefits, and HCBS waiver services.

In addition to case management, monitoring, and reporting activities required for all waiver services, the following additional requirements are employed when a family member is paid as a care provider for CDASS clients:
a. At least quarterly reviews of expenditures, and health, safety, and welfare status of the client.
b. Monthly reviews by the fiscal agent of hours billed for family member-provided care.

The Department contracts with the Colorado Department of Public Health and Environment to license and survey agencies administering personal care services. This includes a review of the service hours billed, documentation of tasks performed, and agency documentation of their oversight of their employee.

○ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

○ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers

have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Providers interested in providing services to Colorado Medicaid clients must first obtain certification from the Department. Certification is obtained by a provider after undergoing a survey by the Colorado Department of Public Health and Environment (CDPHE). CDPHE will recommend a provider for Medicaid certification after the provider has successfully completed a survey. The Department will review the recommendation by CDPHE and either certify the provider or ask that the provider improve the conformance to rules and/or regulations before certifying the provider.

The Department also distributes a Provider Bulletin that contains notification of changes to existing programs or updates about new programs and services. Providers are able to contact the fiscal agent or Department directly to inquire about enrollment or provider qualification requirements.

Once a provider has obtained Medicaid certification, the provider is referred to the Colorado Medical Assistance Program fiscal agent to obtain a provider number and a Medicaid provider agreement. Any certified, willing and interested providers may request an enrollment packet from the Colorado Medical Assistance Program fiscal agent. The fiscal agent enrolls providers in accordance with Medical Assistance Program regulations and the Department's directives. The fiscal agent maintains provider enrollment information in the Medical Assistance Program Medicaid Management Information System (MMIS).

The enrollment application is designed to address requirements for providers who render specific types of services. Providers who have questions about how to complete the application may contact the fiscal agent for technical assistance. The fiscal agent processes applications and sends written notification of the action to the provider within ten days of receipt of the application.

Providers whose applications are approved will be sent a provider number and information to help the provider to begin to submit claims. Incomplete applications are delayed in processing, but the provider will be sent a letter identifying the missing information or incomplete documents. Providers whose applications are denied will be advised of the reason for denial.

CDPHE has a responsibility over the following service providers: Adult Day, Day Treatment, Personal Care Services, Respite providers, SLPs and TLPs.CDPHE does not survey providers of the following services: Medication Reminders, PERS, Home Modification, CDASS, Mental Health Counseling, Substance Abuse Counseling, and Non-Medical Transportation. Providers of these services obtain Medicaid certification from the Department by completing the Medicaid provider enrollment process through the fiscal agent prior to serving Medicaid clients.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
C.a.1 # & % of licensed/certified waiver providers, by type, that met licensing stds or cert reqrmts at time of scheduled or periodic recert. survey Numerator: # of licensed/certified waiver providers, by type, that met licensing stds or cert reqrmts at time of scheduled or periodic recert. survey Denominator: Total licensed/certified waiver providers, by type, surveyed during perfce period

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:
CDPHE Survey Reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: CDPHE	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
C.a.2 # & % of waiver providers enrolled within the perfce period, by type, that have the reqd prof'l licensure or cert prior to serving waiver participants N: # of waiver providers enrolled within the perfce period, by type, that have the reqd prof'l licensure or certification prior to serving waiver participants D: Total # of waiver providers enrolled within the performance period, by type.

Data Source (Select one):
Other
If 'Other' is selected, specify:
CDPHE Survey Reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☒ **Other** Specify: CDPHE	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS Data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
C.a.6 Number and percent of non-surveyed licensed/certified waiver providers, by type, that continually meet waiver licensure/certification standards Numerator: Number of non-surveyed licensed/certified waiver providers, by type, that continually meet waiver licensure/certification standards Denominator: Total number of non-surveyed licensed/certified waiver providers, by type

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS Data

Responsible Party for	**Frequency of data**	**Sampling Approach**

data collection/generation *(check each that applies):*	**collection/generation** *(check each that applies):*	*(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
C.b.1 Number and percent of non-surveyed non-licensed/non-certified providers that initially and continually meet waiver requirements Numerator: Number of non-surveyed non-licensed/non-certified providers that initially and continually meet waiver requirements Denominator: Total number of non-surveyed non-licensed/non-certified waiver providers

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS Data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
C.b.3 Number and percent of newly enrolled CDASS attendants who meet the background check requirements monitored by the FMS vendors and Department N:

Number of newly enrolled CDASS attendants who meet the background check requirements monitored by the FMS vendors and the Department D: Total number of newly enrolled CDASS attendants

Data Source (Select one):
Reports to State Medicaid Agency on delegated
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: FMS	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
C.c.1 Number and percent of surveyed BI waiver providers who meet Department waiver training requirements in accordance with state requirements and the approved waiver Numerator: Number of surveyed BI waiver providers who meet Department waiver training requirements in accordance with state requirements and the approved waiver Denominator: Total number of surveyed waiver providers

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100%**

		Review
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: CDPHE	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Performance Measure:
C.c.2 Number and percent of BI waiver non-surveyed providers who meet department training requirements in accordance with state requirements and the approved waiver N: Number of BI waiver non-surveyed providers who meet Department training requirements in accordance with state requirements and the approved waiver D: Total BI waiver non-surveyed providers

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS Provider Records

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

C.a.1
Providers who are interested in providing HCBS services that are required by Medical Assistance Program regulations to be surveyed prior to certification to ensure compliance with licensing and qualification standards and requirements. Certified providers are re-surveyed according to the CDPHE schedule to ensure ongoing compliance.

The Department is provided with monthly and annual reports detailing the number and types of agencies that have been surveyed, the number of agencies that have deficiencies and types of deficiencies cited, the date deficiencies were corrected, the number of complaints received, complaints investigated, substantiated, and resolved.

The Department uses CDPHE survey reports as the primary data source for this performance measure.

C.a.2
Licensed/certified providers must be in good standing with their specific specialty practice act and with current state licensure regulations. Following Medicaid provider certification, all providers are referred to the Department's fiscal agent to obtain a provider number and a Medicaid provider agreement. The fiscal agent enrolls providers in accordance with Medical Assistance Program regulations and the Department's directives and maintains provider enrollment information in the MMIS. All provider qualifications and required professional licenses are verified by the fiscal agent upon initial enrollment and in a revalidation cycle; at least every five years. Data reports verifying required professional licensure and certification are maintained by the Department's waiver provider enrollment staff.

C.a.6
All provider qualifications are verified by the fiscal agent upon initial enrollment and in a revalidation cycle; at least every five years. Data reports verifying non-surveyed providers continually meet waiver requirements are maintained by the Department's waiver provider enrollment staff. Department records are the primary data source for this performance measure.

C.b.1
The Department reviews the waiver provider qualifications. The fiscal agent enrolls providers in accordance with program regulations and maintains provider enrollment information in the MMIS. All provider qualifications are verified by the fiscal agent upon initial enrollment and in a revalidation cycle; at least every five years. Data reports verifying non-licensed/non-certified providers continually meet waiver requirements are maintained by the Department's waiver provider enrollment staff.

Department records are the primary data source for this performance measure.

C.b.3
FMS provides the Department with monthly and quarterly reports of the number of CDASS attendants that were eligible for hire based on CBI criminal history and Board of Nursing checks prior to the attendant providing services to waiver participants under the CDASS option. The Department reviews FMS monthly and quarterly reports as the primary discovery method for this performance measure.

C.c.1
CDPHE reviews personnel records as part of their provider surveying activities and includes training deficiencies identified during the surveys in the written statement of deficiencies.

C.c.2
Department regulations for provider general certification standards require provider agencies to maintain a personnel record for each employee and supervisor that includes documentation of qualification and required training completed.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on

the methods used by the state to document these items.

C.a.1
Providers who are not in compliance with CDPHE and other state standards receive deficient practice citations. Depending on the risk to the health and welfare of clients, the deficiency will require, at minimum, a plan of correction to CDPHE. Providers that are unable to correct deficient practices within prescribed timelines are recommended for termination by CDPHE and are terminated by the Department. When required or deemed appropriate, CDPHE refers findings made during survey activities to other agencies and licensing boards and notifies the Department immediately when a denial, revocation, or conditions on a license occur. Complaints received by CDPHE are assessed for immediate jeopardy or life-threatening situations and are investigated in accordance with applicable federal requirements and time frames.

The Department reviews all CDPHE surveys to ensure deficiencies have been remediated and to identify patterns and/or problems on a statewide basis by service area, and by the program. The results of these reviews assist the Department in determining the need for technical assistance; training resources and other needed interventions.

C.a.2
The Department initiates termination of the provider agreement for any provider who is in violation of any applicable certification standard, licensure requirements, or provision of the provider agreement and does not adequately respond to a corrective action plan within the prescribed period of time.

C.a.6
If areas of non-compliance with standards exist, the Department issues a list of deficiencies to the provider. The provider is required to submit an acceptable Plan of Correction (POC) to the Department within a specified timeframe. If areas of non-compliance exist where the health and welfare of participants receiving services are in jeopardy, then the provider is required to correct the problem immediately and provide documentation of corrections to Department. The Department initiates termination of the provider agreement for any provider who is in violation of any applicable certification standard, licensure requirements, or provision of the provider agreement, and does not adequately respond to a POC within the prescribed period of time.

C.b.1
If areas of non-compliance with standards exist, the Department issues a list of deficiencies to the provider. The provider is required to submit an acceptable Plan of Correction to the Department within a specified timeframe. If areas of non-compliance exist where the health and welfare of participants receiving services are in jeopardy, then the provider is required to correct the problem immediately and provide documentation of corrections to Department. Providers that do not remediate deficiencies in accordance with the POC are terminated from the program.

C.b.3,
The FMS ensures that the prospective attendants that do not meet these requirements or have not been requested to be hired by a member and/or authorized representative through the Department established process are not eligible for hire by waiver participants. The Department’s review of the FMS monthly and quarterly reports, operational materials and requested documentation ensure deficiencies are remediated.

C.c.1
The Department reviews CDPHE provider surveys to ensure plans of correction are followed up on and waiver providers are trained in accordance with Department regulations.

C.c.2
The Department initiates termination of the provider agreement for any provider who is in violation of any applicable certification standard, licensure requirements, training requirements, or provision of the provider agreement and does not adequately respond to a corrective action plan within the prescribed period of time.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

◉ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

○ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the

amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

Please Refer to Attachment #2

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Person-Centered Support Plan (PCSP)

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

☐ **Registered nurse, licensed to practice in the state**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**

☐ **Licensed physician (M.D. or D.O)**

☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☒ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

The minimum qualifications for HCBS Case Managers that conduct the person-centered service plan is:
1. A bachelor's degree; or
2. Five (5) years of experience in the field of LTSS, which includes Developmental Disabilities; or
3. Some combination of education and relevant experience appropriate to the requirements of the position.
4. Relevant experience is defined as:
a. Experience in one of the following areas: long-term care services and supports, gerontology, physical rehabilitation, disability services, children with special health care needs, behavioral science, special education, public health or non-profit administration, or health/medical services, including working directly with persons with physical, intellectual or developmental disabilities, mental illness, or other vulnerable populations as appropriate to the position being filled; and
b. Completed coursework and/or experience related to the type of administrative duties performed by case managers may qualify for up to two (2) years of required relevant experience.
Safeguards to assure the health and welfare of waiver participants, including response to critical events or incidents remain unchanged.

Agency supervisor educational experience:
The agency's supervisor(s) shall meet minimum standards for education and/or experience and shall be able to demonstrate competency in pertinent case management knowledge and skills.

☐ **Social Worker**
Specify qualifications:

☐ **Other**
Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

○ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

◉ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

The Department implemented major changes to the business process and structure of case management services available to individuals receiving Home and Community-Based Services (HCBS). CMS granted the Department an extension until July 1, 2024 to come into compliance with Conflict-Free Case Management.

The State Medicaid Agency allows for entities to provide both case management and direct care waiver services only when no other willing and qualified providers are available. When a Case Management Agency (CMA) submits a waiver request to the Department the CMA must provide the Department with the following information:

1. Specific service that is lacking in the CMA Defined Service Area.
2. Number of other providers available in the CMA Defined Service Area for this service.
3. Number of Medicaid members being served by the CMA for this service.
4. If the lack of service is in a particular area, indicate the area and the number of members being served in that area.
5. Efforts the CMA has made to develop the service that is lacking.
6. Procedure the CMA follows to ensure the member has been offered a choice of providers.
7. Procedure that the CMA uses to avoid any possible bias of using only the CMA when the service may be available from another provider agency.
8. Written documentation indicating Direct Service Provider functions and CMA functions are being administered separately.
9. Any other information the CMA may feel is pertinent to obtain a waiver.

The Department reviews the above information to ensure that the CMA's waiver is in compliance with state laws, regulations, and policies in reference to service provisions at 10 C.C.R. 2505-10, Section 8.393.1.M. prior to granting a waiver.

The State currently allows an individual's HCBS provider to develop the Person Centered Support Plan (PCSP) in Sedgwick, Phillips, Logan, Morgan, Washington, Yuma, Kit Carson, Cheyenne, Lincoln, Elbert, Kiowa, Prowers, Bent, Baca, Otero, Crowley, Las Animas, Huerfano, Costilla, Conejos, Alamosa, Rio Grande, Mineral, Saguache, Archuleta, La Plata, Montezuma, Dolores, San Juan.

For those counties where the Department allows the HCBS provider to develop the PCSP due to lack of other available willing and qualified providers, per the contract the Case Management Agency (CMA) is required to do the following in regard to mitigating conflict: Obtaining a waiver annually from the Department to provide direct services based on criteria in applicable Department regulations. If the contractor is granted a waiver to provide services, the contractor shall provide written notification to the member and/or guardian of the potential influence the contractor has on the service planning process and ensure the member and/or guardian are informed of their choice.

The Contractor shall provide the member and/or guardian with written information about how to file a provider agency and/or CMA agency complaint. Upon the member and/or guardian's request, the contractor shall provide an option for the member and/or guardian to request a different CMA to develop the PCSP. The contractor shall provide an option for the PCSP to be monitored by a different CMA entity or individual.

When granted a waiver the CMA must provide the following:

1. CMAs that are granted a waiver to provide services must provide written notification to the member and/or guardian about the potential influence the CMA has on the support planning process (such as exercising free choice of providers, controlling the content of the PCSP, including assessment of risk, services, frequency and duration, and informing the member of their rights).
2. The CMA must also provide the member and/or guardian written information about how to file a provider agency complaint as well as how to make a complaint against the CMA.
3. Upon member and/or guardian request the CMA must provide an option for the member and/or guardian to choose a different entity or individual to develop the PCSP. The CMA must also provide an option for the PCSP to be monitored by a different Case Management entity or individual.

The Department requires that all CMAs provide information about the full range of waiver services to eligible members and/or guardians. The Department does not establish rules about how this information is to be provided. The Department requires the use of standardized PCSP to be used by all HCBS case managers. The PCSP includes a list of all services available to the member provided in the waiver. In addition to the list of waiver services provided

by the support plan, CMAs may choose to provide the information to members in a format that best meets the members' needs.

The Department issued Operational Memo 23-002 which explains the process for an entity to request a waiver for Conflict Free Case Management.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

CMAs are contractually obligated to provide information to clients about the potential services, supports, and resources that are available to long-term care clients. CMAs are located throughout the State. The Department has opted not to mandate that CMAs use a specific form or method to inform clients about all of the supports available to clients.

In 2017, the Department implemented an improved monitoring system to better collect administrative data from CMAs. This new monitoring system will assist the Department in not only assuring CMAs are providing meaningful information and support to clients but also identifying a Best Practice approach to provide clients and/or family members with meaningful information and supports to actively engage in and direct the process.

In addition, the Department has taken steps to improve access to information using the Department's website. Information continues to be added in order to assist the client and/or family members to make informed decisions about waiver services, informal supports, and State Plan benefits.

Clients, guardians, and/or legal representatives may choose among qualified providers and services. The case manager will advise the client and/or guardians or the legal representative of the range of services and supports for which the client is eligible throughout the person-centered support planning process. The choice of services and providers for the waiver benefit package is ensured by facilitating a person-centered support planning process and providing a list of all providers from which to choose. Waiver clients and/or guardians and legal representatives are informed they have the authority to select and invite individuals of their choice to actively participate in the person-centered support planning process.

When scheduling to meet with the client and or the client’s legal guardian or representative the case manager makes reasonable attempts to schedule the meeting at a time and location convenient for all participants. In addition, the client has the authority to select and invite individuals of his/her choice to actively participate in the Person-Centered Support Planning process. Case managers develop emergency backup plans with the client and/or legal guardian or representative during the planning process and document that plan on the PCSP. The client must be seen at the time of the initial and annual planning process to ensure that the client is in the home.

The case manager shall perform quarterly monitoring contacts with the member, as defined by the member’s certification period start and end dates. An in-person monitoring contact is required at least one (1) time during the Person-Centered Support Plan certification period. The case manager shall ensure the one (1) required in-person monitoring contact occurs, with the Member physically present, in the Member’s place of residence or location of services.

Upon Department approval in advance, contact may be completed by the case manager at an alternate location, via the telephone, or using a virtual technology method. Such approval may be granted for situations in which in-person face-to-face meetings would pose a documented safety risk to the case manager or client (e.g., natural disaster, pandemic, etc.).

The case manager shall perform three additional monitoring contacts each certification period either in-person, on the phone, or through other technological modalities based on the member's preference of engagement. To facilitate person-centered practices, CMAs may use phone or other technological contact to engage in the development and monitoring of the PCSP.

All forms completed through the Person-Centered Support Planning process are available for signature through digital or wet signatures based on the member’s preference.

All waiver services are available throughout the state.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and

policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Case management functions include the responsibility to document, monitor, and oversee the implementation of the PCSP [10 C.C.R. 2505-10, Section 8.393]. The case manager meets with the client and/or legal guardian to complete a comprehensive Level of Care Eligibility Determination Screen (LOC Screen), making reasonable attempts to schedule the meeting at a time and location convenient for all participants. To facilitate person-centered practices, CMAs may use phone or other technological contact to engage in the development and monitoring of the PCSP. For each certification period, the level of care determination or redetermination will be in person (unless a documented safety risk is met as provided below).

The case manager shall perform quarterly monitoring contacts with the member, as defined by the member's certification period start and end dates. An in-person monitoring contact is required at least one (1) time during the Person-Centered Support Plan certification period. The case manager shall ensure the one (1) required in-person monitoring contact occurs, with the Member physically present, in the Member's place of residence or location of services.

Upon Department approval in advance, contact may be completed by the case manager at an alternate location, via the telephone, or using a virtual technology method. Such approval may be granted for situations in which in-person face-to-face meetings would pose a documented safety risk to the case manager or client (e.g., natural disaster, pandemic, etc.).

The case manager shall perform three additional monitoring contacts each certification period either in-person, on the phone, or through other technological modalities based on the member's preference of engagement. To facilitate person-centered practices, CMAs may use phone or other technological contact to engage in the development and monitoring of the PCSP.

The client and/or legal guardian have the authority to select and invite individuals of their choice to actively participate in the LOC Screen. The client and the client's chosen group provide the case manager with information about the client's needs, preferences, and goals. In addition, the case manager obtains diagnostic and health status information from the client's medical provider and determines the client's level of care using the state-prescribed LOC Screen instrument.

The case manager also identifies if any natural supports provided by a caregiver living in the home are above and beyond the workload of a normal family/household routine. The case manager works with the client and/or the group of representatives to identify any risk factors and addresses risk factors with appropriate parties.

Beginning in December 2021 or sooner, the case manager will complete a needs assessment (Assessment), basic or comprehensive, as determined by the client. The Assessment collects information about the client's strengths and support needs in these areas: health; functioning; sensory & communication; safety & self-preservation; housing, employment, volunteering, and training; memory & cognition; and psychosocial. The Assessment also identifies the client's goals and needed referrals and will determine if specific waiver targeting criteria is met. Prior to the Assessment is completed, the case manager will explain the assessment process to the client and/or guardian and explain options for waivers and waiver services, as well as the option to choose between the basic or comprehensive assessment. The comprehensive option covers all of the areas of the basic option but collects more detailed information about the client. The Assessment identifies which HCBS waiver(s) the client is eligible for and be utilized to develop the PCSP.

As the PCSP is being developed, options for services and providers are explained to the client and/or legal guardian by the case manager. Before accessing waiver benefits, clients must access services through other available sources such as State Plan and EPSDT benefits. The case manager arranges and coordinates services documented in the PCSP.

Referrals are made to the appropriate providers of the client's and/or legal representative's choice when services requiring a skilled assessment, such as skilled nursing or home health aide (Certified Nursing Aide) are determined appropriate.

The PCSP defines the type of services, frequency, and duration of services needed. The support plan also documents that the client and/or legal guardian have been informed of the choice of providers and the choice to have services provided in the community or in a nursing facility. The client may contact the case manager for ongoing case management such as assistance in coordinating services, conflict resolution, or crisis intervention. The service plan must be finalized in accordance with CFR 441.301 c (2)(ix), "Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation."

The case manager reviews the LOC Screen and PCSP with the client during the required monitoring contact. This review

includes the evaluation and assessment strategies for meeting the needs, preferences, and goals of the client. It also includes evaluating and obtaining information concerning the client's satisfaction with the services, the effectiveness of services being provided, an informal assessment of changes in the client's function, service appropriateness, and service cost-effectiveness.

If complaints are raised by the client about the person-centered support planning process, case manager, or other CMA functions, case managers are required to document the complaint on the CMA complaint log and assist the client to resolve the complaint. Complaints that are raised by the client about the support planning process, case manager, or other CMA functions, are required to be documented on the CMA complaint log. The case manager and/or case manager's supervisor are also required to assist in the resolution of the complaint.

This complaint log is reviewed by the Department on a quarterly basis. Department staff is able to identify trends or discern if a particular case manager or CMA is receiving an unusual number or increase in complaints and remediate accordingly.

The client may also contact the case manager's supervisor or the Department if they do not feel comfortable contacting the case manager directly. The contact information for the case manager, the case manager's supervisor, the CMA administrator, and the Department is included in the copy of the service plan that is provided to the client. The client also has the option of lodging an anonymous complaint to the case manager, CMA, or the Department.

Clients, family members, and/or advocates who have concerns or complaints may contact the case manager, case manager's supervisor, CMA administrator, or Department directly. If the Department receives a complaint, the HCBS waiver and benefits administrator investigates the complaint and remediates the issue.

The case manager is required to complete a re-screening, at a time and location chosen by the client, within twelve months of the initial or previous LOC Screen. A LOC Screen shall be completed sooner if the client's condition changes or as needed by program requirements. Upon Department approval, the LOC Screen and/or development of the PCSP may be completed by the case manager at an alternate location or via the telephone. Such approval may be granted for situations in which there is a documented safety risk to the case manager or client (e.g. natural disaster, pandemic, etc.).

In cases of emergency or evacuation, the case manager may authorize needed services using a temporary interim service plan, not to exceed 60 days. This plan will be developed when additional services, essential to the member's health and safety, related to the emergency situation are identified. The case manager will authorize the services using the most effective means of written communication. Service providers may provide services authorized in this manner until the case manager is able to complete a service plan revision which will backdate to the date of the temporary interim service plan. This type of interim temporary plan will only be used for already enrolled waiver participants who have been determined eligible for the waiver pursuant to the eligibility process in the waiver.

State laws, regulations, and policies that affect the PCSP development process are available through the Medicaid agency.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Risks are assessed as part of the Person-Centered Support and are documented in the client's electronic record. Case managers are required to provide clients with all of the choices available to the client for Long Term Care. These choices include continuing to live in the client's community residence or choosing to live in a Nursing Facility.

The case manager discusses the possible risks associated with the client's choice of living arrangement with the client and/or guardian. The case manager and the client then develop strategies for reducing these risks. Strategies for reducing these risks include developing back-up plans. Back-up plans are designed to be client-centered and often include relying on the client's choice of family, friends, or neighbors to care for the client if a provider is unable to do so. For life or limb emergencies, clients are instructed to call his/her emergency number (i.e. 911).

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

CMAs are required to provide clients with a choice of qualified providers. CMAs are located throughout the State. The Department has opted not to mandate that CMAs use a specific form or method to inform clients about all of the supports available to clients.

The Department has also developed an informational tool in coordination with the Colorado Department of Public Health and Environment (CDPHE) to assist clients in selecting a service agency. The Department has provided all CMAs with this informational tool. In addition, the guide is available on the CDPHE website.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

CMAs are required to prepare the PCSP according to their contract with the Department and CMS waiver requirements. The Department monitors each CMA annually for compliance. A sample of documentation including individual PCSP is reviewed for accuracy, appropriateness, and compliance with regulations at 10 C.C.R. 2505-10, Section 8.393.

The PCSP must include the client's assessed needs, preferences, goals, natural supports, specific services, amount, duration, and frequency of services, documentation of choice between waiver services and institutional care, and documentation of choice of providers. CMA monitoring by the Department includes a statistical sample of PCSP reviews. During the review, PCSP and prior authorizations are compared with the documented level of care for appropriateness and adequacy. A targeted review of PCSP documentation and authorization review is part of the overall administrative and programmatic evaluation by the Department.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☐ **Operating agency**
- ☐ **Case manager**
- ☒ **Other**

Specify:

Written copies are maintained at the Case Management Agency (CMA) and are also available electronically to both the client's CMA and the State Medicaid agency via the State's case management IT system.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

Case managers are responsible for PCSP development, implementation, and monitoring. Case managers are required to meet with clients annually for PCSP development. When scheduling to meet with the client and or the client's legal guardian or representative, the case manager makes reasonable attempts to schedule the meeting at a time and location convenient for all participants. Once the PCSP is implemented case managers are required to conduct monitoring with the client to ensure the PCSP continues to meet the client's goals, preferences, and needs. Case managers are also required to contact the client when significant changes occur in the client's physical or mental condition. To facilitate person-centered practices, CMAs may use phone or other technological contact to engage in the development and monitoring of PCSP.

The case manager shall perform quarterly monitoring contacts with the member, as defined by the member's certification period start and end dates. An in-person monitoring contact is required at least one (1) time during the Person-Centered Support Plan certification period. The case manager shall ensure the one (1) required in-person monitoring contact occurs, with the Member physically present, in the Member's place of residence or location of services.

Upon Department approval in advance, contact may be completed by the case manager at an alternate location, via the telephone or using virtual technology method. Such approval may be granted for situations in which in-person face-to-face meetings would pose a documented safety risk to the case manager or client (e.g. natural disaster, pandemic, etc.).

The case manager shall perform three additional monitoring contacts each certification period either in-person, on the phone, or through other technological modality based on the member's preference of engagement.

Participants exercise free choice of providers:

Each Case Management Agency (CMA) is required to provide clients with a free choice of willing and qualified providers. CMAs have developed individual methods for providing choice to their clients. In order to ensure that clients continue to exercise a free choice of providers, the Department has added a signature section to the PCSP that allows clients to indicate whether they have been provided with a free choice of providers. All forms completed through the Person-Centered Support Planning process are available for signature through digital or wet signatures based on the member's preference.

In an effort to better monitor CMA compliance with this requirement, the Department has developed a client survey/questionnaire that is administered to clients as specified in the Quality Improvement Strategy (QIS). The survey identifies client satisfaction with waiver services, case management services, Medicaid and other medical services, etc. The survey also inquires whether or not clients were provided choices, including but not limited to: a choice in waiver services, LTC service delivery (HCBS or nursing facility), qualified providers, participation in Person-Centered Support Planning, etc. Clients are also asked if they have received a list of client rights and responsibilities, complaint procedures, critical incident reporting guidelines, and contingency options. Survey results are analyzed, tracked, and trended each year according to program area and CMA. Improvements based on the data collected from this tool will be implemented as specified in the QIS.

Participant access to non-waiver services in the PCSP, including health services:

As of 2017, the PCSP includes a section for health services and other non-waiver services. At that time, the Department added acute care benefits and Behavioral Health Organizations breakout sessions to the annual case managers training conference to ensure case managers have a greater understanding of the additional health services available to long-term care clients.

Methods for prompt follow-up and remediation of identified problems:

Clients are provided with this information during the initial and annual Person-Centered Support Planning process using the Client Roles and Responsibilities and the Case Managers Roles and Responsibilities form. The form provides information to the client about the following, but not limited to, case management responsibilities:

Assists with the coordination of needed services.
Communicate with the service providers regarding service delivery and concerns Review and revise services, as necessary
Notifying clients regarding a change in services

Case managers are required to conduct monitoring with waiver participants. The monitoring includes verifying that services are furnished in accordance with the PCSP. The case management system for PAR development and submission allows case managers to see the unit decrement on the PAR. Additionally, case managers verify with individuals and provider agencies to ensure services are delivered in accordance with the PCSP. Monitoring requires that case managers monitor the access to services, if services are meeting the individual's needs, the use of the contingency plan, health, and safety, including follow-up to any critical incident reports, and the use of non-waiver services.

The form also states that clients are responsible for notifying their case manager of any changes in the client's care needs and/or problems with services. If a case manager is notified about an issue that requires prompt follow-up and/or remediation the case manager is required to assist the client. Case managers document the issue and the follow-up in the State case management IT system.

In cases of emergency or evacuation, the case manager may authorize needed services using a temporary interim service plan, not to exceed 60 days. This plan will be developed when additional services, essential to the member's health and safety, related to the emergency situation are identified. The case manager will authorize the services using the most effective means of written communication. Service providers may provide services authorized in this manner until the case manager is able to complete a service plan revision which will backdate to the date of the temporary interim service plan. This type of interim temporary plan will only be used for already enrolled waiver participants who have been determined eligible for the waiver pursuant to the eligibility process in the waiver.

Methods for systematic collection of information about monitoring results that are compiled, including how problems identified during monitoring are reported to the state:

The Department will conduct annual internal programmatic reviews using the Department prescribed Programmatic Tool. The tool is a standardized form with waiver-specific components to assist the Department to measure whether or not CMAs remain in compliance with Department rules, regulations, contractual agreements, and waiver-specific policies.

Evidentiary information supporting the CMA's internal programmatic reviews is submitted to the Department. Department staff then reviews a portion of each CMAs internal programmatic review using the sampling methodology described in the QIS. The Department staff compares information submitted by the CMA to State case management IT system documentation and Prior Authorization Request (PAR) submissions, client signature pages including but not limited to intake, service planning, the release of information or HIPAA, and the Professional Medical Information Page (PMIP). If the Department discovers errors outside the allowable margin, the agency may be subject to a full audit.

In addition, the Department audits each CMA for administrative functions including qualifications of the individuals performing the assessment and support planning, the process regarding the evaluation of needs, client monitoring (contact), case reviews, complaint procedures, provision of client choice, waiver expenditures, etc. This information is compared with the programmatic review for each agency. This information is also reviewed and analyzed in aggregate to track and illustrate state trends and will be the basis for future remediation.

The Department also has a Program Integrity section responsible for an ongoing review of sample cases to reconcile services rendered compared to costs. Cases under review are those referred to Program Integrity through various sources such as Department staff, CDPHE, and client complaints. The policies and procedures Program Integrity employs in this review are available from the Department.

Costs are also monitored by Department staff reviewing the 372 reports and budget expenditures.

b. Monitoring Safeguards. *Select one:*

- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

The Department implemented major changes to the business processes and structure of case management services available to individuals receiving HCBS services. These changes will have a direct impact on person-centered support planning and service delivery in Colorado. CMS granted the Department an extension until 2024 to come into compliance with Conflict-Free Case Management.

The State Medicaid Agency allows for entities to provide both case management and direct care waiver services only when no other willing and qualified providers are available. The Department issued Operational Memo 23-002 which explains the process for an entity to request a waiver for Conflict Free Case Management.

When a CMA submits a waiver request to the Dept the CMA must provide the Dept with the following information:
1. Specific service that is lacking in the CMA Defined Service Area.
2. Number of other providers available in the CMA Defined Service Area for this service.
3. Number of Medicaid members being served by the CMA for this service.
4. If the lack of service is in a particular area, indicate the area and the number of members being served in that area.
5. Efforts the CMA has made to develop the service that is lacking.
6. Procedure the CMA follows to ensure the member has been offered a choice of providers.
7. Procedure the CMA uses to avoid any possible bias of using only the CMA when the service may be available from another provider agency.
8. Written documentation indicating Direct Service Provider functions and CMA functions are being administered separately.
9. Any other information the CMA may feel is pertinent to obtaining a waiver.

The Dept reviews the above information to ensure that the CMA's waiver is in compliance with State laws regulations and policies in reference to service provision at 10 C.C.R. 2505-10, 8.7400 prior to granting a waiver.

The state currently allows an individual's HCBS provider to develop the Person Centered Support Plan (PCSP) in Sedgwick, Phillips, Logan, Morgan, Washington, Yuma, Kit Carson, Cheyenne, Lincoln, Elbert, Kiowa, Prowers, Bent, Baca, Otero, Crowley, Las Animas, Huerfano, Costilla, Conejos, Alamosa, Rio Grande, Mineral, Saguache, Archuleta, La Plata, Montezuma, Dolores, San Juan.
Per the contract, the CMA is required to do the following in regards to mitigating conflict.

For those counties where the Dept allows the HCB service provider to develop the PCSP due to a lack of other available willing and qualified providers, per the contract the CMA is required to do the following in regards to mitigating conflict: Obtaining a waiver annually from the Department to provide direct services based on criteria in applicable Department regulations. If the Contractor is granted a waiver to provide services, the Contractor shall provide written notification to the member and/or guardian of the potential influence the Contractor has on the Person-Centered Support Planning process. The Contractor shall provide the member and/or guardian with written information about how to file a provider agency and/or CMA agency complaint. Upon the member and/or guardian's request, the Contractor shall provide an option for the member and/or guardian to request a different CMA to develop the PCSP. The Contractor shall provide an option for the PCSP to be monitored by a different CMA entity or individual.

1. CMAs that are granted a waiver to provide services must provide written notification to the member and/or guardian about the potential influence the CMA has on the Person-Centered Support Planning process (such as exercising free choice of providers, controlling the content of the PCSP, including assessment of risk, services, frequency and duration, and informing the member of their rights).
2. The CMA must also provide the member and/or guardian with written information about how to file a provider agency complaint as well as how to make a complaint against the CMA.
3. Upon member and/or guardian request the CMA must provide an option for the member and/or guardian to choose a different entity or individual to develop the support plan. The CMA must also provide an option for the PCSP to be monitored by a different CMA entity or individual.

The Dept requires that all CMAs provide information about the full range of waiver services to eligible members and/or guardians. The Department does not establish rules about how this information is to be provided. The Dept requires the use of a universal PCSP is used by all HCBS case managers. The PCSP includes a list of all services available to the member provided in the waiver. In addition to the list of waiver services provided by the PCSP,

CMAs may choose to provide the information to members in a format that best meets the member's needs. For example, many CMAs prepare a comprehensive list of qualified HCBS providers in their area that is provided to members during the Person-Centered Support Planning process.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
D.a.1 Number and percent of waiver participants whose Person-Centered Support Plan (PCSP) address the needs identified in the Level of Care Screen (LOC Screen) and determination Numerator: Number of participants whose PCSPs address the needs identified in the LOC screen & determination Denominator: Total number of waiver participants reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Program Review Tool/Super Aggregate report

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence

		Interval = 95% confidence level with a +/- 5% margin of error
☒ **Other** Specify: QIO	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: Proportionate consolidated representative sample of CO.0006, CO.0268, and CO.0288
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	Specify:

Performance Measure:
D.a.2 Number and percent of waiver participants whose PCSPs address the waiver participant's personal goals N: Number of waiver participants whose PCSPs address the waiver participant's personal goals D: Total number of waiver participants reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Program Review Tool/Super Aggregate Report

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with a +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify:

		Proportionate consolidated representative sample of CO.0006, CO.0268, and CO.0288
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
D.a.3 Number and percent of waiver participants whose PCSPs address identified health and safety risks through a contingency plan Numerator: Number of waiver participants whose PCSPs address identified health and safety risks through a contingency plan Denominator: Total number of waiver participants reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Program Review Tool/Super Aggregate Report

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with a +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: Proportionate consolidated representative sample of CO.0006, CO.0268, and CO.0288
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
D.c.1 Number and percent of waiver participants whose PCSPs were revised, as needed, to address changing needs Numerator: Number of waiver participants whose PCSPs were revised, as needed, to address changing needs Denominator: Total

number of participants who required a revision to their PCSP to address changing needs that were reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Program Review Tool

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
D.c.2. Number and percent of waiver participants with a prior PCSP that was updated within one year Numerator: Number of waiver participants with a prior PCSP that was updated within one year Denominator: Total number of waiver participants with a prior PCSP in the sample

Data Source (Select one):
Other
If 'Other' is selected, specify:
State's case management IT system Data/Super Aggregate Report

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval =

		95% confidence level +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: Proportionate consolidated representative sample of CO.0006, CO.0268, and CO.0288
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
D.d.2 Number and percent of waiver participants whose scope and type of services are delivered as specified in the PCSP N: # of waiver participants whose scope and type of services are delivered as specified in the PCSP D: Total # of waiver participants in the sample

Data Source (Select one):
Other
If 'Other' is selected, specify:
Participant's record in the State's case management IT system/Bridge records and Medicaid Management Information System (MMIS) Data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% /confidence level with a +/- 5% margin of error

☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: Proportionate consolidated representative sample of CO.0006, CO.0268, and CO.0288
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
D.d.4 Number and percent of waiver participants whose amount of services are

delivered as specified in the PCSP Numerator: Number of waiver participants whose amount of services is delivered as specified in the PCSP Denominator: Total number of waiver participants in the sample

Data Source (Select one):
Other
If 'Other' is selected, specify:
Participant's record in the State's case management IT system/Bridge records and Medicaid Management Information System (MMIS) Data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with a +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: Proportionate consolidated representative sample of CO.0006, CO.0268, and CO.0288
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
D.d.5 Number and percent of waiver participants whose frequency and duration of services are delivered as specified in the PCSP Numerator: # of waiver participants whose frequency and duration of services are delivered as specified in the PCSP Denominator: Total # of waiver participants in the sample

Data Source (Select one):
Other
If 'Other' is selected, specify:
Participant's record in the State's case management IT system/Bridge records and Medicaid Management Information System (MMIS) Data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with a +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: Proportionate consolidated representative sample of CO.0006, CO.0268, and CO.0288
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
D.e.1 Number and percent of waiver participants whose PCSPs document a choice between/among HCBS waiver services and qualified waiver service providers
Numerator: Number of waiver participants whose PCSPs document a choice between/among HCBS waiver services and qualified waiver service providers.
Denominator: Total number of waiver participants in the sample

Data Source (Select one):
Other
If 'Other' is selected, specify:
State's case management IT system Data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval =

		95% confidence level with a +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: Proportionate consolidated representative sample of CO.0006, CO.0268, and CO.0288
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The Department utilizes the Super Aggregate Report as the primary data source for monitoring the PCSP assurance and performance measures. The Super Aggregate Report is a custom report consisting of two parts: data pulled directly from the state's case management system, the state's case management IT system the Bridge, and data received from the annual program evaluations document, the QI Review Tool. (Some performance measures use state's case management IT system only data, some use QI Review Tool only data, and some use a combination of state's case management IT system, Bridge, and QI Review Tool data). The Super Aggregate Report provides initial compliance outcomes for performance measures in the PCSP sub-assurances and performance measures.

D.a.1
All of the services listed in the PCSP must correspond with the needs listed in the ADLs, Supervision, and medical sections of the LOC Screen. If a participant scores two or more on the LOC Screen, the participant's need must be addressed through a waiver/state plan service or by a third party (natural supports, another state program, private health insurance, or private pay). The reviewers use the state's case management IT system and/or Bridge to discover deficiencies for this performance measure and report in the QI Review Tool.

D.a.2
PCSP must appropriately address personal goals as identified in the Personal Goals section of the PCSP. Goals should be individualized and documented in the HCBS Goals sections of the participant's record. The reviewers use the state's case management IT system and/or Bridge to discover deficiencies for this performance measure and report in the QI Review Tool.

D.a.3
Health and safety risks must be addressed in the participant's record through a contingency plan. The narrative in the contingency plan must be individualized and include a plan to address situations in which a participant's health and welfare may be at risk in the event that services are not available. The reviewers use the state's case management IT system to discover deficiencies for this performance measure and report in the QI Review Tool.

D.c.1
If SP revision need is indicated, the revision must be: included in the participant's record; supported by documentation in the applicable areas of the LOC Screen, Log notes, or CIRS, and address all service changes in accordance with Department policy, delivered to the participant or the participant's representative; and, signed by the participant or the legal guardian, as appropriate. All forms completed through the Person-Centered Support Planning process are available for signature through digital or wet signatures based on the member's preference. The reviewers use the state's case management IT system and/or Bridge to discover deficiencies for this performance measure and report in the QI Review Tool.

D.c.2
The PCSP start date must be within one year of the prior PCSP start date, for existing, non-new waiver participants in the sample. Discovery data for this performance measure is pulled directly from the state's case management IT system.

D.d.2, D.d.4, D.d.5
The Department compares data collected from MMIS claims and the participant's PCSP to discover deficiencies for this performance measure. Case managers are required to perform follow-up activities with participants and providers to ensure the PCSP reflects the appropriate services authorized in the amount necessary to meet the participant's identified needs.

D.e.1
PCSP Service and Provider Choice page must indicate that the participant has been provided a choice between/among HCBS waiver services and qualified waiver service providers. Discovery data for this performance measure is pulled directly from the state's case management IT system.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on

the methods used by the state to document these items.

D.a.1, D.a.2, D.a.3, D.c.1, D.c.2, D.d.2, D.d.4, D.d.5, D.e.1
The Department provides comprehensive remediation training CMAs annually to assist with improving compliance with service planning performance measures and in developing future individual PCSP. The remediation process includes a standardized template for individual CMA Corrective Action Plans (CAPs) to ensure all of the essential elements, including root-cause analysis, are addressed in the CAP. Time-limited CAPs are required for each performance measure when the threshold of compliance is at or below 85%. The CAPS must also include a detailed account of actions to be taken, staff responsible for implementing the actions, and timeframes, and a date for completion. The Department reviews the CAPs, and either accepts or requires additional remedial action. The Department follows up with each individual CMA quarterly to monitor the progress of the action items outlined in their CAP.

The Department compiles and analyzes CMA CAPs to determine a statewide root cause for deficiencies. Based on the analysis, the Department identifies the need to provide policy clarifications, and/or technical assistance, design specific training annually, and determine the need for modifications to current processes to address statewide systemic issues.

The Department monitors service planning CAP outcomes continually to determine if individual CMA technical assistance is required, what changes need to be made to training plans, or what additional training needs to be developed. The Department will analyze future QIS results to determine the effectiveness of the training delivered. Additional training, technical assistance, or systems changes will be implemented based on those results.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified

strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- (●) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ( ) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ( ) **Yes. The state requests that this waiver be considered for Independence Plus designation.**
- (●) **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

There is one participant-directed service available to participants of this waiver program. The case manager provides information including service description, eligibility criteria, and required paperwork to potential and current clients. During the initial assessment and service planning process and at the time of reassessment, the case manager must provide information to the client and/or legal guardian on the participant-directed service, Consumer Directed Attendant Support Services (CDASS).

The client and/or legal guardian interested in participant direction must obtain a completed Physician Attestation of Consumer Capacity indicating that the client is of sound judgment and has the ability to direct his/her care, or the client requires the assistance of an authorized representative to direct care on his/her behalf. In order to ensure that the physician's judgment can be consistently applied, the Physician Attestation of Consumer Capacity is a Department approved form that includes definitions of the following: stable health, ability to manage the health aspects of his/her life, ability to direct his/her own care, and authorized representative.

CDASS requires that a client is in stable health. If the physician indicates that the client is unable to direct his/her care, the case manager must ensure that the client or legal guardian designates an authorized representative. Clients that have been designated as able to direct his/her care may also elect to designate an authorized representative.

The authorized representative may not be the client's attendant. The authorized representative must submit an affidavit stating that he or she is at least 18 years of age; has known the client for at least two years; has not been convicted of any crime involving exploitation, abuse, or assault on another person; and does not have a mental, emotional, or physical condition that could result in harm to the client. The client and/or authorized representative works with the case manager who determines the level of care the client requires through the completion of a Uniform Long Term Care (ULTC) 100.2 assessment and the development of the service plan. The case manager refers the client and/or authorized representative to the Department contracted training and operations vendor for CDASS. The Financial Management Services (FMS) agency for CDASS is contracted to provide employment-related supports as the client's agent.

CDASS is the most flexible option for participant-directed care. CDASS attendants are employed and supervised by the client and/or authorized representative. This program offers the client and/or authorized representative the ability to recruit, hire, train, schedule, and set wages within the limitations established by the Department. The case manager calculates the client's individual allocation based on the client's needs using the Department's guidelines and prescribed methods. The needs determined for allocation must reflect the needs identified by a comprehensive assessment using the ULTC 100.2 and documented in the service plan. The case manager then refers the client and/or authorized representative to Training Vendor for training.

The Training Vendor provides training to assure that case managers, clients, and/or authorized representatives understand the philosophy and responsibilities of participant-directed care. At a minimum, this training includes: an overview of the program, client and/or authorized representative rights and responsibilities, planning, and organizing attendant services, managing personnel issues, communication skills, recognizing and recruiting quality attendant support, managing health, allocation budgeting, accessing resources, safety and prevention strategies, managing emergencies, and working with the FMS. The FMS is required to monitor the client's and/or authorized representative's submittal of required timesheet information to determine that it is complete, accurate, and timely; manage the payment of state-required sick time and family and medical leave benefits on behalf of CDASS clients and/or authorized representatives; work with the case manager to address client performance problems; provide monthly reports to the client and/or authorized representative for the purpose of financial reconciliation, and monitoring the expenditure of the annual allocation. The FMS provides financial management services for CDASS clients and/ or authorized representatives.

After the client and/or authorized representative complete the training provided by the Training Vendor, an Attendant Support Management Plan (ASMP) must be developed and submitted to the case manager for approval. The ASMP must describe at least the following: the clients current health status; the client's consumer-directed attendant support needs; a detailed listing of the amount, scope, and duration of services to be provided; the client's plans for securing consumer attendant support services, utilizing the monthly allocation, and handling emergencies. If areas of concern are identified upon the case manager's review of the ASMP, the case manager assists the participant in further developing the plan. CDASS may not begin until the plan is approved by the case manager. Existing Medicaid-funded services continue until the conditions for CDASS have been met and the start date for CDASS services is set.

The CDASS client completes an update to their ASMP when the client has a change to their CDASS allocation or services based on their needs. The case manager is responsible for reviewing the submitted plan for completion and

accuracy. The plan is put into place immediately upon case management approval or based on an agreed-upon date between the client and the case manager. All CDASS forms are available for signature through digital or wet signatures based on the member's preference.

Clients who have a dispute regarding their assessed service needs, including their CDASS allocation or CDASS attendant support management plan, have the ability to initiate an appeal before an Administrative Law Judge. The Case Management Agency (CMA) case manager shall provide the client with a Long Term Care Waiver Program Notice of Action (LTC 803) to inform the client of their appeal rights in accordance with Code of Colorado Regulation 10 CCR 2505-10, section 8.057. A client has the right to request a review of their assessed service needs identified in the CDASS task worksheet and CDASS monthly allocation at any time through their case manager. Additional language has been added to the waiver.

A client or their authorized representative is informed of the ability to select one of the contracted FMS vendors during CDASS training with the CDASS training and operations vendor. Each FMS vendor has provided informational materials regarding their company to the training vendor. This material is provided to the client or authorized representative during CDASS training. The client is able to contact the FMS vendor with any questions they may have. The client's case manager reviews the choice of FMS vendor with the client.

In order to assess the client and/or authorized representatives effectiveness in participant direction and satisfaction with the quality of services being provided; the case manager must contact the client and/or the authorized representative at least monthly for the first three months, quarterly for the remainder of the first year, and twice a year thereafter. If the client and/or authorized representative report a change in functioning which requires a modification to the clients Attendant Support Management Plan, the case manager performs a reassessment.

Under the F/EA model, the client is considered the employer of record and uses the FMS as a fiscal agent to process payroll and employee-related forms and documents. Under F/EA the program participant or representative is the common law employer of workers hired, trained, and managed by the participant or representative. The F/EA pays workers and vendors on the participant's behalf. The F/EA withholds, calculates, deposits, and files withheld Federal Income Tax and both employer and employee Social Security and Medicare Taxes. The F/EA also pays employees accrued sick time and family and medical leave on behalf of the participant and in accordance with state regulations. The F/EA is responsible for developing administrative and systems management tools for the participant to track employee accrued sick time and family and medical leave. The F/EA remains responsible for ensuring that the CDASS participant's allocation does not exceed their authorized amounts and established program maximums. This model allows the client the most choice in directing and managing their services as they are the sole employer of the attendant.

Assurance of Health and Welfare:
When a participant elects to utilize CDASS as a service delivery option the case manager and participant will update, review, and discuss all facets of the ASMP. This will include assurances of service needs identified from the CDASS task worksheet that will be addressed through attendant services. Additionally, the case manager will review the total attendant compensation the participant has determined from their allocation. Ongoing, the ASMP will be reviewed every 6 months with the case manager. The ASMP shall be modified by the client, or client authorized representative if applicable when there is a change in the client's needs. In the event the case manager or participant has identified concerns related to the participant service needs being met through their ASMP, the case manager will refer the participant to the CDASS training vendor for additional training in determining attendant compensation. The case manager will review with the participant the other service delivery options available to meet their needs. If the participant is not in agreement with their needs being met, they may request a reassessment from the case manager or may file an appeal at any time.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for

participants who exercise this authority.

○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.

◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

☒ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**

☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**

☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

○ **Waiver is designed to support only individuals who want to direct their services.**

○ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**

◉ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

1. If the client chooses to self-direct they have the option of CDASS.

2. To access CDASS, the client must obtain a statement from his or her primary care physician indicating that the person is in stable health, has sound judgment and the ability to direct his or her care, or has an authorized representative who is able to direct the client's care on his or her behalf; and

3. Clients have the option to self-direct and those that choose CDASS must demonstrate the ability to handle the financial/budgeting aspects of self-directed care and/or has an authorized representative who is able to handle financial/budgeting aspects of the eligible person's care. The client and/or authorized representative demonstrate this ability by completing training and submitting an Attendant Support Management Plan to the case manager for approval.

Assurance of Health and Welfare :
When a participant elects to utilize CDASS as a service delivery option the case manager and participant will update, review, and discuss all facets of the ASMP. This will include assurances of service needs identified from the CDASS task worksheet that will be addressed through attendant services. Additionally, the case manager will review the total attendant compensation the participant has determined from their allocation. Ongoing, the ASMP will be updated every 6 months with the case manager. In the event the case manager or participant has identified concerns related to the participant service needs being met through their ASMP, the case manager will refer the participant to the CDASS training vendor for additional training in determining attendant compensation. The case manager will review with the participant the other service delivery options available to meet their needs. If the participant is not in agreement with their needs being met, they may request a reassessment from the case manager or may file an appeal at any time.

Appeals processes are as follows: Clients who have been terminated from participating in CDASS or have a dispute regarding their assessed service needs, including their CDASS allocation, have the ability to initiate an appeal before an Administrative Law Judge. The Case Management Agency (CMA) case manager shall provide the client with a Long Term Care Waiver Program Notice of Action (LTC 803) to inform the client of their appeal rights in accordance with Code of Colorado Regulation 10 CCR 2505-10, section 8.057. When a termination to CDASS has been initiated, the case manager will work with the client to secure an alternative service delivery option. A client has the right to request a review of their assessed service needs identified in the CDASS task worksheet and CDASS monthly allocation at any time through their case manager.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

At intake and at the annual reassessment, the case manager is required to provide a client and/or the legal guardian with the service options that are available. These options may include agency-based services and/or participant-directed services. The case manager informs the client and/or the legal guardian about the potential benefits and risks for each service option as well as informs them about the client and/or authorized representative responsibilities.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one):*

- ○ **The state does not provide for the direction of waiver services by a representative.**
- ◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☒ **Waiver services may be directed by a legal representative of the participant.**

☒ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.** Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

The client and/or legal guardian interested in participant direction must obtain a completed Physician Attestation of Consumer Capacity indicating that the client is of sound judgment and has the ability to direct his/her care, or the client requires the assistance of an authorized representative to direct care on his/her behalf. In order to ensure that the physician's judgment can be consistently applied, the Physician Attestation of Consumer Capacity is a Department approved form that includes definitions of the following: stable health, ability to manage the health aspects of his/her life, ability to direct his/her own care, and authorized representative.

If the physician indicates that the client is unable to direct his/her care, the case manager must ensure that the client or legal guardian designates an authorized representative. Clients that have been designated as able to direct his/her care may also elect to designate an authorized representative.

Consumer Directed Attendant Support Services (CDASS) clients are required to be in stable health, as indicated by a signed Physician Attestation of Consumer Capacity. If a client's physician indicates that the client is not in stable health, then the client may not receive CDASS and may instead choose other agency-based services.

For consumer-directed services, the authorized representative must have the judgment and ability to direct attendant support services and must complete the Authorized Representative Designation and Affidavit form. The authorized representative must assert on this form that he/she does not receive compensation to care for the client; is at least eighteen years of age; has known the client for at least two years; has not been convicted of any crime involving exploitation, abuse, or assault on another person; and does not have a mental, emotional, or physical condition that could result in harm to the client. The form also requires that the authorized representative provide information about the relationship he/she has with the client and informs the authorized representative about the responsibilities of CDASS. All CDASS forms are available for signature through digital or wet signatures based on the member's preference.

Authorized representatives may not receive compensation for providing representation or attendant support services to the clients they have agreed to represent. The authorized representative may not work as the client's attendant.

In order to assess the client, guardian, and/or authorized representative's effectiveness in participant direction and satisfaction with the quality of services being provided, the case manager must contact the client and/or the authorized representative at least monthly for the first three months, quarterly for the remainder of the first year, and twice a year thereafter. During this contact, the case manager assesses that the authorized representative is fulfilling the obligations of the role and acting in the best interests of the participant.

The case manager also reviews monthly statements provided by the Financial Management Services (FMS) contractor and contacts the FMS and client, guardian, or authorized representative if an issue with the utilization of the monthly allocation has been identified.

Should the case manager determine that the authorized representative is not acting in the best interests of the participant or demonstrates an inability to direct the attendant support services, the case manager must take action in accordance with Department guidelines. For CDASS, these guidelines include the development of a plan for progressive action that may include: mandatory retraining, the designation of a new authorized representative, and/or the discontinuation of CDASS services.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Consumer Directed Attendant Support Services	☒	☒

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☒ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

◉ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

The Department contracts with the FMS contractor(s) in accordance with the State of Colorado Procurement Code and Rules, 24-101-101 through 24-112-101-10. Criteria for the selection of the FMS contractor(s) will include the ability to provide appropriate and timely personnel, accounting, fiscal management services, and training to clients and/or authorized representatives.

The FMS contractors offer participant-directed supports that ensure payments to members' service providers are appropriately managed, tax and insurance compliance is maintained, accrued sick time and family and medical leave are managed, and program fiscal rules are upheld.

In accordance with the Colorado Procurement Code, the Department solicits FMS contractors through a Request for Proposal (RFP) process every five years unless the need to procure a contractor during a contract cycle is necessary. An evaluation committee performs a value analysis of RFP bids and selects for award the contractors whose proposals it determines meet the RFP criteria and are the most advantageous for the State. The Department aims to maintain a minimum of three contractors at all times.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

The Department employs a Fiscal Employer Agent model for FMS.

Payments to FMS contractors are made in accordance with the State fiscal rules and managed by the Medicaid Management Information System. FMS performance is supervised by a contract manager.

On a monthly basis, the department compensates the FMS vendors through a per member per month (PMPM) payment for each client that was enrolled in CDASS during that month.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- ☒ **Assist participant in verifying support worker citizenship status**
- ☒ **Collect and process timesheets of support workers**
- ☒ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- ☒ **Other**

Specify:

Provides mandatory training to the participant and/or authorized representative related to FMS functions. Clients and case management training for CDASS is provided by a training vendor.

The Department contracts with Fiscal Management Services (FMS) organizations. The Department does not consider the training vendor an FMS.

Performs Colorado Bureau of Investigation criminal history and Board of Nursing checks.

Ensures attendants meet the established minimum qualifications.

Manages and pays accrued sick time and family medical leave to attendants.

Supports furnished when the participant exercises budget authority:

- ☒ **Maintain a separate account for each participant's participant-directed budget**
- ☒ **Track and report participant funds, disbursements and the balance of participant funds**
- ☐ **Process and pay invoices for goods and services approved in the service plan**

☒ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**

☒ **Other services and supports**

Specify:

The client is the employer of record under the Fiscal Employer Agent model

Additional functions/activities:

☒ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**

☒ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**

☒ **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**

☒ **Other**

Specify:

The client is the employer of record under the Fiscal Employer Agent model.
The FMS' are paid on a per member per month basis. The payments were bid on by the vendors during the RFP process. These prices are subject to change at contract renewal or if the contracts are re-procured.

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

Oversight of FMS entities is assured by the Department through the establishment and oversight of a contractual agreement. The contract is overseen by an administrator at the Department and performance is assessed quarterly. An on-site review is conducted at least annually.

The FMS must permit the Department and any other government agency to monitor all activities conducted by the FMS, pursuant to the terms of the contract. Monitoring consists of an internal evaluation of FMS procedures, review of reports, review of complaint logs, a re-examination of program data, on-site review, formal audit examinations, and/or any other reasonable procedures.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☒ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

The case manager provides information including service description, eligibility criteria, and required paperwork to potential and current clients. During the initial assessment and service planning process and at the time of reassessment, the case manager must also provide information to the client and/or legal guardian on the participant-directed options.

The client or guardian interested in participant direction must obtain a completed Physician Attestation of Consumer Capacity indicating that the client is of sound judgment and has the ability to direct his/her care, or the client requires the assistance of an Authorized Representative (AR) to direct care on his/her behalf. In order to ensure that the physician's judgment can be consistently applied, the Physician Attestation of Consumer Capacity is a Department approved form that includes definitions of the following: stable health, ability to manage the health aspects of his/her life, ability to direct his/her own care, and authorized representative. If the physician indicates that the client is unable to direct his/her care, the case manager must ensure that the client or legal guardian designates an AR. Clients that have been designated as able to direct his/her care may also elect to designate an AR.

CDASS clients are required to be in stable health, as indicated by a signed Physician Attestation of Consumer Capacity. If a client's physician indicates that the client is not in stable health, then the client may not receive CDASS and may instead choose other agency-based services.

The case manager assists with the completion of and reviews the required paperwork. The case manager then determines the level of care the client requires through the completion of an assessment including using the ULTC tool and collaborates with the client and/or AR in the development of the service plan. The case manager refers clients and/or AR that choose participant direction to the training vendor.
CDASS is the most flexible option for participant-directed care and requires more case manager support. Attendants are employed and supervised by the client and/or authorized representative. This program offers the client and/or authorized representative the ability to recruit, hire, train, schedule, and set wages within the limitations established by the Department. The case manager calculates the client's individual allocation based on the client's needs using the Department's guidelines and prescribed methods. The needs determined for allocation must reflect the needs identified by a comprehensive assessment using the ULTC and documented in the service plan. The case manager then refers the client and/or AR to the training vendor.

The training vendor provides training to assure that clients and/or AR understand the philosophy and responsibilities of participant-directed care. At a minimum, this training includes: an overview of the program, client and/or authorized representative rights and responsibilities, planning, and organizing attendant services, managing personnel issues, communication skills, recognizing and recruiting quality attendant support, managing health, allocation budgeting, accessing resources, safety and prevention strategies, managing emergencies, and working with the FMS. The FMS is required to monitor the client's and/or authorized representative's submittal of the required information to determine that it is complete, accurate, and timely; work with the case manager to address client performance problems, and provide monthly reports to the client and/or authorized representative for the purpose of financial reconciliation. The FMS provides financial management services for CDASS clients and/ or authorized representatives.

After the client, guardian, and/or AR completes the training, the attendant Support Management Plan (ASMP) must be developed and submitted to the case manager for approval. The ASMP must describe at least the following: the client's current health status; the client's consumer-directed attendant support needs; a detailed listing of the amount, scope, and duration of services to be provided; the client's plans for securing consumer attendant support services, utilizing the monthly allocation, and handling emergencies. If areas of concern are identified upon the case manager's review of the ASMP, the case manager assists the participant in further developing the plan. CDASS may not begin until the ASMP is approved by the case manager. Existing Medicaid-funded services continue until the conditions for CDASS have been met and the start date for CDASS services is set.

In order to assess the client and/or AR's effectiveness in participant direction and satisfaction with the quality of services being provided; the case manager must contact the client or the authorized representative at least monthly for the first three months, quarterly for the remainder of the first year, and twice a year thereafter. If the client and/or AR report a change in functioning that requires a modification to the client's Attendant Support Management Plan, the case manager performs a reassessment.

☒ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Mental Health Counseling	☐
Personal Care	☐
Personal Emergency Response Systems (PERS)	☐
Non-medical Transportation	☐
Remote Support	☐
Home Modification	☐
Peer Mentorship	☐
Behavioral Management and Education	☐
Home Delivered Meals	☐
Substance Abuse Counseling	☐
Consumer Directed Attendant Support Services	☒
Day Treatment	☐
Adult Day Health	☐
Specialized Medical Equipment and Supplies/Assistive Devices	☐
Supported Living Program	☐
Respite	☐
Transition Setup	☐
Independent Living Skills Training	☐
Transitional Living Program	☐

☒ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Clients and/or legal guardians that choose Consumer Directed Attendant Support Services (CDASS) are referred to the training vendor for mandatory training. The Fiscal Management Services (FMS) training vendor provides training to assure that clients and/or authorized representatives understand the philosophy and responsibilities of participant-directed care. At a minimum, this training includes: an overview of the program, client and/or authorized representative rights and responsibilities, planning, and organizing attendant services, managing personnel issues, communication skills, recognizing and recruiting quality attendant support, managing health, allocation budgeting, accessing resources, safety and prevention strategies, managing emergencies, and working with the FMS. The FMS is required to monitor the client's and/or authorized representative's submittal of the required information to determine that it is complete, accurate, and timely; work with the case manager to address client performance problems, and provide monthly reports to the client and/or authorized representative for the purpose of financial reconciliation. The role of the FMS is to provide financial management services for CDASS clients and/ or authorized representatives.

Oversight of FMS entities is assured by the Department through the establishment and oversight of a contractual agreement. The contract is overseen by an administrator at the Department and performance is assessed quarterly. An on-site review is conducted at least annually.

The FMS must permit the Department and any other government agency to monitor all activities conducted by the FMS, pursuant to the terms of the contract. Monitoring consists of an internal evaluation of FMS procedures, review of reports, review of complaint logs, a re-examination of program data, on-site review, formal audit examinations, and/or any other reasonable procedures.

The role of the training vendor is to support CDASS clients with training services that enable successful self-directed attendant services. The training vendor was procured by the Department using the same Request for Proposal Process used for the FMS vendors. The training vendor is compensated based on the actual number of client/authorized representatives trained that month. The training vendor also receives quarterly performance payments which include; a quarterly statewide training session payment, a quarterly skills training payment, and a quarterly performance standard payment.

Appendix E: Participant Direction of Services

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k. Independent Advocacy *(select one)*.

- (●) **No. Arrangements have not been made for independent advocacy.**
- ( ) **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

CDASS is a voluntary service delivery option from which a client may choose to withdraw at any time. If the client and/or authorized representative chooses to withdraw, he/she must contact the case manager. If a client chooses to withdraw from CDASS they would then be able to return to agency-based services unless the client was terminated from HCBS services. The case manager would then assist the client in transitioning to equivalent care in the community. A client may choose to return to participant-directed services as long as the client remains eligible. Participant-directed services continue while the transition to provider-managed care is in process.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

The Case Manager may involuntarily terminate the use of Consumer Directed Attendant Support Services (CDASS) under the following conditions: The client and/or authorized representative no longer meet program criteria due to deterioration in physical or cognitive health and refuses to designate a new authorized representative to direct services; the client and/or authorized representative demonstrate a consistent pattern of overspending the monthly allocation leading to the premature depletion of funds, the client provides false information, false records, or is convicted of fraud; and the Department has determined that adequate attempts to assist the client and/or authorized representative to resolve the overspending have failed; the client and/or authorized representative exhibit inappropriate behavior toward attendants, case managers, or the Financial Management Services (FMS), the Department has determined that the FMS has made adequate attempts to assist the client and/or authorized representative to resolve the inappropriate behavior, and those attempts have failed; there is documented misuse of the monthly allocation by the client and/or authorized representative; there has been intentional submission of fraudulent CDASS documents to case managers, the Department, or the FMS; and/or instances of convicted fraud and/or abuse; the client and/or authorized representative consistently fail to manage and meet EVV compliance requirements as outlined in the training materials located on the Participant Directed Program Website: https://hcpf.colorado.gov/participant-directed-programs. Termination may be initiated immediately for clients being involuntarily terminated by the case manager. Clients who are involuntarily terminated according to the above provisions, with the exception of EVV compliance, may not be re-enrolled in CDASS as a service delivery option. Clients and/or authorized representatives terminated due to EVV non-compliance are eligible to re-enroll in CDASS after 365 days from termination. The case manager must ensure that equivalent services are secured to assure participant health and welfare.

CDASS clients are required to be in stable health, as indicated by a signed Physician Attestation of Consumer Capacity. If a client’s physician indicates that the client is not in stable health, then the client may not receive CDASS and may instead choose other agency-based services.

The process to terminate a client from CDASS can be initiated by the case manager immediately in accordance with Code of Colorado Regulation 10 CCR 2505-10, section 8.510.13. The case manager completes an 803 Notice of Action to inform the client they are being terminated from CDASS and provide the client with their appeal rights. The case manager will work with the client to secure alternative service delivery options.

The case manager is required to notify the participant of the termination from Consumer Directed Attendant Support Services by issuing a notice of adverse action 11 days prior to the effective date of service termination. This notice provides the participant with their appeal timeframe and rights. Prior to the effective date of termination, the case manager works with the participant to secure alternative waiver services and agency-based care, non-Medicaid services, or natural supports in the community.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		89
Year 2		99
Year 3		110
Year 4		123
Year 5		137

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☒ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☒ **Recruit staff**

☐ **Refer staff to agency for hiring (co-employer)**

☐ **Select staff from worker registry**

☒ **Hire staff common law employer**

☒ **Verify staff qualifications**

☒ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

The Fiscal Management Services (FMS) is compensated for the costs of the Colorado Bureau of Investigation (CBI) criminal history background checks at the time of a prospective attendant enrollment through the FMS administration fee.

If a member and/or authorized representative chooses to obtain a CBI criminal background check report for a working attendant or to obtain other types of reports, the member/authorized representative is responsible for the costs of the additional reports. The member and/or authorized representative will have access to information on how to request and pay for these reports along with resources to understand the information they entail. For CBI reports that have been updated to clarify charges as a stipulation of conditional employment, the FMS will request and pay for the report one additional time. It is the member/authorized representative and prospective attendant's responsibility to notify the FMS when the CBI report has been updated.

☒ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

Prior to employment as a CDASS attendant, the Financial Management Service (FMS) vendor selected by the member and/or authorized representative will perform a background check which includes a Criminal Background Check through Colorado Bureau of Investigation (CBI). The Department maintains a list of crimes of high risk established by stakeholders. This list prohibits a potential attendant who has been convicted of any one of the crimes from employment as a CDASS attendant unless the member and/or authorized representative seek an exception to hire the individual through the Department established process. The process requires that the Department receive a written attestation that: the background check report was received and reviewed, that the reason for initial ineligibility is understood, that the member chooses to hire this person. The exception request must include a member and/or authorized representative developed safety plan containing specific safety elements.

The safety plan will be developed by the CDASS member and/or authorized representative and will be specific to the circumstances of the member, the member's needs and the attendant they choose to hire through the exception process. The safety plan must include the member's rationale for hiring this person despite the CBI Criminal Background Check report findings, oversight measures they will utilize, supports and resources they plan to access, and back up plans if the attendant must be terminated. The Training and Operations vendor staff walk members/authorized representatives through possible health and safety risk scenarios and encourage them to create plans that are comprehensive. The Department will inquire if the member/authorized representative needs to update the safety plan to reflect any additional support relative to the exception granted attendant. The CDASS member/authorized representative will be provided educational and training resources that can help them better understand the crimes, potential risks, and community resources if they need additional safety and health support.

Exception requests must be reviewed and granted by the Department.

The criteria that the unit will use to base its decision to grant exceptions is as follows:

1. Did the member/authorized representative receive the CBI Criminal Background Check report.
2. Did the member/authorized representative review the report.
3. Does the member/authorized representative understand the report and the results that have made the individual initially ineligible for hire as an attendant.
4. What is the severity of the results.
5. What is the age of the results.
6. Does the member/authorized representative have a complete safety plan that is unique to the hiring decision of this attendant.

a. A safety plan must have the following elements:

i. The rationale for the member/authorized representative choosing to hire the attendant despite the CBI Criminal Background Check report results.

ii. What monitoring will be used to ensure the attendant is meeting the member's needs.

iii. How the Department will provide oversight to attendants that receive exceptions.

iv. What entities and methods the member/authorized representative will use to report fraud and MANE concerns.

v. What specific resources the member/authorized representative will use to seek out support for fraud and MANE concerns.

vi. What will be the back up plan to ensure continuity of services if this attendant must be terminated or is not available.

Additional information located in Main B. Optional

☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☒ **Determine staff wages and benefits subject to state limits**

☒ **Schedule staff**

☒ **Orient and instruct staff in duties**

☒ **Supervise staff**

☒ **Evaluate staff performance**

☒ **Verify time worked by staff and approve time sheets**

☒ **Discharge staff (common law employer)**

☐ **Discharge staff from providing services (co-employer)**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

☒ **Reallocate funds among services included in the budget**

☒ **Determine the amount paid for services within the state's established limits**

☒ **Substitute service providers**

☒ **Schedule the provision of services**

☐ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**

☒ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**

☒ **Identify service providers and refer for provider enrollment**

☐ **Authorize payment for waiver goods and services**

☒ **Review and approve provider invoices for services rendered**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The needs determined for allocation must reflect the needs identified by a comprehensive assessment using the Uniform Long Term Care (ULTC) 100.2 assessment and documented in the service plan. The case manager calculates the client's individual allocation based on the client's needs using the Department's guidelines and prescribed methods. The established methods include the case manager's determination of the number of Personal Care, Homemaker, and Health Maintenance Activities hours needed on a weekly basis. A worksheet converts the service hours into an annual allocation amount. This is the amount of the participant-directed budget for waiver services over which the participant has authority.

The Department makes a concerted effort to ensure that the process to determine a client's allocation is transparent to the client and/or guardian. When a Consumer Directed Attendant Support Services (CDASS) client and/ or authorized representative participates in CDASS training, the training vendor provides the client and/or authorized representative with basic information about how the allocation is derived. If clients and/or authorized representatives request more detailed information, the training vendor refers the client to their case manager for an individualized explanation. In addition, the worksheets used to determine allocations are available to the public on the Department's website.

The case manager determines the client's CDASS budget by calculating the number of personal care, homemaker, and health maintenance service hours needed utilizing the CDASS task worksheet. The case manager completes the task worksheet with the client and/or the client's legal representative to obtain the frequency and duration of support needed for the task worksheet. The number of weekly service hours from the task worksheet for personal care, homemaker, and health maintenance services is then entered into a CDASS Monthly Allocation Worksheet which calculates the client's CDASS monthly allocation utilizing the Department's established rate for these services. This is done by the case manager.

The training vendor is responsible for training case managers, clients and CDASS authorized representatives regarding consumer-directed services. The training vendor completes training with all new clients/authorized representatives who are interested in CDASS. The training vendor maintains a customer service line that is available to clients, authorized representatives, and case managers to answer their questions regarding CDASS. The training vendor performs quarterly case management training regarding CDASS. However, the case managers are responsible for determining a client's allocation. Here is a link to the task worksheet: http://consumerdirectco.com/forms/

The training and operations vendor receives compensation monthly through a deliverables-based contract. This includes initial training and retraining of participants, answering support calls, and hosting call-in sessions regarding topics of interest to consumer direction.

Each Financial Management Services (FMS) vendor has a contracted rate for the F/EA model. The FMS vendor will continue billing using the contacted F/EA model reimbursement.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Case managers provide the client and/or authorized representative written notification of the approved allocation to be used for CDASS. If there is a change in client condition or service needs, the client and/or authorized representative may request the case manager to perform a reassessment. Should the reassessment indicate that a change in need for attendant support is justified, the client and/or authorized representative must amend the Attendant Management Support Plan. The case manager must also complete a PAR revision indicating the change and submit it to the Department's fiscal agent and to the FMS.

In approving an increase in the allocation, the case manager will consider the following: any deterioration in the client's functioning or change in the natural support condition, the appropriateness of attendant wages as determined by the Department's established rate for equivalent services, and the appropriate use and application of funds to CDASS services.

In approving a decrease in the allocation, the case manager will consider the following: any improvement of functional condition or changes in the available natural supports, inaccuracies or misrepresentation in previously reported condition or need for service, and the appropriate use and application of funds to CDASS services.

The case manager notifies the client or his/her legal representative when CDASS allocation is denied or reduced. Notice of client appeal rights is mailed using the Department-approved Notice of Action form number 803 generated by the BUS and includes the appeal rights and filing instructions.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- (●) **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ( ) **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The case manager will review monthly reports provided by the Financial Monitoring Services (FMS) to monitor client spending patterns and service utilization to assure appropriate budgeting. If the case manager determines that the client's spending patterns indicate a premature depletion of the budget, the case manager will contact the client and/or authorized representative to determine the reason for overspending. If needed, the case manager will review the service plan to ensure that the client's needs are adequately reflected in the documentation.

If the client requires an allocation increase the case manager will complete a reassessment. If the client requires further training, the case manager will refer the client and/or the authorized representative to the training vendor for additional training.

If the client and/or authorized representative complete training and continues to spend in a manner indicating premature depletion of funds the client will be required to select another authorized representative.

After all the above steps have been pursued, and the pattern of spending continues which is not planned and documented in the service plan, the client may be terminated from CDASS and the case manager will assist the client in transitioning to agency services.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The Case Management Agency (CMA) notifies the client and/or legal guardian when any of the adverse actions identified at 42 CFR Part 431, Subpart E. These adverse actions include not being given the choice of home and community-based services as an alternative to institutional care, are denied the choice of services or providers, or if services are denied, suspended, reduced, or terminated. Notice of client appeal rights is mailed using the Department-approved LTC 803 Notice of Action (LTC 803 form) and/or the prior authorization request (PAR) denial letter generated by the state's case management IT system which includes the appeal rights and instructions on how to file an appeal. The CMA is required to provide information regarding the right to request a fair hearing to the client or legal representative when they apply for publicly funded programs as set forth in 10 CCR. § 2505-10-8.057.7 and 10 CCR § 2505-10- 8.393.2.B.2.d et seq.

An explanation of appeal rights is made available to all clients when they are approved or denied eligibility for publicly funded programs and when services are denied or reduced. A notice of service status form is mailed to applicants and/or clients defining the proposed action and information on appeal rights. The process and procedures for requesting a fair hearing with the State's Office of Administrative Courts (OAC) are listed on the reverse side of the notice. Case managers are required to assist applicants and/or clients in developing a written request for an appeal if they are unable to complete the request alone.

Appeal rights are also included in the Long Term Care Plan Information form. The case manager reviews this form with the applicant/client/ and/or authorized representative at the time of initial evaluation and reevaluation. A copy of this form is provided to the client and/or authorized representative. During the monitoring of the CMA, the Department's CMA reviewers survey a random sample of client records. Included in the record review is an examination of the LTC 803 Notice of Action to ensure that each CMA is using the approved form to convey information to the client on fair hearing rights. The Department monitors also have access to the state's case management IT system which allows them to review LTC 803 forms as reviewers receive individual complaints.

Client appeal rights are maintained on an LTC 803 Notice of Action form in the BUS. Case managers are instructed to send a Notice of Action whenever there is a change or reduction in services or when a client has been denied HCBS services due to functional or financial ineligibility. The LTC 803 forms completed are available for the case manager and case manager supervisor's signature through digital or wet signatures.

If a client submits an appeal within the required time frame, the client may choose to continue receiving HCBS waiver services. The continuation of services is available under the condition that if the denial or reduction is upheld, the client may be financially liable for services rendered.

Clients who have not received HCBS services and are denied due to ineligibility are provided with appeal rights and referred to alternative community resources including home health and other state plan benefits, if applicable.

Every Medicaid action that is appealed to the OAC is reviewed by the Department. When a client appeals a decision, the OAC notifies the Department of the appeal hearing and a case manager participates in the hearing. Following the hearing, the administrative law judge issues an Initial Decision and sends it to the Office of Appeals (OA). The OA distributes the Initial Decision to all parties, including the Department, to review.

All parties then have an opportunity to file exceptions to the administrative law judge's Initial Decision. The OA is responsible for reviewing all of the documents presented at the hearing, as well as subsequent filings of exceptions to ensure that the Initial Decision is in compliance with the Department's regulations. The OA then issues a Final Agency Decision to affirm, reverse, or remand the administrative law judge's decision.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the

types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

Case managers provide individuals and families with information on how to report a grievance or complaint to multiple individuals. The grievance or complaint may be reported to the case manager, the case manager's supervisor, the case management agency administrator, and/or Department staff. It is not a requirement for complaints to go through the case manager.

Case Management Agencies (CMAs) are responsible for operating an internal grievance system and the CMA grievance is overseen by the Department.

The Department currently has an informal complaint/grievance process that includes direct contact with clients. Clients, family members, and/or advocates that have concerns or complaints may contact the Department directly. If the Department receives a complaint the Office of Community Living investigates the complaint and remediates the issue.

A Home Health Hotline is maintained by the Colorado Department of Public Health and Environment(CDPHE)-Health Facilities and Emergency Services Division. This hotline is set up for complaints about care providers, fraud, abuse, and misuse of personal property involving home health agencies. A second critical incident line is used by agencies licensed and/or surveyed by CDPHE to report issues such as unexpected death or disability, abuse, neglect, and misuse of personal property. Both hotlines are maintained by CDPHE. CDPHE evaluates the complaint and initiates an investigation. The participant does not use either hotline to report complaints or grievances against the CMAs or case managers as CMAs are not licensed or surveyed by CDPHE.

If complaints are raised by the client about the person-centered support planning process, the case manager, or other CMA functions, case managers are required to document the complaint on the CMA complaint log and assist the client to resolve the complaint. This complaint log comes to the Department on a quarterly basis. The Department is then able to review the log and note trends to discern if a certain case manager or agency is receiving an increase in complaints.

In addition to being available to the clients as needed, case managers contact clients quarterly and inquire about the quality of services the clients are receiving. If ongoing or system-wide issues or concerns are identified by a CMA, the CMA administrator will bring the issue to the Department's attention for resolution. The client may also contact the case manager's supervisor or the Department if they do not feel comfortable contacting the case manager directly. The contact information for the case manager's supervisor, the CMA administrator, and the Department is included on the copy of the support plan that is provided to the clients. The clients also have the option of lodging an anonymous complaint to the case manager, the CMA, or the Department.

Participants are informed that filing a grievance or making a complaint is not a prerequisite for a fair hearing. Instructions for requesting a fair hearing are provided to the client with any notice of adverse action. These instructions do not require that the client file a complaint or grievance.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

A Home Health Hotline is maintained by the Colorado Department of Public Health and Environment (CDPHE)-Health Facilities and Emergency Services Division. This hotline is set up for complaints about care providers, fraud, abuse, and misuse of personal property. CDPHE evaluates the complaint and initiates an investigation. Most investigations will be initiated within three days of CDPHE receiving a complaint. For complaints considered to be a severe risk to the client's health and welfare, an investigation is initiated within 24 hours after the complaint is received. Investigations may lead to targeted surveys or full surveys of the agency involved. Investigation surveys may result in deficient practice citations for agencies that are reported to the Department and require that a plan of correction be submitted to CDPHE within specified timelines. Immediate jeopardy situations require actions to correct the situation at the time of the survey. A second critical incident line for voluntary reporting by licensed agencies is maintained by CDPHE for such issues as unexpected death or disability, abuse, neglect, and misuse of personal property for voluntary reporting by licensed agencies. CRS Title 25 Section 25-1-124 and 42 CFR Chapter IV, Section 484.10(f).

In addition, Case Management Agencies (CMAs) maintain a log system for complaints and grievances and either resolve the problem themselves or refer to the appropriate oversight agency.

The Department has a formal complaint/grievance process that includes direct contact with clients when the client would like to file a complaint outside the case management entity. Clients, family members, and/or advocates that have concerns or complaints about person-centered support planning with their case management entity may contact the Department directly. When the Department receives a complaint, the complaint is forwarded to the program administrator or HCBS provider manager to investigate and remediate the issue. The Department reviews the complaint/grievance process through Case Management Agency contract deliverables to verify case managers better inform their clients, family members, and/or advocates on how to file a complaint outside the case management entity.

For those agencies that currently allow the individual's HCBS service provider to develop the person-centered support plan, the Department will review safeguards and look for instances of self-referral during the agency’s regularly scheduled monitoring visit. The State currently allows the individual's HCBS service provider to develop the person-centered support plan in Alamosa, Bent, and Montrose count as there is no other available willing and qualified entity.

State laws, regulations, and policies referenced in the description are available through the Department.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

Death:
• Unexpected or expected

Mistreatment/Abuse Neglect/Exploitation:
o Mistreatment means:
-Abuse
-Caretaker neglect
-Exploitation
-A harmful act

o Abuse means:
-The nonaccidental infliction of physical pain or injury, as demonstrated by, but not limited to, substantial or multiple skin bruising, bleeding, malnutrition, dehydration, burns, bone fractures, poisoning, subdural hematoma, soft tissue swelling, or suffocation;
-Confinement or restraint that is unreasonable under generally accepted caretaking standards; or
-Unlawful sexual behavior as defined in Section 16-22-102(9), C.R.S.

o Caretaker Neglect means:
-Neglect occurs when adequate food, clothing, shelter, psychological care, physical care, medical care, habilitation, supervision, or other treatment necessary for the health, safety, or welfare of a person is not secured for or is not provided by a caretaker in a timely manner and with the degree of care that a reasonable person in the same situation would exercise or a caretaker knowingly uses harassment, undue influence, or intimidation to create a hostile or fearful environment for waiver participant.

o Exploitation means:
-An act or omission committed by a person who:
• Uses deception, harassment, intimidation, or undue influence to permanently or temporarily deprive a person of the use, benefit, or possession of anything of value;
• Employs the services of a third party for the profit or advantage of the person or another person to the detriment of the person receiving services;
• Forces, compels, coerces, or entices a person to perform services for the profit or advantage of the person or another person against the will of the person receiving services; or
• Misuses the property of a person receiving services in a manner that adversely affects the person to receive health care or health care benefits or to pay bills for basic needs or obligations.

o Harmful Act means:
-An act committed against the participant by a person with a relationship to the participant when such act is not defined as abuse, caretaker neglect, or exploitation but causes harm to the health, safety, or welfare of the participant.

Injury/Illness to Client:
• An injury or illness that requires treatment beyond first aid which includes lacerations requiring stitches or staples, fractures, dislocations, loss of limb, serious burns, skin wounds, etc.
• An injury or illness requiring immediate emergency medical treatment to preserve life or limb.
• An emergency medical treatment that results in admission to the hospital.
• A psychiatric crisis resulting in unplanned hospitalization

Damage to Consumer’s Property/Theft
• Deliberate damage, destruction, theft, or use of a waiver recipient’s belongings or money.
• If the incident is mistreatment by a caregiver that results in damage to the consumer’s property or theft the incident shall be listed as mistreatment.

Medication Management Issues:

• Issues with medication dosage, scheduling, timing, set-up, compliance, and administration, or monitoring that results in harm or an adverse effect that necessitates medical care.

Lost or Missing Person:

• Person is not immediately found, their safety is at serious risk, or there a risk to public safety.

Criminal Activity:

• A criminal offense that is committed by a person.

• A violation of parole or probation that potentially will result in the revocation of parole/probation.

Unsafe Housing/Displacement:

• Individual is residing in unsafe living conditions due to a natural event (such as a fire or flood) or environmental hazard (such as infestation) and is at risk of eviction or homelessness.

Critical incidents are required to be reported by licensed home health care agencies, personal care agencies and homemaker agencies, Adult Day Centers, and Case Management Agencies. Oversight is provided by the Colorado Department of Health Care Policy & Financing and/or the Department of Public Health & Environment (CDPHE) and Human Services (DHS).

Critical incidents regarding allegations of abuse, neglect, and exploitation are to be reported immediately by case managers to the protective services unit of the county department of social services in the individual's county of residence and/or local law enforcement agency as required by C.R.S. 26-3.1-102. In addition, critical incidents are required to be reported to the Department within 24 hours by the case manager. Case managers report critical incidents to Department staff using the Critical Incident Reporting System (CIRS) accessible through the state's case management IT system.

The county departments of social services are also required to use the Colorado Adult Protective Services automated system to enter information on referrals, information and referral phone calls, and ongoing cases. DHS is responsible for the administration and oversight of the Adult Protection Program.

The Colorado State Long-Term Care Ombudsman Program is an independent program that advocates for residents of Alternative Care Facilities (ACF). The authority of the long-term care ombudsman program comes from Title VII, Chapter 2, of the Older Americans Act, as well as Title 26, Article 11.5, of the Older Coloradans Act. The primary purpose of the Long-Term Care Ombudsman Program is to promote and protect the residents' rights guaranteed to residents under federal and state law. Certified Long-Term Care Ombudsmen are trained to receive complaints and resolve problems in situations involving quality of care, use of restraints, transfer and discharge, abuse, and other aspects of resident dignity and rights. Ombudsman services are free, confidential, and resident directed.

The Department's interagency agreement with CDPHE requires that the agency responds to and remediates quality of care complaints about services provided by Medicaid-certified home health agencies.

Case managers are responsible for following up with appropriate individuals and/or agencies in the event any issues or complaints have been presented. Each client and/or legal guardian is informed at the time of initial assessment and reassessment to notify the case manager if there are changes in the care needs and/or problems with services.

The Department and the contract QIO review and track critical incident reports to ensure that a resolution is reached and the client's health and safety have been maintained.

Out-of-State providers must comply with comparable requirements in that state's waiver for reporting to law enforcement and Adult Protective Services.

The Department identifies incidents that were not reported through the critical incident system by pulling hospital/ER claims to cross-reference data in the critical incident system. The Department uses the cross-referenced information to confirm if the member's file has an incident reported, which case management agency is associated with the member, and additional training is needed to case management agencies and providers.

In the event an individual must evacuate their current setting, the Department has developed processes that will ensure the health, safety, and welfare of the client while allowing for additional flexibility in the location and timeliness of the critical incident reporting due to the emergent need. The member’s case manager will enter the member’s critical incident and any identified follow-up to the critical incident utilizing existing timelines identified by the Department and may request an extension in timelines for entry from the Department to the urgent nature of the evacuation.

In cases of emergency or evacuation, the case manager may authorize needed services using a temporary interim service plan, not to exceed 60 days. This plan will be developed when additional services, essential to the member's health and safety, related to the emergency situation are identified. The case manager will authorize the services using the most effective means of written communication. Service providers may provide services authorized in this manner until the case manager is able to complete a service plan revision which will backdate to the date of the temporary interim service plan. This type of interim temporary plan will only be used for already enrolled waiver participants who have been determined eligible for the waiver pursuant to the eligibility process in the waiver.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The Case Management Agency (CMA) provides information about mistreatment, abuse, neglect, and exploitation to the participants, guardians, involved family members, and authorized representatives at initial enrollment and annually thereafter. This includes information on the right to be free from mistreatment, abuse, neglect, and exploitation, how to recognize signs of mistreatment, abuse, neglect, and exploitation, and how to report mistreatment, abuse, neglect, and exploitation to the appropriate authorities. The information is provided to participants, guardians, involved family members, and authorized representatives in the form of a packet. The packet is provided by the CM and explained verbally at initial enrollment and annually thereafter. This information packet also includes information about the types and definitions of Critical Incident Reports and how to report a Critical Incident Report.

Clients and/or legal representatives are informed by the case manager about the CMA's complaint policy and the availability of the Home Health Hotline, an 800 telephone number maintained by the Colorado Department of Public Health and Environment (CDPHE). Home health agencies are also required to provide all clients with the Home Health Hotline number. Additionally, home health agencies are required to maintain an internal complaint log system under one of the conditions of licensure. CDPHE reviews the complaint log during annual surveys.

Information and training are provided to Consumer Directed Attendant Support Services (CDASS) clients and/or his/her authorized representatives by the Consumer Directed training and operations vendor. The training includes in-depth instruction about recognizing and preventing abuse, neglect, and exploitation. During the training, clients and/or authorized representatives are provided with a list of resources to use if they experience an incident involving abuse, neglect, or exploitation. The training also includes information about how to safely terminate an attendant as well as focuses on emergency backup, safety, and prevention strategies.

CDASS clients will also be encouraged to contact the proper authorities if they have been subjected to abuse, neglect, or exploitation by an attendant.

The Department has developed Policies and Procedures for the Critical Incident Reporting System (CIRS). Similar resources are also available to clients and case managers about emergency backup and safety and prevention strategies.

Case managers must document if abuse, neglect, or exploitation is suspected during the initial and annual assessment process. The client and/or the client’s representative participate in the development of the Person-Centered Support Plan (PCSP) and are provided a copy of the completed document. The Department uses its case management system, the State's case management IT system, to track the provision of this information and training. The case manager must confirm within the PCSP that the client and/or client’s representative have been informed of and trained on the process for reporting critical incidents including abuse, neglect, and exploitation.

Resource materials are available through the case manager and the Department’s website. This information packet developed by the Department will be distributed by case managers to clients and/or client representatives at the initial intake and annual Continued Stay Review (CSR). This information includes a list of client roles and responsibilities, case management roles, and how to file a complaint or appeal outside of the CMA system. This information is distributed by case managers to clients and/or client representatives at the initial intake and annual Continued Stay Review (CSR).

Clients are encouraged to report critical incidents to their provider(s), case manager, Adult Protective Services (APS), local ombudsman, and/or any other client advocate. The information packet includes what types of critical incidents to report and to whom the critical incident should be reported.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Oversight is provided by the Department, CDPHE, and/or DHS. The response to a critical incident is unique to the type of incident and the parties involved. However, the Department and/or the contract QIO vendor reviews all critical incidents.

Critical Incidents involving providers surveyed by CDPHE which meet occurrence reporting criteria must be reported to the Department and CDPHE, and are responded to by CDPHE. A Home Health Hotline is maintained by CDPHE, Health Facilities, and Emergency Services Division. This hotline is set up for complaints about the quality of care, fraud, abuse, and misuse of personal property. CDPHE evaluates the complaint and initiates an investigation. The investigation begins within twenty-four hours or up to three days depending upon the nature of the complaint and risk to the client's health and welfare. Investigation results of the complaints reported to CDPHE are posted for public view on CDPHE's website at www.colorado.gov/pacific/cdphe/find-and-compare-facilities.

Investigations may lead to targeted surveys or full surveys of the agency involved. Investigation surveys may result in deficient practice citations for agencies that are reported to the Department. Deficiencies are categorized as isolated (1-49% of clients surveyed), patterned (50-99% of clients surveyed), widespread (100% of those surveyed), and/or immediate jeopardy/life-threatening. Depending upon the risk to the health and safety of clients, the deficiency will require at a minimum that a plan of correction be submitted to CDPHE within specified timelines. If an agency has numerous and severe deficiencies, the provider may lose its Medicaid certification.

A second line is maintained by CDPHE for such issues as unexpected death or disability, abuse, neglect, and misuse of personal property for voluntary reporting by licensed agencies.

CMAs must also maintain a log system for complaints and grievances. Issues must be resolved internally or referred to the appropriate oversight agency as required by 42 CFR Chapter IV, Section 484.10(f), 10 CCR 2505-10 8.393.1.g(iv), and 6 CCR 1011-1 Chapter 2 section 7.2.

Incidents involving providers not surveyed by CDPHE must be reported by providers to the appropriate case manager and responded to by the Department.

Incidents involving CDASS must be reported to the Financial Management Services (FMS) and/or the Department. The Department and/or the FMS will respond to the incident depending upon the nature of the incident and the parties involved.

All incidents involving abuse, neglect, or exploitation must also be reported to the County Department of Social Services and are responded to by the county agency. The Department defines substantiated abuse, neglect, and exploitation as those allegations in which a report is made to law enforcement and/or protective services was investigated and that credible evidence of abuse, neglect, or exploitation exists.

All other critical incidents are responded to by the Department.

Time frames for investigations completed by Adult Protective Services (APS) vary by type of investigation. If the incident involves an immediate or imminent risk to the client's health, safety, and/or welfare the case manager collaborates with APS to adjust services in order to ensure the health and safety of the participant.

Investigations completed by Adult Protective Services are subject to confidentiality requirements and are shared only with appropriate parties to ensure the health, safety, and welfare of the member. Providers and other family members are not provided information if it conflicts with the confidentiality of the member. The results of investigations completed by CDPHE are provided to the complainant via letter once the investigation is completed. Complaint investigations are posted on the CDPHE website once completed and are available for public viewing.

For all complaints, CDPHE contacts, as appropriate, based on professional judgment and CDPHE policy and procedure, the client and or complainant, provider staff, and any other parties who were involved or who may have information regarding the complaint. Complaint investigations are maintained according to all state and federal requirements and are submitted to the Department within the monthly complaint log. Any serious findings are sent to the Department within 24 hours to the designated Department address.

Critical incidents reported to CDPHE are also posted for public view on CDPHE's website.

The information packet developed by the Department will be provided to each client during his/her initial intake and annual Continued Stay Review (CSR). This information includes a list of client rights, how to file a complaint outside the SEP system, and information describing the Critical Incident Report. Clients are encouraged to report critical incidents to their provider(s), case manager, APS, local ombudsman, and/or any other client advocate. The information packet includes what types of critical incidents to report and to whom the critical incident should be reported.

State laws, regulations, and policies referenced in the description are available through the Department.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The Department contracts with a Quality Improvement Organization, QIO, to review all Critical Incidents. The QIO monitors Critical Incidents for the completion of necessary follow-up to ensure the health, safety, and welfare of waiver participants. The QIO provides monthly reports to the Department on the number and types of Critical Incidents, a summary of Critical Incidents, and follow-up action completed. There is an immediate notification process for the QIO to notify the Department of high risk or priority Critical Incidents

The QIO will also support the Department in the analysis of CIR data, understanding the root cause of identified issues, and providing recommendations to changes in CIR and other waiver management protocols aimed at reducing/preventing the occurrence of future critical incidents.

CIR TRIAGE is as follows: assignment of levels of priority to Critical Incidents Types to determine the most effective order in which to process each report.

o HIGH PRIORITY: those which need immediate attention and must be addressed when received as no indication of ensuring health and safety is demonstrated. CIRs that would be considered High Priority would be those categorized as:

- Mistreatment (abuse, neglect, exploitation) in which immediate action must be taken to ensure an individual's health and safety, or if law enforcement has not been notified per Mandatory Reporting Requirements.
- Missing Person in which an individual with a line of sight supports/high care needs has not been found when CIR is submitted.
- Unsafe housing or displacement from a natural disaster, fire, or stemming from caretaker neglect, which leaves the individual without housing and needs immediate attention and housing to ensure health and safety.
- Death under suspicious circumstances that needs investigation, involves mistreatment, law enforcement, or where the cause of death is unknown and autopsy must be performed by a coroner.
- Injury/Illness in which no treatment has been sought, trends imply mistreatment, or those which have no immediate intervention noted to ensure the health and safety of an individual receiving services. DIDD Waivers also include Safety and Emergency Control Procedures resulting in serious injury caused by staff with no least restrictive measures utilized prior to holds/restraints or if mistreatment by staff is suspected.
- Medication Mismanagement in which error leads to an adverse medical crisis (or death) and needs immediate attention to ensure health and safety or mistreatment or theft/mistreatment by staff is a concern.
- Criminal Activity in which individual receiving services is incarcerated for a major serious offense such as homicide and needs immediate follow-up due to seriousness of charge and notification to the Department for possible media coverage of the event.
- Damage/Theft of Property to an individual receiving services self or property which results in a need for immediate action to ensure health and safety or must be reported to Law Enforcement
- Any other CIR in which immediate assurance of health and safety is crucial and has not been addressed by CMA/Agency/staff.
- Any CIR in which there is media involvement or coverage
- It should also be noted that Critical Incidents vary greatly, and the priority level may be subjective. This is also not an all-inclusive list due to variance in events.

o MEDIUM PRIORITY: those Critical Incidents that may have some immediate follow-up documented, but still need some sort of action to ensure the health and safety of an individual receiving services or other questions relating to more immediate follow-up. These may be subjective and can vary in documentation and need for clarification.

o LOW PRIORITY: those Critical Incidents that have been remediated by CMA/agencies, 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. Critical Incidents that would be Low Priority would be:

- Death, expected. Resulting from long-term illness or natural causes, hospice or palliative care was utilized and documented.
- Missing Person in which the person was immediately found, had no injury and a plan was implemented to prevent a recurrence.

The Department receives monthly complaint reports from CDPHE for licensed and surveyed agencies. The reports provide the Department with information about the type of complaint or occurrence, the source of the complaint or occurrence, when the complaint or occurrence is investigated, and the investigation findings. From these reports, Department staff can trend critical incidence and/or request to see a copy of the individual complaint or occurrence reports from CDPHE.

In instances whereupon review of the complaint report the Department identifies individual provider issues, the

Department will address these issues directly with the provider and client/guardian. If the Department identifies trends or patterns affecting multiple providers or clients, the Department will communicate a change or clarification of rules to all providers in monthly provider bulletins. If existing rules require an amendment the Department will develop rules or policies to resolve widespread issues.

In addition, case managers are required to maintain records for all critical incidents that are reported or are known to case managers. The Department performs CMA monitoring through a review of critical incidents and complaint reporting. All case managers must complete training on Critical Incident Reporting requirements within 120 days of the hire date per contract requirements.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Department has provided clients safeguards concerning the use of restraints as set forth in 26-20-102, 26-20-103, 26-20-104, 26-20-106, 26-20-107, 26-20-108, and 26-20-109, C.R.S. The use of restraints is only permitted in the delivery of respite at Nursing Facilities.

As set forth in 6 CCR 1011-1, Chapter VII, Part 1.106 et seq. and at 10 CCR 2505-10, Section 8.515.85F, a Supported Living Program (SLP) is prohibited from the use of restraints and seclusion. For an SLP to meet the criteria for HCBS waiver participation, the setting must facilitate community integration; protect the health, welfare, and safety of the client; and be home-like and person-centered. The use of interventions that restrict participant movement; participant access to other individuals, locations, or activities; restrict participant rights; or employment of aversive methods to modify behavior are prohibited. . To detect any unauthorized use of restraints or seclusion, the Department has added a signature section to the PCSP that allows clients to indicate that he/she was provided information regarding client rights, complaint procedures, and who to contact to report critical incidents.

As set forth in 6 CCR 1011-1, Chapter VII, Part 1.106 et seq. and at 10 CCR 2505-10, Section 8.516, a Transitional Living Program (TLP) is prohibited from the use of restraints and seclusion. For a TLP to meet the criteria for HCBS waiver participation, the setting must facilitate community integration; protect the health, welfare, and safety of the client; and be home-like and person-centered. The use of interventions that restrict participant movement; participant access to other individuals, locations, or activities; restrict participant rights; or employment of aversive methods to modify behavior is prohibited. To detect any unauthorized use of restraints or seclusion, the Department has added a signature section to the service plan that allows clients to indicate that he/she was provided information regarding client rights, complaint procedures, and who to contact to report critical incidents.

Restraints are allowed only in respite services provided at a Nursing Facility. Nursing Facilities shall comply with the Protection of Persons from Restraint Act at Section 26-20-101, et seq., C.R.S. as well as regulations set forth in 6 CCR 1011-1, Chapter V, Part 9.9 et seq. A Nursing Facility may only use chemical, emergency, mechanical, and/or physical restraints upon the order of a physician and only when necessary to prevent injury to the resident or others, based on a physical, functional, emotional, and medication assessment. Restraints shall not be used for disciplinary purposes, for staff convenience, punishment, or to reduce the need for care of residents during periods of understaffing.

In all instances of restraint, there must be evidence that the restraint is used only after the failure of less restrictive alternatives or that such alternatives would be ineffective under the circumstances. As an additional safeguard, an intervention strategy must be developed if the behavior necessitating the restraint recurs more than once within a week or two times within a month. The intervention strategy should be documented in the PCSP and reviewed with the resident or resident’s representative.

Whenever restraints are used, a method of communication shall be provided to the resident, in the form of a call signal switch or similar device that is within reach. Restraints are initiated either through the evaluation of professional staff or on the written authorization of a physician. Restraints are authorized only when there is a documented danger of injury to self or others. Restraints shall only be used when other more positive interventions have failed. The needed use for restraints must be documented in the health record and PCSP. If the restraint was not initiated by a physician’s authorization, a physician’s order for the restraint must be obtained no later than 24 hours after the restraint is first used.

The education and training requirements that personnel who are involved in the administration of restraints are outlined in 6 CCR 1011-1, Chapter V, Part 6.1 and 6.3. All persons assigned to direct resident care shall be prepared through formal education or on-the-job training in the principles, policies, procedures, and appropriate techniques of resident care. The facility shall provide educational programs for employees to be informed of new methods and techniques. Additional annual in-service education for staff includes a variety of topics such as accident prevention, behavior management, and person-centered care.

The nature of the emergency shall be documented in the health record and a physician’s order for the restraint shall be obtained as soon as practicable but in no event later than 24 hours after the restraint is first used.

Facilities are required to permit access during reasonable hours to the premises and residents by the State Ombudsman and the designated local long-term care ombudsman in accordance with the federal "Older Americans Act of 1965", pursuant to Section 25-27-104 (2) (d), C.R.S. Additionally, each facility is required to maintain a mechanism to address resident/resident family concerns. Facilities are also required to allow case managers and family members to contact residents.

Out-of-State providers must comply with comparable requirements in that state's waiver for the use of restraints.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The Department of Public Health and Environment's (CDPHE) survey of Supported Living Programs (SLP), Transitional Living Program (TLP), and Nursing Facilities (NF) includes an environmental tour of the facility in which surveyors tour the entire facility looking for the use of restraints. According to Federal guidelines, this survey is conducted annually or more frequently if CDPHE has received a complaint about the facility. The surveyors review the clients they have identified during the tour as having restraints or for larger facilities the surveyors review a random sample of clients who have restraints.

The review involves interviewing the client and/or legal guardian to determine if the client and/or legal guardian understand why the restraint is being used and that he/she has chosen and/or given permission for the restraint. After the interview has been conducted the surveyor reviews the client's PCSP to assess that the client has been assessed for safety and looks to see that the use of less restrictive measures was documented as being unsuccessful. The client's file will also be reviewed to ensure that the restraint has been developed with and based on a physician's order and that the client and/or legal guardian has signed a form giving the facility permission to use the restraint. If problems or inconsistencies are noted the error is noted as a deficiency by CDPHE. These data are tracked, trended, and analyzed by the CIRs Team on a monthly and quarterly basis. Specific provider trends are relayed to the Benefits division to address.

The Department provides each CMA with a quarterly and annual report outlining identified CIR trends for that CMA coverage area. The CMA utilizes this information to target case management action to mitigate trends.

Beginning July 1st, 2013, SLP & TLP providers will be surveyed every 18 to 26 months until eligibility for the extended survey cycle can be established. Thereafter, providers eligible for the extended survey cycle may be surveyed up to every 36 months. Providers are eligible for the extended survey cycle if they have been licensed for three years, have not had enforcement activity, a pattern of deficient practice, or a substantiated complaint resulting in a deficiency cited at a level of actual harm or life-threatening situation. If CDPHE receives a complaint involving abuse, neglect, or substandard care, the findings of the investigation may be grounds to conduct a survey regardless of the date of the last survey.

CDPHE has delegated authority for Life Safety Code to the Colorado Division of Fire Protection through an interagency agreement.

In accordance with the State Operations Manual, a survey of Life Safety Code issues has been designated through an interagency agreement to the Colorado Division of Fire Protection.

The Department relies on information from the survey completed by CDPHE in order to certify or revoke the certification of these providers.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

The Department has provided clients safeguards concerning the use of restraints as set forth in 26-20-102, 26-20-103, 26-20-104, 26-20-106, 26-20-107, 26-20-108, and 26-20-109, 2010 C.R.S.

The Colorado Revised Statutes referenced above also apply to many restrictive interventions as restraint is defined as:

“Any method or device used to involuntarily limit freedom of movement, including but not limited to bodily physical force, mechanical devices, or chemicals.”

The client rights established in 6 CCR 1011-1, Chapter VII, Section 13 provide safeguards concerning the use of restrictive interventions. These rights include, but are not limited to:
•The right to privacy.
•The right not to be isolated or kept apart from other residents.
•The right not to be sexually, verbally, physically, or emotionally abused, humiliated, intimidated, or punished.
•The right to live free from involuntary confinement, or financial exploitation and to be free from physical or chemical restraints.
•The right to full use of the facility's common areas, in compliance with the documented house rules.
•The right to have visitors, in accordance with house rules, including the right to privacy during such visits.
•The right to make visits outside the facility in which case the administrator and the resident shall share responsibility for communicating with respect to scheduling.
•The right to exercise choice in attending and participating in religious activities.
•The right to choose to participate in social activities, in accordance with the PCSP.

Restraints shall not be used for disciplinary purposes, for staff convenience, punishment, or to reduce the need for care of residents during periods of understaffing. In all instances of restraint, there must be evidence that the restraint is used only after the failure of less restrictive alternatives or that such alternatives would be ineffective under the circumstances. As an additional safeguard, an intervention strategy must be developed if the behavior necessitating the restraint recurs more than once within a week or two times within a month. The intervention strategy should be documented in the care plan and reviewed with the resident or resident’s representative.
Whenever restraints are used, a method of communication shall be provided to the resident, in the form of a call signal switch or similar device that is within reach. Restraints are initiated either through the evaluation of professional staff or on the written authorization of a physician. Restraints are authorized only when there is a documented danger of injury to self or others. The use of restraints is a measure of last resort when other more positive interventions have failed.
The needed use for restraints must be documented in the health record and PCSP. If the restraint was not initiated by a physician’s authorization, a physician’s order for the restraint must be obtained no later than 24 hours after the restraint is first used.

6 CCR 1011-1, Chapter VII, Section 6 requires that the facility shall document personnel has received all required training. Prior to providing direct care, the facility shall provide an orientation of the physical plan and adequate training including training specific to the particular needs of the populations served and resident rights.

Clients being provided respite care in a nursing facility are subject to the following regulations: as set forth in 6 CCR 1011-1, Chapter V, Part 9.9 et seq. A Nursing Facility may only use chemical, emergency, mechanical, and/or physical restraints upon the order of a physician and only when necessary to prevent injury to the resident or others, based on a physical, functional, emotional, and medication assessment. Restraints shall not be used for disciplinary purposes, for staff convenience, or to reduce the need for care of residents during periods of understaffing. Whenever restraints are used, a call signal switch or similar device within reach or an appropriate method of communication shall be provided to the resident. In an emergency when there is a documented danger of injury to self or others, a registered nurse or licensed practical nurse may order a physical restraint. The nature of the emergency shall be documented in the health record and a physician’s order for the restraint shall be obtained as soon as practicable but in no event later than 24 hours after the restraint is first used.

Clients living in an SLP & TLP are subject to the following regulation 6 CCR 1011-1 Chapter 7, Part 12.13-12.14 in regard to the use of restraints:
12.13 An assisted living residence shall not use restraints of any kind or deprive a resident of his or her liberty for purposes of care or safety except as allowed by Part 11.2(I), Part 25, or as set forth below. 12.14 A device that facilitates a resident's well-being and/or independence may be used only if all of the following criteria are met:
(A) The resident has the functional ability to alter his or her position;
(B) The resident is able to remove the device to allow for normal movement;
(C) The device improves the resident's physical or emotional state and allows the resident to participate in activities that would otherwise be difficult or impossible, and (D) There is an order from a practitioner for its use.
(1) There shall also be interdisciplinary documentation from both the practitioner and a therapist describing the benefits and hazards associated with the device and information on its appropriate use.
(2) A resident's continued use of such device shall be re-evaluated by both therapist and practitioner at least annually or whenever the resident experiences a significant change in status.
(3) Documentation of compliance with this subpart (D) shall be retained in the resident's care plan.

Out-of-State providers must comply with comparable requirements in that state's waiver for the use of restrictive procedures.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

The Colorado Department of Public Health and Environment's (CDPHE) survey of Supportive Living Program (SLP), Transitional Living Program (TLP), and Nursing Facilities (NF) includes an environmental tour of the facility in which surveyors tour the entire facility looking for the use of restrictive interventions. This survey is conducted annually or more frequently if CDPHE has received a complaint about the facility. The surveyors review the clients they have identified during the tour as having restrictive interventions. For larger facilities, the surveyors review a random sample of clients who have restrictive interventions.

The review involves interviewing the client and/or legal guardian to determine if the client and/or legal guardian understand why the restrictive interventions are being used and that he/she has chosen and/or given permission for the restrictive intervention. After the interview has been conducted the surveyor reviews the client's PCSP to assess that the client has been assessed for safety and looks to see that the use of less restrictive measures was documented as being unsuccessful. The client's file will also be reviewed to ensure that the restrictive interventions have been developed with and based on a physician's order and that the client and/or legal guardian have signed a form giving the facility the permission to use the restrictive intervention. If problems or inconsistencies are noted the error is noted as a deficiency by CDPHE.

Beginning July 1st, 2013, SLP & TLP providers will be surveyed every 18 to 26 months until eligibility for the extended survey cycle can be established. Thereafter, providers eligible for the extended survey cycle may be surveyed up to every 36 months. Providers are eligible for the extended survey cycle if they have been licensed for three years, have not had enforcement activity, a pattern of deficient practice, or a substantiated complaint resulting in a deficiency cited at a level of actual harm or life-threatening situation. If CDPHE receives a complaint involving abuse, neglect, or substandard care, the findings of the investigation may be grounds to conduct a survey regardless of the date of the last survey.

In accordance with the State Operations Manual, a survey of Life Safety Code issues has been designated through an interagency agreement to the Colorado Division of Fire Protection.

The Department relies on information from the survey completed by CDPHE in order to certify or decertify/revoke the certification of these providers.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of

3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The Department has rules which prohibit the use of seclusion in all settings where a waiver's participants receive services.

The Department has provided clients safeguards concerning the use of seclusion as set forth in 26-20- 102, 26-20-103, 26-20-104, 26-20-106, 26-20-107, 26-20-108, and 26-20-109, C.R.S.

Nursing Facilities are subject to the regulations: as set forth in 6 CCR 1011-1 Chapter 5, Section 23.10.

Facilities are required to permit access during reasonable hours to the premises and residents by the State Ombudsman and the designated local long-term care ombudsman in accordance with the federal "Older Americans Act of 1965", pursuant to Section 25-27-104 (2) (d), C.R.S. Additionally, each facility is required to maintain a mechanism to address resident/resident family concerns. Facilities are also required to allow case managers and family members to contact residents.

Nursing Facilities (NF) includes an environmental tour of the facility in which surveyors tour the entire facility looking for the use of seclusions. According to Federal guidelines, this survey is conducted every three years or more frequently if CDPHE has received a complaint about the facility. The surveyors review the clients they have identified during the tour as having seclusions, or for larger facilities, the surveyors review a random sample of clients who have seclusions.

In accordance with the State Operations Manual, the Department maintains an Interagency Agreement that delegates CDPHE the authority to survey and investigate complaints

CDPHE has delegated authority for Life Safety Code to the Colorado Division of Fire Protection through an interagency agreement.

Beginning July 1st, 2013, SLP & TLP providers will be surveyed every 18 to 26 months until eligibility for the extended survey cycle can be established. Thereafter, providers eligible for the extended survey cycle may be surveyed up to every 36 months. Providers are eligible for the extended survey cycle if they have been licensed for three years, have not had enforcement activity, a pattern of deficient practice, or a substantiated complaint resulting in a deficiency cited at a level of actual harm or life-threatening situation. If CDPHE receives a complaint involving abuse, neglect, or substandard care, the findings of the investigation may be grounds to conduct a survey regardless of the date of the last survey.

Only after the plan of correction has been accepted will a license or recommendation for certification be issued. CDPHE sends the survey and licensing information to the Department for review. The Department may certify the provider for Medicaid enrollment based on the CDPHE recommendation and survey results. Agencies denied licensure or recommendation for certification by CDPHE are not approved as Medicaid providers.

In accordance with the State Operations Manual, a survey of Life Safety Code issues is delegated through an interagency agreement to the Colorado Division of Fire Protection.

The Department relies on information from the survey completed by CDPHE in order to certify or decertify/ revoke the certification of these providers.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i

and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

In Supported Living Programs (SLPs), Transitional Living Programs (TLPs), and nursing facilities, qualified medication administration staff may administer or assist the client in the administration of medication. For clients whose medications are administered by facility staff, a current record of the client's medications will be maintained that includes the name of the drug, the dosage, route of administration, and directions for administering the medication. The facility will only administer medications upon the written order of a licensed physician or another authorized practitioner.

As part of the health inspection and survey process, CDPHE reviews medication administration procedures, storage of all medication, including controlled substances, medication audit and disposal practices, and reporting required for drug reactions and medication errors. If deficiencies are cited in any of these areas, CDPHE will follow up with the provider to ensure compliance with the regulations.
In addition, the Department monitors Critical Incident Reports submitted by providers for instances of a critical incident resulting from a medication management issue.

Under Colorado's statute, the Colorado Department of Public Health and Environment (CDPHE) has established minimum requirements for course content, including competency evaluations, for medication administration. CDPHE approves and maintains a list of approved training entities of medication administration courses. CDPHE also maintains a current list of persons who have passed the competency evaluation by an approved training entity. CDPHE reviews the medication policies, procedures, and practices of each TLP, SLP, and nursing facility to ensure compliance with state and federal regulations. CDPHE conducts standard surveys of facilities once every three years, on a regular 9-15 month certification cycle. Facilities with past or present deficiencies that impact direct client care are surveyed earlier in the certification cycle.

CDPHE sends monthly reports to the Department summarizing the surveys completed.

Out-of-State providers must comply with comparable requirements in that state's waiver for medication administration.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

Colorado State Board of Health regulations (6 CCR 1011-I Chapter V) specify general requirements for Medicaid Long Term Care Facilities, which include Supported Living Programs (SLPs) and Nursing Facilities (NFs). Colorado State Board of Health regulations (6 CCR 101 I-I, Chapter XXIV) specify the requirements for medication administration in Medicaid Long Term Care Facilities. Prescription and non-prescription medications shall be administered only by qualified medication administration staff and only upon written order of a licensed physician or other licensed authorized practitioner. Such orders must be current for all medications. Non-prescription medications must be labeled with a resident's full name. No resident shall be allowed to take another's medication nor shall staff be allowed to give one resident's medication to another resident. The contents of any medication container having no label or with an illegible label shall be destroyed immediately. Medication that has a specific expiration date shall not be administered after that date. Each facility shall document the disposal of discontinued, outdated, or expired medications.

Facilities using medication reminders for persons who are not self-administering must have qualified medication administration staff members available to assist with or administer the medication reminder. The facility shall ensure that if a licensed nurse fills the medication reminder or a family member or friend gratuitously fills the medication reminder, a label shall be attached to the medication reminder box showing the resident's name, each medication, the dosage, the quantity, the route of administration, and the time that each medication is to be administered. Each medication reminder shall have a medication record or sheet on which all administrations are recorded. If medications in the medication reminder are not consistent with the labeling, assistance to the resident shall not proceed and the qualified medication administration staff member shall immediately notify the proper persons as outlined in the facility's policies and procedures. Once the issue is resolved and the medications are correctly assigned to the various compartments of the medication reminder, the qualified medication administration staff member may resume the administration or assistance to the resident from the medication reminder. All medication problems must be resolved prior to the next administration.

The Colorado Department of Public Health and Environment is responsible for the oversight of medication management in Nursing Facilities, SLPs, TLPs, IHSS agencies, Adult Day Centers, and Day Treatment through certification and licensure surveys, as well as complaint surveys. The Colorado Department of Public Health and Environment (CDPHE) conducts regular surveys of SLPs, TLPs, IHSS agencies, Adult Day Centers, Day Treatment centers, and Nursing Facilities. The survey includes a review of medication storage procedures, medication administration procedures, documentation procedures, and a review of credentialing of all staff, including those who administer medication. If during a survey there is a finding that rises to the level of deficiency, the Department will receive the Deficiency List (DL), which outlines the cited deficiency and let the level of each citation.
The Department works with CDPHE to monitor the submitted Plan of Correction (POC) by the facility and any remediation for deficiencies cited.

State monitoring is conducted on behalf of the Department By CDPHE. A third of the total SLPs and TLPs are inspected every fiscal year by CDPHE. The CDPHE fiscal year runs from July 1 to June 30th. During inspections, the health team inspects each facility for compliance with Chapter VII operating licensing, Chapter 24 medication administration regulations, and Volume 8 - regulations. Therefore, two deficiency lists are generated if there are citations under each regulation set. Any issues or concerns regarding Life Safety Code found during an inspection are forwarded to the Colorado Department of Fire Prevention and Control (DFPC). Nursing Facilities are surveyed every 9-15 months.

The Department reviews and tracks ongoing critical incidents to ensure that a resolution is reached and the client's health and safety are maintained. Should a facility demonstrate a pattern of non-compliance or be issued an outcome level deficiency, CDPHE will consider enforcement action in the form of intermediate conditions. Additionally, if information concerning potentially harmful practices is identified by CDPHE, they will conduct either a desk or on-site revisit of the facility to ensure compliance with the POC and/or intermediate condition.

PRN or "as needed" medications of any kind shall not be placed in medication reminders. Only medications intended for oral ingestion shall be placed in the medication reminder. Medications that must be administered according to special instructions, including but not limited to such instructions as "30 minutes or an hour before meals", rather than administered routinely (unspecified--one, two, three, or four times a day, etc.), may not be placed in a medication reminder. Medications in the medication reminder box may only be used at the time specified on the box. Medication reminder boxes may not be filled for more than two weeks at a time. All

prescription and non-prescription medication shall be maintained and stored in a manner that ensures the safety of all residents.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

A client living in a Supported Living Program (SLP), Transitional Living Program (TLP) or receiving respite in a Nursing Facility, who is unable to administer his/her medication independently shall have medications administered by a qualified medication administration staff as defined in CCR 1011-I, Chapter XXIV, State Board of Health Medication Administration Regulations.

All qualified medication administration staff are required to take the medication administration course designed to teach unlicensed staff to safely administer medications in settings authorized by law. Staff who successfully complete the medication administration course are not certified or licensed in any way and are not trained or authorized to make any type of judgment, assessment, or evaluation of a client. Staff who successfully complete the course are considered Qualified Medication Administration Persons.

iii. Medication Error Reporting. *Select one of the following:*

- ◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
  Complete the following three items:

  (a) Specify state agency (or agencies) to which errors are reported:

  Medication errors are currently required to be reported to the Department of Public Health and Environment for clients receiving services from an SLP, TLP, or Home Health agency are monitored by CDPHE. CDPHE compiles the deficiencies and provides the Department with monthly and annual reports of CDPHE survey findings.

  (b) Specify the types of medication errors that providers are required to *record:*

  The following is a list of Medication errors that are required to be recorded and reported by a Qualified Medication Administration Person (QMAP):
  1. wrong client
  2. wrong time
  3. wrong medication
  4. wrong dose
  5. wrong route

(c) Specify the types of medication errors that providers must *report* to the state:

The following is a list of Medication errors that are required to be recorded and reported by a Qualified Medication Administration Person (QMAP):

1. wrong client
2. wrong time
3. wrong medication
4. wrong dose
5. wrong route

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The annual CDPHE surveys of Supported Living Programs (SLPs), Transitional Living Programs (TLPs), and nursing facilities include a medication review, focused on a random sample of at least five clients, or more than five for the larger facilities.

CDPHE samples client records according to the following formula:
• 3-20 residents = minimum of 3 and up to 5 sample client records
• 21-30 residents = 6 sample client records
• 31-40 residents = 7 sample client records
• 41-50 residents = 8 sample client records
• 51-60 residents = 9 sample client records
• 61-70 residents = 10 sample client records
• More than 71 residents = 10 + 10% sample client records (e.g. 100 residents = 10 + (10% of 100) = 20 sample clients records)

The medication review involves reviewing the physicians' orders, comparing those to medication administration records, looking at the medication bottles, and then observing staff administering the medication to the client. If problems or inconsistencies are noted, for example, if a prescription directs that the drug is to be dosed twice a day and records indicate that it has only been dosed once, the medication error is noted as a deficiency by CDPHE.

The Department reviews and tracks ongoing critical incidents to ensure that a resolution is reached and the client's health and safety are maintained. Should a provider demonstrate a pattern of non-compliance or be issued an outcome level deficiency, CDPHE will consider enforcement action in the form of intermediate conditions. Additionally, if information concerning potentially harmful practices is identified by CDPHE, they will conduct either a desk or on-site revisit of the facility to ensure compliance with the POC and/or intermediate condition.

The QIO will support the Department in the analysis of CIR data, understanding the root cause of identified issues, and providing recommendations to changes in CIR and other waiver management protocols aimed at reducing/preventing the occurrence of future critical incidents. The Department reviews and tracks ongoing critical incidents to ensure that a resolution is reached and the client's health and safety is maintained.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
G.a.1 # and % of waiver participants &/or family/guardians who received info/education on how to identify & report abuse, neglect, exploitation (ANE), unexplained death & other critical incidents (CI) N: # of waiver participants &/or family/guardians who rcvd info/ed on how to id & report ANE, unexplained death & other CI D: Total # of waiver participants &/or family/guardians in the sample

Data Source (Select one):
Other
If 'Other' is selected, specify:
State's case management IT System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval =

		95% confidence level, +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: Proportionate consolidated representative sample of CO.0006, CO.0268, and CO.0288
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Performance Measure:
G.a.2 Number and percent of all critical incidents that were reported by the Case Management Agency (CMA) within required timeframe as specified in the approved waiver N: Number of all critical incidents reported by the CMA within the required timeframe as specified in the approved waiver D: Total number of all critical incidents reported by the CMA

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G.a.3 Number and percent of all critical incidents that were remediated N: Number of all critical incidents that were remediated D: Total number of critical incidents

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G.a.4 # and % of complaints against licensed waiver providers reported to CDPHE involving allegations of ANE that were resolved according to CDPHE regs N: # of

complaints against licensed waiver providers reported to CDPHE involving allegations of ANE resolved according to CDPHE regs D: Total complaints against licensed waiver providers reported to CDPHE involving allegations of ANE

Data Source (Select one):
Other
If 'Other' is selected, specify:
Monthly Complaint Reports Submitted by CDPHE

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G.a.6 Number and percent of newly enrolled and revalidated waiver providers trained on how to identify, address, and seek to prevent critical incidents N: # of newly enrolled and revalidated waiver providers trained on how to identify, address, and seek to prevent critical incidents D: Total # of newly enrolled and revalidated waiver providers

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record of Training

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other**	☒ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
G.b.3 Number and percent of annual reports provided to Case Management Agencies (CMAs) on identified trends in critical incidents N: Number of annual reports provided to the CMAs on identified trends in critical incidents D: Total number of annual reports required to be provided to CMAs

Data Source (Select one):
Other
If 'Other' is selected, specify:
Critical Incident Reports and State's case management IT System Data and/or CDPHE Reports; Record Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G.b.4 Number and percent of preventable critical incidents reported that have been effectively resolved N: Number of preventable critical incidents reported that have been effectively resolved D: Total number of preventable critical incidents reported

Data Source (Select one):
Other
If 'Other' is selected, specify:
State's case management IT System Data/Critical Incident Reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G.b.6 Number and percent of critical incidents where the root cause has been identified N: Number of critical incidents where the root cause has been identified D. Total number of critical incidents

Data Source (Select one):
Critical events and incident reports

If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
G.c.2 Number and percent of providers surveyed during the performance period that met requirements for use of physical or mechanical restraints. Numerator: Number providers surveyed during the performance period that met requirements for use of physical or mechanical restraints Denominator: Total number of providers surveyed during the performance period.

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample**

		Confidence Interval =
☒ **Other** Specify: CDPHE	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:

G.c.3 Number and percent of providers surveyed in the performance period that met requirements for implementing Rights Modification Numerator: Number of surveyed providers surveyed in the performance period that met the requirements for implementing Rights Modification Denominator: Total number of providers surveyed during the performance period

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: CDPHE	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G.c.4 Number and percent of providers surveyed that met the requirements for the use of training and support plans with restrictive procedures Numerator: Number of providers surveyed that met the requirements for use of training and support plans with restrictive procedures Denominator: Total number of providers surveyed

Data Source (Select one):
Reports to State Medicaid Agency on delegated
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other**	☒ **Annually**	☐ **Stratified**

Specify: CDPHE		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G.c.6 Number and percent of waiver participants with Restrictive Intervention Plans where proper procedures were followed in initially establishing the Restrictive Intervention Plan N:# of wvr participants w/ Restrictive Intervention Plan where proper procedures were followed in initially establishing the Restrictive Intervention Plan D:# of wvr participants w/ a Restrictive Intervention Plan

Data Source (Select one):
Other

If 'Other' is selected, specify:
State's case management IT system/Critical incident reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other**	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Specify:	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
G.d.3 Number and percent of waiver participants who received care from a medical professional within the past 12 months Numerator: The number of participants who received care from a medical professional within the last 12 months Denominator: The total number of participants reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative**

		Sample Confidence Interval = 95% confidence level with +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: Proportionate consolidated representative sample of CO.0006, CO.0268, and CO.0288
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The Dept. uses information entered into the State's case management IT system and the Critical Incident Reporting System (CIRS) and/or complaint logs as the primary method for discovery for the Health and Welfare assurance and performance measures.
CMAs are required to report critical incidents into the state prescribed critical incident reporting system (CIRS) and follow up on each Critical Incident Report (CIR) through the CIRS. Following the receipt of the initial critical incident report, the QIO reviews the documentation to determine if the instance was substantiated. If the documentation does not clearly state whether instance was substantiated, the QIO requests follow up by the CMA to gather the needed information from the parties involved.

G.a.1
An information packet developed by the Dept. must be provided to participants during initial intake and annual CSR. The information includes participant rights, how to file a complaint outside the system, information describing the CIRS and time frames for starting an investigation, the completion of the investigation or informing the participant/complainant of the results of the investigation. Participants are encouraged to report critical incidents to their provider(s), case manager, protective services, local ombudsman and/or any other advocate. The information also includes what types of incidents to report and to whom the incident should be reported.
Compliance with this performance measure requires that the signature section in the service plan indicates that participants (and/or family or guardian) have been provided information regarding rights, complaint procedures, and have received information/education on how to report abuse, neglect, exploitation (ANE) and other critical incidents.

G.a.2
Critical incidents are reported to the Dept. via the web-based CIRS. CMAs and waiver service providers are required to report critical incidents within specific timeframes. The Department monitors critical incident reporting through the CIRS and/or complaint logs.

G.a.3
All follow up action steps taken must be documented in the participant’s CIRS record. Documentation must include a description of any mandatory reporting to Adult Protective Services, referral to law enforcement, notification to ombudsman, or additional follow-up with the participant. The CIR Administrator determines if adequate follow up was conducted and if all appropriate actions were taken and may require additional follow up or investigation, if needed.

G.a.4
Critical incidents involving providers surveyed by DPHE must be reported to the Dept. and DPHE and are responded to by DPHE. A hotline is set up for complaints about quality of care, fraud, abuse, and misuse of personal property. DPHE evaluates the complaint and initiates an investigation if warranted. The investigation begins within twenty-four hours or up to three days depending upon the nature of the complaint and risk to the participant’s health and welfare.

G.a.6
CMAs and providers are required to attend preventative strategies trainings. Training records of preventative strategies training are maintained by the Dept.

G.b.3
The Dept. examines data for specific trends to include individuals that have multiple CIRs; identifies participants who have more than one CIR in 30 days, more than three CIRs in six months, and more than five CIRs in 12 months. The Dept. produces critical incident trend reports to be provided to all CMAs at least annually. Records of the reports and dates provided are maintained by the Dept.

G.b.4
The Dept. examines data in the CIRS to determine when critical incidents were preventable and whether resolutions were effective.

G.b.6

Root cause identified/trends reduced as a result of systemic intervention data are tracked and analyzed by the CIR Team on a monthly and quarterly basis, including through mortality review committee.

G.c.1, G.c.2, G.c.3, G.c.4, G.c.6
The Dept monitors restrictive interventions to ensure all participants who need a restrictive intervention plan have one. The Dept. also monitors the inappropriate/ineffective use of restrictive interventions through the CIRS and provider survey reports. These incidents receive additional scrutiny by the Dept staff that includes review of the original written incident report to ensure restrictive intervention was used in compliance with statutory and regulatory requirements. The CIRS monitoring operates on a daily/continuous basis.
Oversight and discovery of restrictive interventions where proper procedures were not followed are completed through the review of complaints regarding services and supports and conducting surveys of CMAs by Dept. staff and providers by DPHE.

Providers must demonstrate during the survey process that they have met requirements for the use of physical or mechanical restraints; met the due process requirements for implementing a restrictive intervention met the requirements for use of training and support plans with restrictive interventions.

G.d.3
Service Plans must demonstrate that waiver participants identified health needs have been addressed through a waiver service and/or other support, i.e. natural supports, other state programs, private health insurance. The QIO reviewers use the State's case management IT system and/or Bridge to discover deficiencies for this performance measure and report in the QI Review Tool.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Issues or problems identified during annual program evaluations will be directed to the Case Management Agency (CMA) administrator and reported in the individual's annual report of findings. CMAs deficient in completing accurate and required CIRs will receive technical assistance (TA) and/or training by Dept. staff. CMAs are required to submit individual remediation action plans for all deficiencies identified within 30 days of notification. The Dept. reviews CMA's remediation action plan and confirms the appropriate steps have been taken to correct the deficiencies.
In addition to annual data collection and analysis, Dept. contract managers and program administrators remediate problems as they arise based on the severity of the problem/by nature of the compliance issue. For issues that arise outside annual review, TA may be provided to CMA case manager, supervisor, or administrator, and a confidential report will be documented in the waiver recipient care file when appropriate. The Dept. reviews and tracks the ongoing referrals and complaints to ensure that a resolution is reached, and the participant's health and safety has been maintained.

G.a.1
The Dept. provides remediation training CMAs annually to assist with improving measure compliance. The remediation process includes a standardized template for individual CMA Corrective Action Plans (CAPs) to ensure all of the essential elements, including a root-cause analysis, are addressed. Time-limited CAPs are required for each performance measure below the 86% CMS compliance standard. The CAPS must also include a detailed account of actions to be taken, staff responsible, and a date for completion. The Dept. reviews the CAPs, either accepts or requires additional remedial action, and follows up with each CMA quarterly to monitor the progress of the actions outlined in their CAP.

G.a.2
The Dept. takes remedial action to address with waiver service providers and/or CMAs when needed for deficient practice in reporting and management of Critical Incidents. This includes formal request for response, TA, Dept. investigation, imposition of corrective action, termination of CMA contract, and termination of waiver service providers.

G.a.3
CMAs deficient in completing accurate and required follow ups will receive TA and/or training by Dept. staff. CMAs are required to submit individual remediation action plans for all deficiencies identified within 30 days of notification. Following receipt of the CMA's remediation action plan, the Dept. reviews the plan and confirms the appropriate steps have been taken to correct the deficiencies.

G.a.4
In instances where upon review of the complaint or occurrence report the Dept. identifies individual provider issues, the Dept. will address these issues directly with the provider and participant/guardian. If the Department identifies trends or patterns affecting multiple providers or participants, the Dept. will communicate a change or clarification of rules to all providers in monthly provider bulletins. If existing rules require an amendment the Dept. will develop rules or policies to resolve widespread issues.

G.a.6
The Dept. requires agencies who do not attend preventative strategies training as required to submit a corrective action plan. If remediation does not occur timely or appropriately, the Dept. issues a "Notice to Cure" the deficiency to the CMA/provider. This requires the agency to take specific action within a designated timeframe to achieve compliance.

G.b.3, G.b.4
The Dept. uses this information to develop statewide trainings, determine the need for individual agency TA for case management and service provider agencies. In addition, the Dept. identifies problematic practices with individual CMAs and/or providers and to take additional action such as conducting an investigation, referring the agency to CDPHE for complaint investigation or directing the agency to take corrective action. If problematic trends are identified by the Dept. in the reports, the Dept will require a written plan of action by the CMA and/or provider agency to mitigate future occurrence.

G.b.6
Specific provider trends are relayed to the Benefits division to determine additional remediation/improvement

strategies to implement.

G.c.1, G.c.6
The Dept. takes remedial action to address with waiver service providers and/or CMAs deficient practice in following the proper procedures of restrictive interventions. This includes formal request for response, TA, Dept. investigation, imposition of corrective action, termination of CMA cnd/or waiver service providers' contract(s).

G.c.2, G.c.3, G.c.4
CDPHE notifies the agencies of deficiencies and determines the appropriate remedial actions: training, TA, Plan of Correction, license revocation

G.c.6
The Dept. takes remedial action to address with CMAs for deficient practice in following the proper procedures of restrictive interventions. This includes formal request for response, TA, Dept. investigation, imposition of corrective action, and/or termination of CMA contract.

G.d.3
The Department provides remediation training for CMAs annually to assist with improving compliance with the ensuring there is accurate RAE/CMA care coordination. The Department compiles and analyzes CMA CAPs to determine a statewide root cause for deficiencies. Based on the analysis, the Department identifies the need to provide policy clarifications, and/or technical assistance, design specific training, and determine the need for modifications to current processes to address statewide systemic issues.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: As needed by severity or non-compliance

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

This Quality Strategy encompasses all services provided in CO.0006 Elderly, Blind, and Disabled (EBD), CO.0268 Community Mental Health Supports (CMHS), and CO.0288 Persons with Brain Injury (BI) waivers. The waiver specific requirements and assurances are included in the appendices for each waiver.
The Department draws from multiple sources when determining the need for and methods to accomplish system design changes. Using data gathered from Colorado Department of Public Health and Environment (CDPHE), Critical Incident Reporting System (CIRS), annual programmatic and administrative evaluations, and stakeholder input, the Department's Office of Community Living Benefits and Services Management Division, in partnership with the Case Management Quality and Performance Division and Office of Information Technology (OIT), uses an interdisciplinary approach to review and monitor the system to determine the need for design changes, including those to the Benefits Utilization System (BUS). Work groups form as necessary to discuss prioritization and selection of system design changes.
Discovery and Remediation Information:
The Department maintains oversight over the consolidated waivers in contracts/interagency agreements through tracking of contract deliverables on a monthly, quarterly, semi-annually, and yearly basis, depending on the details of each agreement. The Department has access to, and reviews all required reports, documentation and communications. Delegated responsibilities of these agencies/vendors are monitored, corrected, and remediated by the Department's Office of Community Living.
Colorado selects a proportionate representative random sample (unless otherwise noted in the waiver application) of waiver participants for annual review, with a confidence level of 95%, margin of error 5%, from the combined population of waiver participants in Waiver Control # CO.0006, Waiver Control #CO.0268, and Waiver Control # CO.0288. The results obtained reflect the performance of the combined system, ensuring that the system for the waivers is responsive to the needs of all individuals served. The Department trends, prioritizes and implements system improvements (i.e., design changes) prompted as a result of an analysis of the discovery and remediation information obtained. The Department chooses this inclusive approach because the following five conditions are met:

1. The design of each of Colorado's 1915(c) HCBS waivers is similar;
2. The similarity was determined by comparing waivers on the approved waiver application appendices:
   a. Participant Services,
   b. Participant Safeguards, and
   c. Quality Management;
3. The quality management approach is the same across waivers, including:
   a. Methodology for discovering information (e.g., data systems, sample selection),
   b. The manner for remediated individual issues,
   c. Process for identifying and analyzing patterns/trends, and
   d. Performance indicators are similar;
4. The provider network is similar; and
5. Provider oversight is the same.

Data for the different measures that do not align across all three waivers (0006, 0268, and 0288) will be submitted with the consolidated reporting evidence.

To ensure the quality review process is completed accurately, efficiently, and in accordance with federal standards, the Department contracted with an independent Quality Improvement Organization (QIO) to complete the QIS Review Tool for the annual Case Management Agency (CMA) program case evaluations. Additionally, the Department performs an inter-rater reliability study of results provided by the QIO to determine accuracy of QIO reviews.
The Department uses standardized tools for level of care (LOC) eligibility determinations, person centered support planning, and critical incident reporting for waiver populations. Through use of the state's case management system, the data generated from LOC eligibility determinations, Person Centered Support Plans, and critical incident reports, and concomitant follow-up are electronically available to CMAs and the Department, allowing effective access and use for clinical and administrative functions as well as for system improvement activities. This standardization and electronic availability provides comparability across CMAs, waiver programs, and allows on-going analysis. In addition, the Department is on track to implement a new case management system in the Spring of 2022 to streamline processes for identifying member needs and coordinating support. This new system will eliminate the need for case managers to complete documentation in multiple systems which will reduce the chance for errors and/or missing information.

Waiver providers that are required by Medical Assistance Program regulations to be surveyed by CDPHE, must

complete the survey prior to certification to ensure compliance with licensing, qualification standards and training requirements. The Department is provided with monthly and annual reports detailing the number and types of agencies that have been surveyed, the number of agencies that have deficiencies and types of deficiencies cited, the date deficiencies were corrected, the number of complaints received, and complaints investigated, substantiated, and resolved. Providers who are not in compliance with CDPHE and other state standards receive deficient practice citations. Department staff review all provider surveys to ensure deficiencies have been remediated and to identify patterns and/or problems on a statewide basis by service area, and by program. The results of these reviews assist the Department in determining the need for technical assistance, training resources, and other needed interventions. The Department initiates termination of the provider agreement for any provider who is in violation of any applicable certification standard, licensure requirements, or provision of the provider agreement and does not adequately respond to a plan of correction within the prescribed period of time.

Following Medicaid provider certification, the fiscal agent enrolls all providers in accordance with program regulations and maintains provider enrollment information in Colorado Medicaid Management Information System (MMIS), the interChange. All provider qualifications are verified by the fiscal agent upon initial enrollment and in a revalidation cycle; at least every five years.

The MMIS, interChange, is designed to meet federal certification requirements for claims processing and submitted claims are adjudicated against interChange edits prior to payment. Claims are submitted through the Department's fiscal agent for reimbursement. The Department also engages in a post-payment review of claims to ensure the integrity of provider billings.

The information gathered from the Department's monitoring processes is used to determine areas that need additional training/technical assistance, system improvements, and quality improvement plans.

Trending:

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

Prioritization:

The Department relies on a variety of resources to prioritize changes in the BUS. In addition to using information from annual reviews, analysis of performance measure data, and feedback from case managers, the Department factors in appropriation of funds, legislation and federal mandates.

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

The Department continually works to enhance coordination with CDPHE. The Department engages in quarterly meetings with CDPHE to maintain oversight of delegated responsibilities; report findings and analysis; provider licensure/certification and surveys; provider investigations, corrective actions and follow-up. Documentation of inter-agency meeting minutes, decisions and agreements will be maintained in accordance with state record maintenance protocol.

Quality improvement activities and results are reviewed and analyzed amongst benefit administrators, case management specialists, and critical incidents administrators.

Implementation: Prior to implementation of a system-level improvement, the Department ensures the following are in place:

- o Process to address the identified need for the system-level improvement;
- o Policy and instructions to support the newly created process;
- o Method to measure progress and monitor compliance with the system-level improvement activities including identifying the responsible parties;
- o Communication plan;
- o Evaluation plan to measure the success of the system-level improvement activities post-implementation;
- o Implementation strategy.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Quality Improvement Committee**	☒ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

Monitoring and Analyzing System Design Changes:
The process used to monitor the effectiveness of system design changes will include systematic reviews of baseline data, reviews of remediation efforts and analysis of results of performance measure data collected after remediation activities have been in place long enough to produce results. Targeted standards have not been identified but will be created on baseline data once the baseline data has been collected.
Roles and Responsibilities:
The Office of Community Living Benefit and Services Management Division and the Case Management and Quality Performance Division hold primary responsibility for monitoring and assessing the effectiveness of system design changes to determine if the desired effect has been achieved. This includes incorporation of feedback from waiver participants, advocates, CMAs, providers, and other stakeholders.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Department is consistently assessing and improving processes and systems on an ongoing basis. The Office of Community Living's Waiver Administration and Compliance unit evaluates the QIS annually as part of the data collection and analysis for CMS 372 reporting. A formal review of the program occurs again after Waiver Year 3, when three years of data has been collected and causes of trends have been analyzed. This review informs the waiver renewal process. The results of the annual 372 analysis and the formal review are shared with leadership as they occur.
Evaluation of the QIS is the responsibility of the Benefit and Services Management Division, Waiver Administration and Compliance Unit and the Case Management and Quality Performance Division, Quality Performance Section. This evaluation takes into account the following elements:
1. Compliance with federal and state regulations and protocols.
2. Effectiveness of the strategy in improving care processes and outcomes.
3. Effectiveness of the performance measures used for discovery.
4. Effectiveness of the projects undertaken for remediation.
5. Relevance of the strategy with current practices.
6. Budgetary considerations.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- (●) **No**
- ( ) **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ( ) **HCBS CAHPS Survey :**
- ( ) **NCI Survey :**
- ( ) **NCI AD Survey :**
- ( ) **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

(a) Per 2 CFR Part 200 - Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards Subpart F – Audit Requirements §200.502 (i), Medicaid payments to a sub-recipient for providing patient care services to Medicaid eligible individuals are not considered Federal awards expended under this part unless a State requires the funds to be treated as Federal awards expended because reimbursement is on a cost-reimbursement basis. Therefore, the Department does not require an independent audit of waiver service providers.

Case Management Agencies (CMAs) are subject to the audit requirements within 2 CFR Part 200 §200.22 and 200.23 for all Medicaid administrative payments. To ensure compliance with components detailed in the OMB Uniform Guidance, CMAs contract with external Certified Public Accountant (CPA) firms to conduct an independent audit of their annual financial statements and conduct the Single Audit when applicable . (Single Audit Act (31 U.S.C. 7501-7507) as amended by the Single Audit Act Amendments of 1996 (P.L. 104-146)). The Department is responsible for overseeing the performance of the CMAs which includes reviewing the Single Audits of all CMAs who meet the $750,000 threshold and issuing management decisions on any relevant audit findings.

(b) & (c) Title XIX of the Social Security Act, federal regulations, the Colorado Medicaid State Plan, state regulations, and contracts establish record maintenance and retention requirements for Medicaid services. A case record/medical record or file must be maintained for each waiver participant. Providers are required to retain records that document the services provided and support the claims submitted for a period of six years. Records may be maintained for a period longer than six years when necessary for the resolution of any pending matters such as an ongoing audit or litigation.

The Department maintains documentation of provider qualifications to furnish specific waiver services submitted during the provider enrollment process and updated according to applicable licensure and survey requirements. This documentation includes copies of the Medicaid Provider Participation Agreement, copies of the Medicaid certification, verification of applicable State licenses, and any other documentation necessary to demonstrate compliance with the established provider qualification standards. All providers are screened monthly against the exclusion lists. Providers are compared against the List of Excluded Individuals/Entities (LEIE), the System for Award Management (SAM), the Medicare Exclusion Database (MED), and the state Medicaid Termination file. Comparing providers against these lists allows the Department to determine if a provider has been excluded by the Office of the Inspector General (OIG), terminated by Medicare, or terminated from another state's Medicaid or Children's Health Insurance Program.

Additionally, the Department monitors the action of licensing boards to ensure Medicaid providers are in good standing.

Claims are submitted to the Department's fiscal agent for reimbursement. Claims data is maintained through the Medicaid Management Information System (MMIS). The MMIS is designed to meet federal certification requirements for claims processing and submitted claims are adjudicated against MMIS edits before payment.

Duties of providers include a requirement of documentation of care, in/out times, and confirmation that care was provided per state rules and regulations. Additionally, there must be the completion of appropriate service notes regarding service provision for each visit. Such confirmation shall be according to agency policy. The Department specifies requirements for providers that are then surveyed and certified by CDPHE. For personal care providers to render services, they must ensure that individuals are appropriately trained and qualified.

Regarding the post-payment review of claims:
The Compliance Division within the Department exists to monitor provider and member compliance with state and federal regulations and Department policies. Division internal reviewers conduct post-payment reviews of provider claims submissions to ensure accuracy of provider billing and compliance with regulations and Department billing policies. Auditing under the Program Integrity and Contract Oversight (PICO) Section, housed within the Division, varies with the review project conducted—including the number and frequency of providers reviewed, the percentage of claims reviewed, and the time period of the claims reviewed. Review projects range in size and focus (i.e. whether on provider type or service type) and can either be a claims data-only review or include records submitted by providers. PICO Section reviewers are responsible for conducting research and creating annual work plans of what review projects will be completed. Data samples and records to be reviewed are typically selected at random.

Additionally, the PICO Section accepts and evaluates all referrals of possible fraud, waste, and abuse of a provider or member. The PICO Section also works with law enforcement agencies on all possible fraud investigations, as well as suspensions and terminations of provider agreements.

The PICO Section also oversees post-payment claims review contracts, specifically with its Recovery Audit Contractor (RAC) program. As with the PICO Section's internal reviewers, the RAC is responsible for conducting research and

creating annual work plans of what review projects will be completed under their respective scope of work. Data samples and records to be reviewed are typically selected at random, however, the RAC is allowed to utilize proprietary algorithms to select providers and claims to audit.

All audit and compliance monitoring activities conducted by PICO Section and the RAC program aim to ensure provider compliance with the requirements of the Provider Participation Agreement and the Health First Colorado Program, specifically the HCBS Waivers Program and as required under §1915(c) of the Social Security Act. Each year, PICO Section reviewers will select a provider claims sample of Medicaid-paid services provided to individuals receiving benefits under the Dept's HCBS Waivers program. The sample will include 5,000 or more HCBS waiver claims from a single state fiscal year, pulled at the claim header level, to be reviewed each year. Individual claim lines that fall under each header are included in the review. The provider claims sample will be a statistically valid sample, reflecting a 95 percent confidence level with +/- 5 percent margin of error; however, the sample may be greater than the 95 percent confidence level with +/- 5 percent margin of error at the discretion of the Department.

HCBS waivers and procedure codes are governed by different state and federal rules, regulations, and policies; each claim will be reviewed for compliance under the rules, regulations, and policies that are applicable. PICO Section reviewers will audit the provider claims sample by conducting a medical records review of those claims to verify that provider documentation substantiates the claims that were submitted to the Department. The PICO Section will utilize the RAC to also conduct audits when practical to ensure all reviews for the claims sample are being conducted timely and efficiently. The scope of a review is determined by appropriate means such as state and federal rules, referrals, internal and RAC resources, prioritization of work plans and other reviews that may require immediate attention (such as fraud investigations) as well as data analysis and mining to determine the extent of an issue.

All PICO Section and RAC reviews adhere to multiple regulation sources at the state and federal level to create review projects, as part of the Department's overall compliance monitoring of providers. Research and creation of annual work plans come from multiple sources, including reviewing fraud, waste, and abuse trends occurring locally and nationally, preliminarily reviewing claims data, reviewing referrals and provider self-disclosures, and employing data analytics tools and algorithms to identify possible aberrancies. Per 10 C.C.R. 2505-10 Section 8.076.2, provider compliance monitoring includes, but is not limited to:

- *Conducting prospective, concurrent, and/or post-payment reviews of claims.*
- *Verifying Provider adherence to professional licensing and certification requirements.*
- *Reviewing goods provided and services rendered for fraud, waste, and abuse.*
- *Reviewing compliance with rules, manuals, and bulletins issued by the Department, the Medical Services Board, and the Department's fiscal agent.*
- *Reviewing compliance with nationally recognized billing standards and those established by professional organizations including, but not limited to, Current Procedural Terminology (CPT), Current Dental Terminology (CDT)), and Healthcare Common Procedure Coding System (HCPCS).*
- *Reviewing adherence to the terms of the Provider Participation Agreement.*

Depending on the type of review project completed, additional rules are included in the criteria of a review project. For instance, concerning audits of HCBS Waiver services rendered by Medicaid providers, review projects by PICO Section reviewers, and the RAC will include whether providers are compliant with multiple HCBS Waiver programs. All PICO Section and RAC reviews are required to follow audit and recovery rules outlined in C.R.S. 25.5-4-301 and 10 C.C.R. 2505-10 Section 8.076.3.

Under 10 C.C.R. 2505-10 Section 8.076.2.C., compliance monitoring activities by the Department or its designee(s) may include, but are not limited to site reviews, desk audits, medical records reviews, claim reviews, and data mining. All identified overpayment recoveries and suspected false claims and/or fraud will be reported to the PICO Section for review, as well as any additional agencies, including the Colorado Medicaid Fraud Control Unit. Any identified overpayments stemming from the reviews will follow rules outlined in 10 C.C.R. 2505-10 Section 8.076.3.

For negotiated rates: As part of the Support Plan review and survey processes detailed in Appendix D of this application, Department staff review the documentation of rate determination and service authorization activities conducted by case managers. Identification of rate determination practices that are inconsistent with Department policies may result in corrective action and/or recovery of the overpayment.

Additional information in Main B. Optional

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
I.a.1. Number and percent of waiver claims coded and paid according to the reimbursement methodology in the waiver N: Number of waiver claims coded and paid according to the reimbursement methodology in the waiver D: Total number of paid waiver claims in this sample

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
MMIS Data

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =*

		95% confidence level with a +/- 5% margin of error
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☒ ***Other*** *Specify:* *Proportionate consolidated representative sample of CO.0006, CO.0268, and CO.0288*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
I.a.3 Number and percent of paid waiver claims with adequate documentation that services were rendered N: Number of claims with adequate documentation of services rendered D: Total number of claims in the sample

Data Source *(Select one):*
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95% confidence level with +/- 5% margin of error*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☒ ***Other*** *Specify:* *Proportionate consolidated representative sample of CO.0006, CO.0268, and CO.0288*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
I.b.1 Number and percent of claims paid where the rate is consistent with the approved rate methodology in the approved waiver N: Number of claims paid where the rate is consistent with the approved rate methodology in the approved waiver D: Total number of paid waiver claims reviewed

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
MMIS Data

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***

☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95% confidence level with a +/- 5% margin of error*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☒ ***Other*** *Specify:* *Proportionate consolidated representative sample of CO.0006, CO.0268, and CO.0288*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
I.b.2 Number and percent of rates adjusted that demonstrate the rate was built in accordance with the approved rate methodology. N: Number of rates adjusted that demonstrate the rate was built in accordance with the approved rate methodology D: Total number of rates adjusted reviewed

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
MMIS Data and Rates Tables

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95% confidence level with a +/- 5% margin of error*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☒ ***Other*** *Specify:*

		Proportionate consolidated representative sample of CO.0006, CO.0268, and CO.0288
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

ii. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

The information gathered for the annual reporting of the performance measures serves as the Department's primary method of discovery.

The state ensures that claims are coded correctly through a number of mechanisms:
1. Rates are loaded with procedure code and modifier combinations, thus any use of incorrect coding results in a claim paid at $0.00 or a denied claim,
2. System edits exist to ensure that only specific (appropriate provider types) are able to bill for waiver services, and
3. Lastly, performing a review of claims in conjunction with the Department's published billing manual identifies any incorrect coding which resulted in a paid claim.

Duties of providers include a requirement of documentation of care, in/out times, and confirmation that care was provided per state rules and regulations. Additionally, there must be the completion of appropriate service notes regarding service provision for each visit. Documentation shall contain services provided, date and time in and out, and a confirmation that care was provided. Such confirmation shall be according to agency policy. This is then reviewed by CDPHE upon survey.

All waiver services included in the participant's support plan must be prior authorized by case managers. Approved Prior Authorization Requests (PARs) are electronically uploaded into the MMIS. The MMIS validates the prior authorization of submitted claims. Claims submitted without prior authorization are denied.

When a claim is billed to Medicaid, in addition to the five accuracy checks in eligibility, benefits, pricing, coordination of benefits, and duplication, the MMIS is configured to check for a Prior Authorization Request (PAR) that matches the procedure code, allowed units, a date span, and billing/attending provider prior to rendering payment. The claims data reported in the quality performance measures were pulled and analyzed from the MMIS.

I.a.1
This performance measure ensures that claims paid for waiver services used the correct coding for each of the waiver services billed. Correct coding is defined as the use of the correct procedure code and modifier combination for each service as determined by the Department. Correct coding ensures that services are paid only when the services are approved, authorized, and billed correctly.

I.a.3
The client's Prior Authorization Request (PAR) is used as documentation of services rendered. Case managers monitor service provision to ensure that services are being provided according to the support plan. Case managers inform the Department when discrepancies exist between a provider's claim and what the participant reports occurred or if the participant reports that the provider is not providing services according to the support plan. The Department initiates an investigation to determine if an overpayment occurred.

I.b.1
This performance measure ensures paid claims for waiver services are paid at or below the rate as specified in the Provider Bulletin and HCBS Billing Manual. In addition, the Department posts all rates in the Provider Rates and Fee Schedule section on the external website for providers to access at their convenience. This performance measure allows the Department to identify any system issues or errors resulting in incorrect reimbursement for services rendered.

I.b.2
Benefits and Services Management (BSM) Division staff review the rate adjustments to verifym that rates adhere to the approved rate methodology in the waiver.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.*

The Benefits and Services Management (BSM) Division staff initiate any edits to the Medicaid Management Information System (MMIS) that are necessary for the remediation of any deficiencies identified by the annual reporting of performance measures. Any inappropriate payments or overpayments identified are referred to the PICO Section for investigation as detailed in Appendix I-1 of the application.

I.a.1
Any incorrect coding which resulted in paid claims is remediated by the Department. The BSM Division staff collaborates with the Department's Rates Division and Health Information Office to initiate any edits to the MMIS that are necessary for remediation of any deficiencies identified by the annual reporting of performance measures.
In the event an overpayment is discovered, an accounts receivable balance is established with the provider. Overpayments are referred to the PICO Section for investigation as detailed in Appendix I-1 of the waiver application.

I.a.3
In the event an overpayment is discovered, an accounts receivable balance is established with the provider. Overpayments are referred to the PICO Section for investigation as detailed in Appendix I-1 of the waiver application.

I.b.1
Errors identified during claims data analysis as paying in excess of the Department's allowable rate may be attributed to wrong rates in prior authorization forms or additional system safeguards not being in place by the Department. PAR entry errors are addressed with CMAs to prevent future billing errors. The providers receiving overpayments are notified of payment errors and the Department establishes an accounts receivable balance to recover overpayments. The Department reviews errors to determine what additional safeguards are needed to prevent future overpayments.

I.b.2
Benefits and Services Management Division staff coordinate with the Department's Claims Systems and Operations Division staff to initiate any edits necessary to the MMIS for the remediation of deficiencies identified during the performance measure reporting.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☒ ***Other*** *Specify:* *As needed based on severity of occurence or compliance issue.*

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- (●) ***No***
- ( ) ***Yes***

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

The HCBS Waiver for Persons with Brain Injury (BI) utilizes Fee-for-Service (FFS), negotiated market price, and public pricing rate methodologies. Each rate has a unit designation and reimbursement is equal to the rate multiplied by the number of units utilized. HCBS BI FFS rate schedules are published through the Dept's Provider bulletin annually, through tribal notices, and posted on the Dept's website. The Provider Rates and Fee Schedule can be accessed here https://hcpf.colorado.gov/provider-rates-fee-schedule. Rates were rebased during the 2021-2022 fiscal year.

The Department's adopted a rate methodology that incorporates the following factors for all services not included in the negotiated price or public pricing methodology described below:

A. Indirect and Direct Care Requirements:
Salary expectations for direct and indirect care workers are based on the Colorado mean wage for each position, direct and indirect care hours for each position, the full-time equivalency required for the delivery of services to HCBS Medicaid clients, and necessary staffing ratios. Wages are determined by the Bureau of Labor Statistics and are updated by the Bureau every two years. Communication with stakeholders, providers, and clients aids in the determination of direct and indirect care hours required and the full-time equivalent of each position. Finally, collaboration with policy staff ensures the salaried positions, wages, and hours required to conform to the program or service design.

B. Minimum Wage Consideration:
The state will prospectively implement a differential in the rate structure to account for variances in minimum wage requirements as directed by the State Legislation or local ordinances to acknowledge unique geographical considerations impacting access to care. Distinct rates by locality, county, metropolitan area, and other types of regional boundary will be considered and implemented as the Department reviews potential access to care considerations impacting rates. Upon the subsequent waiver amendment or renewal, the Department will update the corresponding rates in accordance with the approved rate methodology. Any changes in the state's rate methodology will be reviewed and amended in accordance with 42 CFR 441.304.

C. Facility Expense Expectations:
Incorporates the facility type through the use of existing facility type property records listing square footage and actual cost. Facility expenses also include estimated repair and maintenance costs, utility expenses, and phone and internet expenses. Repair and maintenance price per square foot is determined by industry standards and varies for facilities that are leased and facilities that are owned. Utility pricing includes gas and electricity which are determined annually through the Public Utility Commission which provides summer and winter rates and therm conversions for appropriate pricing. Finally, internet and phone services are determined through the use of the Build Your Own Bundle tool available through the Comcast Business website.

D. Administrative Expense Expectations:
Identifies computer, software, office supply costs, and the total number of employees to determine administrative and operating costs per employee.

E. Capital Overhead Expense Expectations:
Identifies and incorporates additional capital expenses such as medical equipment, supplies, and IT equipment directly related to providing the service to Medicaid clients. Capital Overhead Expenses are rarely utilized for HCBS services, but may include items such as massage tables for massage therapy or supplies for art and play therapy.

All Facility, Administrative, and Capital Overhead expenses are reduced to per employee cost and multiplied by the total FTE required to provide services per Medicaid client. To ensure rates do not exceed funds appropriated by the Colorado State Legislature a budget neutrality adjustment is applied to the final determined rate.
Following the development of the rate, stakeholder feedback is solicited and appropriate and necessary changes may be made to the rate.

HCBS BI FFS rates utilizing the methodology described above include:
- *Adult Day Health - Day*
  - *Adult Day Health - Adult Day Tier 1*
  - *Adult Day Health - Adult Day Tier 2*
- *Behavioral Management and Education*
- *Day Treatment*
- *Consumer Directed Attendant Support Services-Health Maintenance Activities*

•Consumer Directed Attendant Support Services-Homemaker
•Consumer Directed Attendant Support Services-Personal Care
•Independent Living Skills Training
•Independent Living Skills Training Telehealth
•Mental Health Counseling-Individual
•Mental Health Counseling-Individual Telehealth
•Mental Health Counseling-Family
•Mental Health Counseling-Family Telehealth
•Mental Health Counseling-Group
•Mental Health Counseling-Group Telehealth
•Non-Medical Transportation-Mobility Van
•Non-Medical Transportation-Wheelchair Van
•Personal Care
•Personal Care - Relative
•Personal Care Remote Supports
•Respite-In Home
•Respite-Skilled Nursing Facility
•Substance Abuse Counseling-Individual
•Substance Abuse Counseling-Individual Telehealth
•Substance Abuse Counseling-Group
•Substance Abuse Counseling-Group Telehealth
•Substance Abuse Counseling-Family
•Substance Abuse Counseling-Family Telehealth
•Substance
•Transitional Living Program
•Supported Living Program
•Home Delivered Meals
•Peer Mentorship
•Transition Setup Coordinator
•Transition Setup Expense

In addition to the methodologies described above, the Department sets reimbursement for the Transitional Living Program (TLP) service and the Supported Living Program (SLP) service through the use of acuity assessments. Clients are assessed biannually to appropriately reimburse for increased staffing ratios associated with higher acuity need levels. The TLP service is authorized on a six-month basis with an initial assessment done at the time of authorization. Services are typically sought to allow for the client to move back into their residence, but if the client is not yet ready a reassessment is conducted for up to an additional six-month stay if necessary.
TLP rates are fee-for-service and do not vary by provider. These rates follow the standard rate methodology currently used by the Department which incorporates:
•salary expectations related to direct and indirect care based on the Colorado mean wage for each position required for service delivery as well as payroll taxes and benefits for each salaried position,
•facility expenses incorporating facility type property record information, repair and maintenance costs, utility expenses, and phone and internet expenses,
•administrative expenses which account for office equipment expenses, technology expenses, office supply expenses, and
•capital overhead expenses that identify and incorporate any additional expenses related to service delivery such as additional specialized equipment expenses.
The salary expectations are adjusted to account for differences in client acuity as determined by the BI SLP assessment tool.

The Department's contracted QIO vendor assesses all clients in SLP services using the Mayo-Portland Adaptability Inventory (MPAI). The QIO assesses all clients every 6 or 12 months, depending on the length of residence, and on notification of a change in acuity from the provider. Both assessments assign an acuity score for a Medicaid client which maps to one of five service tiers. These tiers are differentiated by the number of direct and indirect client care time which translates to higher salary expectations for the clients with higher acuity.
SLP rates are fee-for-service and do not vary by provider. SLP providers submit scores for current clients on a Department-prescribed acuity assessment form every six months. Supported Living Program rate structure was changed

effective January 1, 2020, from an acuity-based weighted average facility-specific rate to an acuity-based tiered rate structure incorporating all factors in the Department's documented rate methodology as mentioned in Appendix I. Before this change, provider reimbursement was based on a weighted average of acuity scores of all residents within a facility. The Department conducted a time study of all SLP facilities to determine the actual direct and indirect care time by client and acuity score. In addition to the time survey, providers were asked to identify additional rate components not previously included in the rate methodology such as additional overhead costs and capital equipment necessary for service delivery. Once all components of service delivery were gathered, verified, and quantified, the Department met with providers to determine the adequate number of tiers and score ranges within each acuity tier and built tiered rates according to time survey data. The new rate structure is based on client acuity scores; however, the providers will now receive reimbursement solely based on the client acuity score tiered rates and will no longer receive a rate based on a weighted average of the client acuity score mix. The change to the rates structure also incorporates changes to client acuity assessments performance and scoring conducted by an independent contractor. The scoring took into consideration additional parts of the Mayo Portland Adaptability Inventory assessments to account for behavioral needs that were not originally captured by facility-performed assessments. Stakeholders provided feedback about the rates and potential sustainability given additional considerations to service rates. Rate changes were approved by Department leadership in the Office of Community Living and Finance Office respectively following the stakeholder feedback period. Upon Department approval, the Department began transitioning the MMIS to change pricing and reimbursement logic to allow for client-specific acuity-based tiered rates.

Currently, the Department only had one provider for Substance Abuse Counseling and that provider only offers Substance Abuse Counseling in a group setting. The Department is seeking additional providers and requesting that the existing provider add settings for this service. The Department also is reviewing the adequacy of rates and the continued need for these services.

Additional discussion on I-2 Rates, Billings, and Claims may be found in Main B. Optional.

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

All billing claims flow directly from providers to the MMIS. The MMIS selects a random sample of around 0.2% of the total monthly claims and the Department's fiscal agent mails an EOMB to the clients identified within the sample.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- ◉ ***No. state or local government agencies do not certify expenditures for waiver services.***
- ○ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

Billing validation is accomplished primarily by the Department's Medicaid Management Information System (MMIS). The MMIS is designed to meet federal certification requirements for claims processing and submitted claims are adjudicated against MMIS edits prior to payment. The Department also validates billings by conducting a post-payment review on a representative sample of claims.

(a) The Colorado Benefits Management System (CBMS) is a unified system for data collection and eligibility. It allows for improved access to public assistance and medical benefits by permitting faster eligibility determinations and allowing for higher accuracy and consistency in eligibility determinations statewide. The electronic files from CBMS are downloaded daily into the MMIS in order to ensure updated verification of eligibility for dates of service claimed. The first edit in the MMIS when a claim is filed ensures that the waiver client is eligible for Medicaid services. Claims submitted for clients who are not eligible on the date of service are denied.

(b) All waiver services included in the participant's support plan must be prior authorized by case managers. Approved Prior Authorization Requests (PARs) are electronically uploaded into the MMIS. The MMIS validates the prior authorization of submitted claims. Claims submitted without prior authorization are denied.

(c) The Department engages in a post-payment review of claims in order to ensure the integrity of provider billings. Annually, a statically valid, random sample of claims (95% confidence level and +/- 5% margin of error) is identified for an audit. These audits include a review of whether required prior authorizations were obtained; support plans included the services billed; and provider documentation (e.g. timesheets, supervisory visit notes, provider training, and case management notes) supports the service billed. Recovery action is undertaken by the Department for any identified overpayments and the federal share of identified overpayments is returned to the Federal Government.

Case managers monitor service provision to ensure that services are being provided according to the support plan. Should a discrepancy between a provider's claim and what the client reports occur, or should the client report that the provider is not providing services according to the support plan, the case manager reports the information to the Department for investigation.

The Dept operates an Electronic Visit Verification (EVV) system to document that a variety of HCBS services are provided to members.

Electronic Visit Verification (EVV) is a technology used to verify that home or community based service visits occur. The purpose of EVV is to ensure that services are delivered to people needing those services and that providers only bill for services rendered. EVV typically verifies visit information through a mobile application on a smart phone or tablet, a toll-free telephone number, or a web-based portal.

EVV captures six points of data as required by the 21st Century Cures Act: individual receiving the service, attendant providing the service, type of service provided, location of service delivery, date of service, and time that service provision begins and ends.

The Department implemented a hybrid or open EVV model. The State contracts with an EVV vendor for a state-managed solution. This solution is available to providers at no cost. Providers may also choose to utilize an alternate EVV system procured and managed by the provider agency. The State EVV Solution and Data Aggregator for alternate vendor data transfer are available for use.

Services which must be electronically verified: As of August 3, 2020, the Department implemented EVV for federally mandated and additional services that are similar in nature and service delivery. The Department mandates Electronic Visit Verification (EVV) per CCR 2505-10 Section 8.001. Required EVV waiver services include:
Consumer Directed Attendant Support Services (CDASS)
Independent Living Skills Training (ILST) and Life Skills Training (LST)
In-Home Support Services (IHSS)
Personal Care
Respite

The Department also mandates EVV for the following State Plan Services:
Home Health
Occupational Therapy

Pediatric Behavioral Therapies
Pediatric Personal Care
Physical Therapy
Private Duty Nursing
Speech Therapy

On February 1, 2022, the Department activated a pre-payment EVV claim edit. EVV-required services, excluding CDASS, require corresponding EVV records prior to payment. This has resulted in improved provider compliance and better oversight of service provision.

Provider agencies utilizing the State EVV Solution have access to a portal to view and modify visit activity, and in limited circumstances, create EVV records. All information entered via the provider portal is notated as manual entry or edit and is subject to Department audit.

In the event the caregiver is unable to collect EVV data at the time of service delivery, provider agencies will need to enter missing data. Within the State EVV Solution, an agency administrator may complete visit maintenance in the EVV Solution provider portal. The administrator will enter the missing data and select a reason code on why a manual entry was done. Manual entry may be entered on a case-by-case basis. Manual entries are subject to increased scrutiny by the Department and providers must maintain service records for these visits.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

- (●) ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***
- ( ) ***Payments for some, but not all, waiver services are made through an approved MMIS.***

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) ***Payments for waiver services are not made through an approved MMIS.***

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

  Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☒ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☐ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***

○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

- ○ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- ◉ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Select County Departments of Public Health provide home health and personal care services for waiver clients. The amount of the payment to public providers does not differ from the amount paid to private providers of the same service.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

- ◉ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- (●) ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ( ) ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ( ) ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***
- (●) ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

(a) Each Case Management Agency (CMA) is designated as an OHCDS

(b) Department regulations require that case managers provide participants, guardians, and/or authorized representatives a listing of all qualified providers in the area. The Department's website also contains a statewide list of qualified providers for waiver services.

(c) The Department maintains documentation of qualifications for all providers. This documentation includes copies of the Medicaid Provider Agreement, copies of the Medicaid certification, verification of applicable State licenses, and any other documentation necessary to demonstrate compliance with the established provider qualification standards.

(d) The OHCDS agencies subcontract with providers or with independent contractors which have been verified by the OHCDS to have met all applicable licensing and/or established provider qualification standards. The Department assures provider qualifications are met by OHCDS subcontractors through administrative monitoring. Verifying and monitoring the service delivery of enrolled participants receiving a defined service from a qualified provider is the responsibility of the OHCDS. These standards are detailed at 10 CCR 2505-10 8.7202.W.

(e) Financial accountability is assured for services delivered in the OHCDS arrangement through the same methods and processes used for services delivered in a direct service provider arrangement and as described in Appendix I-1 and Appendix I-2.d of this application.

Participants have free choice of all qualified providers, across the state, to include those not affiliated with an OHCDS.

iii. Contracts with MCOs, PIHPs or PAHPs.

- (●) ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ( ) ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ( ) ***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ( ) ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

  In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans

that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds *(1 of 3)*

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☒ ***Appropriation of State Tax Revenues to the State Medicaid agency***

☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

☒ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

The Department of Health Care Policy and Financing (HCPF) has a Colorado Health Care Affordability and Sustainability Fee Cash Fund created by the Colorado Legislature to fund the Medicaid Buy-In Program for Working Adults with Disabilities. Eligible Members pay a monthly premium. The funds are transferred to HCPFs Operating Bank Account. The funds are expended as part of ongoing operations at HCPF and are treated in the same way the Department would pay other expenditures.
There are no IGTs or CPEs as there are no other Colorado State Departments involved.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds *(2 of 3)*

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable****. There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any

intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***

○ ***The following source(s) are used***

Check each that applies:

☐ ***Health care-related taxes or fees***

☐ ***Provider-related donations***

☐ ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

○ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***

◉ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

Clients living in an Supported Living Program (SLP) or Transitional Living Program (TLP) must make payment for room and board from their own funds. A uniform room and board payment for all SLPs is established by the Department. If there an increase in the Old Age Pension amount, this standard room and board payment rises in a dollar-for-dollar relationship to an increase in the SSI grant standard.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ○ ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- ◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ ***Nominal deductible***
- ☐ ***Coinsurance***
- ☐ ***Co-Payment***
- ☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- ◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor*

D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Hospital, Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	63028.11	10748.91	73777.02	88227.85	20980.63	109208.48	35431.46
2	67108.40	12325.48	79433.88	89413.35	21126.72	110540.07	31106.19
3	68419.35	13332.00	81751.35	90614.78	21273.83	111888.61	30137.26
4	65390.86	13888.00	79278.86	91832.36	21421.97	113254.33	33975.47
5	62389.49	14468.00	76857.49	93066.30	21571.14	114637.44	37779.95

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care: Hospital	Level of Care: Nursing Facility
Year 1	823	303	520
Year 2	924	335	589
Year 3	1113	353	760
Year 4	1294	372	922
Year 5	1504	391	1113

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

The Department estimated the average length of stay (ALOS) on the waiver by using the historical data included in the annual 372 data report for SFY 2019-20 and SFY 2018-19. The historical average for the ALOS from SFY 2018-19 to SFY 2019-20 is 295.85 days.

Update for WYs 2-5 in Amendment with the requested effective date of 7/1/2023:
Using the 372 reporting, the historical average for the ALOS from SFY 2019-20 to SFY 2020-21 is 302.00 days.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

For each service, the Department considered the number of clients utilizing each service, the number of units per user, the average cost per unit, and the total cost of the service. The Department typically examines historical growth rates. Once the historical data were analyzed, the Department selected trend factors to forecast, the number of clients utilizing each service, and the number of units per user. Many services on the 372 report for SFY 19-20 showed significant decreases in the number of users and utilization (e.g. Alternative Care Facilities, personal care non-relative). The Department feels that these data have been skewed downward due to COVID-19 and only represent a temporary decline in these services. The Department believes that these services will revert to pre-COVID levels and has tried to show that in the projection of users and utilizers. Caseload, utilization per client, and cost per unit are multiplied together to calculate the total expenditure for each service and added to derive Factor D. For services that have multiple service levels, these service levels are shown separately.

Historical growth rates: The source of data is 372 waiver reports. The Department reviews data from SFY 2007-08 through SFY 2019-20 but might only include certain SFYs in the development of trends. For example, the Department may look at data from SFY 2007-08 and beyond but apply a trend that only incorporates growth rates from SFY 2018-19 and SFY 2019-20.

The State has estimated users and units per user for Remote Supports by analyzing similar utilization in other states that currently offer this service, specifically Ohio. Remote Supports data from Ohio was sourced from a 2017 study conducted by the Ohio State University in partnership with the Ohio Department of Developmental Disabilities. Using Ohio's utilizer rates and the rate at which clients substitute Remote Support for other agency-based services, the State estimated the utilizers and units per utilizer for each waiver.

The units/utilizer for the new Remote Supports options were calculated by estimating the substitution rate for the existing Personal Care services. In this case, the State estimated that 10.37% of existing personal care units would be substituted for the new Personal Care - Remote Supports delivery options.

The cost per unit for Personal Care - Remote Supports was based upon the unit rate for Ohio's Remote Support option and is a cost/hour of $8.56, a 15-minute cost of $2.14.

The State has used the average cost per utilizer of the Personal Emergency Response System (PERS) Installation service from previous fiscal years to estimate the unit rate for Remote Support Technology. The estimated rate for BI is $57.40. This amount is based upon SFY 2019-20 actuals for PERS - Installation.

Updates for WY 1-5 with Amendment requested effective date of 1/1/2023:

The State is updating Appendix J to reflect the 2% ATB rate increase approved in the budget request for Long Bill HB22-1329 for the following services:
Adult Day Tier 1
Adult Day Tier 2
Day Treatment
Personal Care (in person)
Personal Care - Relative (in person)
Personal Care Remote Supports
Respite - In-Home
Respite - Nursing Facility
Behavioral Management and Education
Consumer Directed Attendant Support Services (CDASS)
Home Delivered Meals
Independent Living Skills Training - Telehealth
Independent Living Skills Training
Mental Health Counseling - Individual - Telehealth
Mental Health Counseling - Family
Mental Health Counseling - Group Telehealth
Mental Health Counseling - Individual
Mental Health Counseling - Group
Mental Health Counseling - Family Telehealth
Non-Medical Transportation

Peer Mentorship
Substance Abuse Counseling - family
Substance Abuse Counseling - Individual Telehealth
Substance Abuse Counseling - Group
Substance Abuse Counseling - Group Telehealth
Substance Abuse Counseling - Family Telehealth
Substance Abuse Counseling -Individual
Supported Living Program
Transition Setup Coordinator

-The State received approval through the Long Bill for the following Targeted Rate Increase:
Transitional Living Program - 41.609%

-The State also received approval through the Long Bill to implement a $15 Base Wage Minimum. The following services received the following increases for this implementation:
Adult Day Tier 1 - 9.893%
Personal Care (in person) Outside Denver - 11.754%
Personal Care - Relative (in person) Outside Denver - 12.597%
Respite - In-home - 8.844%
CDASS Health Maintenance Activities Outside Denver - 8.510%
CDASS Homemaker Outside Denver- 14.130%
CDASS Personal Care Outside Denver - 14.130%
Supported Living Program 5.875%
CDASS Health Maintenance Activities In Denver - 6.572%

The State uses a blended rate of the different component services under CDASS: Homemaker, Personal Care, and Health Maintenance to calculate the overall CDASS rate.

Notes:
The State received approval for the rate increases through Appendix K CO.0288.Ro6.01 effective 7/01/2022.
For some services, the State estimates rates based on a weighting of the location in which services are rendered and the rates in each location. The State received a base wage adjustment for services outside of Denver County and updated the weighted rates for this service based on new utilization trends and the updated rates. Due to this weighting, rate increases may not align with the rate increases that were approved in the long bill for counties outside of Denver.

The Department used utilization data for Denver vs. Non-Denver services between July 1, 2021 and June 30, 2022 to estimate utilization for this service.

The rates provided in the Appendix J submission align with the Department's fee schedule rates (https://hcpf.colorado.gov/provider-rates-fee-schedule) for HCBS Services. The Department weights certain rates using utilization data for services that have multiple rates based on the location where a service is rendered.

Update for WYs 2-5 in Amendment with the requested effective date of 7/1/2023:
For each service, the Department considered the number of clients utilizing each service, the number of units per user, the average cost per unit, and the total cost of the service. The Department typically examines historical growth rates. Once the historical data was analyzed, the Department selected trend factors to forecast, the number of clients utilizing each service and the number of units per user. In most cases, to estimate the number of users or the units per user for services on the BI waiver for WY1 through WY5, the department took the average two-year growth value (SFY 2019-20 and SFY 2020-21) and applied it to the most recent value for the number of users or units per user reported on the 372 for SFY 2020-21.

Many services on the 372 report for SFY 2019-20 showed significant decreases in the number of users and utilization (e.g. Alternative Care Facilities, Homemaker Services, Personal Care Non-relative). The Department feels that these data have been skewed downward due to COVID-19 and only represent a temporary decline in these services. The Department believes that these services will revert to pre-COVID levels and has tried to reflect that in the projection of users and utilizers. Caseload, utilization per client, and cost per unit are

multiplied together to calculate the total expenditure for each service and added to derive Factor D. For services that have multiple service levels, these service levels are shown separately.

Update for Amendment with the requested effective date of 11/11/2023:
The Department is updating Appendix J Average Cost/Unit to reflect rate increases approved during the recent legislative session through Long Bill SB23-214. The rate increases include a 3% across-the-board (ATB) Increase, a base wage increase for services outside Denver County to $15.75/hour, and a minimum wage increase to $17.29/hour for services inside Denver County. The increases will be effective on 07/01/2023 through an Appendix K Amendment. The Department is updating Appendix J to reflect the Appendix K approval and for permanent ongoing approval in the waiver. The Department's rate sheet that reflects the services receiving these increases is located at https://hcpf.colorado.gov/provider-rates-fee-schedule. The rate increases by services are as follows:

The 3% ATB increase is being implemented for the following services: Adult Day, Day Treatment, Personal Care, Respite, Behavioral Management and Education, Consumer Directed Attendant Support Services, Home Delivered Meals, Independent Living Skills Training, Mental Health Counseling, Non-Medical Transportation, Peer Mentorship, Substance Abuse Counseling, Supported Living Program, Transition Setup Coordinator, Transitional Living Program.

The base wage increase for services outside Denver County is being implemented for the following services: Personal Care, Respite-In-Home, Consumer Directed Attendant Support Services, Non-Medical Transportation, Supported Living Program, and Transitional Living Program.

The Denver County minimum wage increase is being implemented for the following services: Personal Care, Respite-In-Home, Consumer Directed Attendant Support Services, Non-Medical Transportation, Supported Living Program, and Transitional Living Program.

Update for Amendment with a requested effective date of 1/1/2024:
Increase the expense limit for Transition Services Setup from $1,500 to $2,000. This was approved through the passage of the Long Bill for State Fiscal Year (SFY) 23-24. The State increased the rate for Transition Services Setup in Appendix J WYs 2-5 to $2,000. The State did not update the users or units/user or rate methodology.

Update for WYs 3-5 in Amendment with a requested effective date of 7/1/2024:
Because of impacts on service utilization resulting from the COVID-19 pandemic, the Department has not changed utilizer or units per utilizer projection for services with decreased utilization during the Public Health Emergency (PHE). Many in-person services saw a continued decrease in utilization beginning in early 2020 of FY 2019-20 through FY 2021-22. Based on 372 data for FY 2021-22, some services showed a decrease in the units per utilizer for that year. For example, Behavioral Programming and Education, Transition Coordination, Transition Services, Day Treatment, and Home Modifications. For these kinds of services, the projected number of utilizers and of units per utilizer were not changed from the previous BI amendment that was approved.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

To calculate State Plan services costs associated with BI waiver clients, the Department analyzed historical D' values. Those values include the D' values from the recent 372 data report for SFY 19-20. D prime has been increasing fairly steadily since SFY 2007-08. The Department has estimated State Plan services costs from SFY 2020-21 to SFY 2026-27 by using the reported State Plan service costs for BI clients in 372 for SFY 2019-20, and growing that number by 2.87% which is the average growth in State Plan service for years SFY 17-18 and SFY 18-19. The growth rates in the cost per client for SFY 17-18 are 1.90% and 3.84% for SFY 18-19 according to 372 data. The Department chose not to utilize the FY 2019-20 data as it shows a sharp decrease of -10.61% and believes this is an outlier and D' will continue to increase. The claims information used to determine Factor D' does not contain costs for prescribed drugs for those dually eligible for Medicare and Medicaid as those claims are not tracked in the MMIS system. Therefore, the costs of those drugs are not included in the estimate of Factor D'.

The projected value for Factor D' is less than the projected Factor G' due to this waiver including the Hospital level of care. The State expects individuals at this level of care to have significant costs (such as higher levels of pharmacy costs or receipt of outpatient procedures) that are not included in the institutional rate.

No Medicare expenditures for prescribed drugs were included in the calculation of Factor D'. Medicare expenditures are not entered into the State's MMIS. All claims associated with a Medicare/Medicaid dual-eligible individual are vetted through the Medicare billing system before entering the State's MMIS. As a result, only Medicaid costs are incorporated into the projections for Factor D'.

The 2.87% annual growth rate from the CMS 372 Report actuals for SFY 2017-18 to SFY 2018-19 is 1.90% and 3.84%, respectively, based on Factor D' values of $10,638 and $11,046.

Update for WYs 2-5 in Amendment with the requested effective date of 7/1/2023:
To calculate State Plan services costs associated with BI Waiver clients, the Department analyzed historical Factor D' (Prime) values. State plan services costs for BI have been increasing fairly steadily since SFY 2007-08. To forecast state plan costs for WY 1 through WY 5, the Department has taken the average of the actual state plan costs coming from 372 data for SFY 2017-18 and SFY 2018-19 to get an average annual growth of 2.87% reflective in WY 2-5. The 2.87% growth rate has been applied using the actual SFY 2020-21 372 Factor D' of $11,322 as a start and then applying the annual growth rate through SFY 2026-27.

Update for WYs 3-5 in Amendment with a requested effective date of 7/1/2024:
To calculate State Plan services costs associated with BI Waiver clients, the Department analyzed historical D' values. D' has been increasing steadily from FY 2019-20 through FY 2021-22. The growth rate that is used was calculated by taking the percent change in the actual cost per client from FY 2020-21 through FY 2021-22. This comes out to 4.17% therefore the Department is assuming this behavior will continue through all the waiver years.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

To calculate ICF/IID costs, the Department used the Factor G per intuitional cost for FY 19-20 as reported on the most recent 372 report, and grew it by 1.34% which is the average percent change in the historical per waiver client costs for FY 18-19 through FY 19-20. So the Department trended expenditure using the average growth of the last two fiscal years.

The Factor G in the CMS 372 reports are previous estimates rather than actuals. Instead of using the Factor G estimate in the CMS 372 report, Department data were used to calculate an actual Factor G amount. The Department data used to calculate the SFY 2019-20 Factor G include yearly average per capita institutional costs per day multiplied by the waiver's average length of stay in SFY 2019-20. The Factor G value used for SFY 2019-20 is $78,086.85

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

When determining the state plan costs for Hospital/NF clients, the Department reviewed the historical data and chose to apply a trend of 0.70%. The annual growth rate for SFY 16-17 to SFY 17-18 is 4.03% and from SFY 2017-18 to SFY 2018-19 is -2.64%, based on Factor G' values of $19,884.28 and $19,360.02, respectively. The growth rate of 0.70% was calculated by taking the average percent change in those two years.
The Factor G' in the CMS 372 reports are previous estimates rather than actuals. Instead of using the Factor G' estimate in the CMS 372 report, Department data were used to calculate an actual Factor G' amount. The Department data used to calculate the SFY 2019-20 Factor G' include yearly average per capita state plan services costs per day multiplied by the waiver's average length of stay in SFY 2019-20.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Adult Day Health	
Day Treatment	
Personal Care	
Respite	
Behavioral Management and Education	
Consumer Directed Attendant Support Services	
Home Delivered Meals	
Home Modification	
Independent Living Skills Training	
Mental Health Counseling	
Non-medical Transportation	
Peer Mentorship	
Personal Emergency Response Systems (PERS)	
Remote Support	
Specialized Medical Equipment and Supplies/Assistive Devices	
Substance Abuse Counseling	
Supported Living Program	
Transition Setup	
Transitional Living Program	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						775518.30
Adult Day Tier 1	15 Minutes	37	710.84	7.22	189893.80	
Adult Day Tier 2	2+ Hours	74	97.98	80.77	585624.50	
Day Treatment Total:						1124.24
Day Treatment	Day	1	13.00	86.48	1124.24	
Personal Care Total:						2733208.46
Personal Care (in person)	15 Minutes	140	2286.00	6.38	2041855.20	
Personal Care - Relative (in person)	15 Minutes	77	1482.00	6.05	690389.70	
Personal Care Remote Supports	15 Minutes	2	221.00	2.18	963.56	
Respite Total:						37658.68
Respite - In-Home	15 Minutes	5	550.00	6.44	17710.00	
Respite - Nursing Facility	Day	6	18.00	184.71	19948.68	
Behavioral Management and Education Total:						109259.52
Behavioral Management and Education	30 Minutes	3	2368.00	15.38	109259.52	
Consumer Directed Attendant Support Services Total:						4419610.68
Consumer Directed Attendant Support Services	15 minutes	89	9111.66	5.45	4419610.68	
Home Delivered Meals Total:						16279.20
Home Delivered Meals	Per Purchase	4	340.00	11.97	16279.20	
Home Modification Total:						165763.60
Home Modification	Per Project	17	2.00	4875.40	165763.60	
Independent Living Skills Training Total:						1347331.03
Independent Living Skills Training (Telehealth)	15 minutes	24	43.59	12.45	13024.69	

GRAND TOTAL:	51872133.95
Total Estimated Unduplicated Participants:	823
Factor D (Divide total by number of participants):	63028.11
Average Length of Stay on the Waiver:	296

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Independent Living Skills Training	15 Minutes	134	799.80	12.45	1334306.34	
Mental Health Counseling Total:						50131.99
Mental Health Counseling - Individual Telehealth	15 Minutes	6	13.00	26.65	2078.70	
Mental Health Counseling - Family	15 Minutes	4	32.00	26.65	3411.20	
Mental Health Counseling - Group Telehealth	15 Minutes	2	1.00	15.73	31.46	
Mental Health Counseling - Individual	15 Minutes	22	50.07	26.65	29356.04	
Mental Health Counseling - Group	15 Minutes	9	107.00	15.73	15147.99	
Mental Health Counseling - Family Telehealth	15 Minutes	1	4.00	26.65	106.60	
Non-medical Transportation Total:						982484.91
Non-medical Transportation	1 Way Trip	153	183.00	35.09	982484.91	
Peer Mentorship Total:						42362.81
Peer Mentorship	15 minutes	3	2281.25	6.19	42362.81	
Personal Emergency Response Systems (PERS) Total:						88770.46
Personal Emergency Response Systems (PERS) - Install/Purchase	1 Time	50	1.00	109.79	5489.50	
Personal Emergency Response Systems (PERS)- Monthly Service	1 Month	153	9.00	60.48	83280.96	
Remote Support Total:						516.60
Remote Support Technology	Per Purchase	9	1.00	57.40	516.60	
Remote Support	15 Minutes	0	0.00	0.01	0.00	
Specialized Medical Equipment and Supplies/Assistive Devices Total:						45908.24

GRAND TOTAL:	51872133.95
Total Estimated Unduplicated Participants:	823
Factor D (Divide total by number of participants):	63028.11
Average Length of Stay on the Waiver:	296

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Medical Equipment and Supplies/Assistive Devices	Per Purchase	73	8.00	78.61	45908.24	
Substance Abuse Counseling Total:						531.84
Family	Hour	1	1.00	63.60	63.60	
Individual Telehealth	Hour	1	1.00	63.60	63.60	
Group	Hour	2	2.00	35.64	142.56	
Group Telehealth	Hour	2	1.00	35.64	71.28	
Family Telehealth	Hour	1	1.00	63.60	63.60	
Individual	Hour	2	1.00	63.60	127.20	
Supported Living Program Total:						40597448.94
Supported Living Program	Day	303	327.00	409.74	40597448.94	
Transition Setup Total:						2896.44
Transition Setup Expense	Per Transition	2	1.00	1207.92	2415.84	
Transition Setup Coordinator	15 Minutes	2	30.00	8.01	480.60	
Transitional Living Program Total:						455328.00
Transitional Living Program	Day	4	170.00	669.60	455328.00	

GRAND TOTAL:	51872133.95
Total Estimated Unduplicated Participants:	823
Factor D (Divide total by number of participants):	63028.11
Average Length of Stay on the Waiver:	296

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						885213.04
Adult Day Tier 1	15 Minutes	41	710.84	7.44	216834.63	
Adult Day Tier 2	2+ Hours	82	97.98	83.19	668378.41	
Day Treatment Total:						1157.91
Day Treatment	Day	1	13.00	89.07	1157.91	
Personal Care Total:						3769676.28
Personal Care (in person)	15 Minutes	168	2567.00	6.80	2932540.80	
Personal Care - Relative (in person)	15 Minutes	86	1528.00	6.36	835754.88	
Personal Care Remote Supports	15 Minutes	2	295.00	2.34	1380.60	
Respite Total:						40840.95
Respite - In-Home	15 Minutes	5	579.00	7.01	20293.95	
Respite - Nursing Facility	Day	6	18.00	190.25	20547.00	
Behavioral Management and Education Total:						150036.48
Behavioral Management and Education	30 Mins	4	2368.00	15.84	150036.48	
Consumer Directed Attendant Support Services Total:						6310730.25
Consumer Directed Attendant Support Services	15 minutes	99	9225.00	6.91	6310730.25	
Home Delivered Meals Total:						16768.80
Home Delivered Meals	Per Purchase	4	340.00	12.33	16768.80	
Home Modification Total:						175514.40
Home Modification	Per Project	18	2.00	4875.40	175514.40	
Independent Living Skills Training Total:						2312915.43
Independent Living Skills Training (Telehealth)	15 minutes	25	71.58	12.82	22941.39	

GRAND TOTAL:	62008159.73
Total Estimated Unduplicated Participants:	924
Factor D (Divide total by number of participants):	67108.40
Average Length of Stay on the Waiver:	302

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Independent Living Skills Training	15 Minutes	136	1313.42	12.82	2289974.04	
Mental Health Counseling Total:						58928.94
Mental Health Counseling - Individual Telehealth	15 Minutes	7	13.00	27.45	2497.95	
Mental Health Counseling - Family	15 Minutes	6	33.00	27.45	5435.10	
Mental Health Counseling - Group Telehealth	15 Minutes	3	1.00	16.20	48.60	
Mental Health Counseling - Individual	15 Minutes	23	50.07	27.45	31611.69	
Mental Health Counseling - Group	15 Minutes	10	118.00	16.20	19116.00	
Mental Health Counseling - Family Telehealth	15 Minutes	2	4.00	27.45	219.60	
Non-medical Transportation Total:						1292680.51
Non-medical Transportation	1 Way Trip	187	197.00	35.09	1292680.51	
Peer Mentorship Total:						43663.12
Peer Mentorship	15 minutes	3	2281.25	6.38	43663.12	
Personal Emergency Response Systems (PERS) Total:						107716.50
Personal Emergency Response Systems (PERS) - Install/Purchase	1 Time	54	1.00	109.79	5928.66	
Personal Emergency Response Systems (PERS)- Monthly Service	1 Month	187	9.00	60.48	101787.84	
Remote Support Total:						516.60
Remote Support Technology	Per Purchase	9	1.00	57.40	516.60	
Remote Support	15 Minutes	0	0.00	0.01	0.00	
Specialized Medical Equipment and Supplies/Assistive Devices Total:						50939.28

GRAND TOTAL:	62008159.73
Total Estimated Unduplicated Participants:	924
Factor D (Divide total by number of participants):	67108.40
Average Length of Stay on the Waiver:	302

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Medical Equipment and Supplies/Assistive Devices	Per Purchase	81	8.00	78.61	50939.28	
Substance Abuse Counseling Total:						723.45
Family	Hour	1	1.00	65.51	65.51	
Individual Telehealth	Hour	1	1.00	65.51	65.51	
Group	Hour	3	2.00	36.71	220.26	
Group Telehealth	Hour	3	1.00	36.71	110.13	
Family Telehealth	Hour	2	1.00	65.51	131.02	
Individual	Hour	2	1.00	65.51	131.02	
Supported Living Program Total:						46257597.30
Supported Living Program	Day	335	337.00	409.74	46257597.30	
Transition Setup Total:						6990.00
Transition Setup Expense	Per Transition	3	1.00	2000.00	6000.00	
Transition Setup Coordinator	15 Minutes	3	40.00	8.25	990.00	
Transitional Living Program Total:						525550.48
Transitional Living Program	Day	4	182.00	721.91	525550.48	
				GRAND TOTAL:		62008159.73
				Total Estimated Unduplicated Participants:		924
				Factor D (Divide total by number of participants):		67108.40
				Average Length of Stay on the Waiver:		302

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						1268178.68
Adult Day Tier 1	15 Minutes	46	710.84	7.44	243277.88	
Adult Day Tier 2	2+ Hours	88	140.00	83.19	1024900.80	
Day Treatment Total:						1157.91
Day Treatment	Day	1	13.00	89.07	1157.91	
Personal Care Total:						4979140.00
Personal Care (in person)	15 Minutes	205	2882.00	6.80	4017508.00	
Personal Care - Relative (in person)	15 Minutes	96	1575.00	6.36	961632.00	
Personal Care Remote Supports	15 Minutes	0	0.00	0.01	0.00	
Respite Total:						80216.29
Respite - In-Home	15 Minutes	6	609.00	7.01	25614.54	
Respite - Nursing Facility	Day	7	41.00	190.25	54601.75	
Behavioral Management and Education Total:						187545.60
Behavioral Management and Education	30 Mins	5	2368.00	15.84	187545.60	
Consumer Directed Attendant Support Services Total:						7163374.84
Consumer Directed Attendant Support Services	15 minutes	111	9339.35	6.91	7163374.84	
Home Delivered Meals Total:						33537.60
Home Delivered Meals	Per Purchase	8	340.00	12.33	33537.60	
Home Modification Total:						201012.74
Home Modification	Per Project	19	2.17	4875.40	201012.74	
Independent Living Skills Training Total:						2463937.34
Independent Living Skills Training (Telehealth)	15 minutes	25	75.16	12.82	24088.78	

GRAND TOTAL:		76150733.76
Total Estimated Unduplicated Participants:		1113
Factor D (Divide total by number of participants):		68419.35
Average Length of Stay on the Waiver:	302	

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Independent Living Skills Training	15 Minutes	138	1379.10	12.82	2439848.56	
Mental Health Counseling Total:						90593.10
Mental Health Counseling - Individual Telehealth	15 Minutes	7	22.00	27.45	4227.30	
Mental Health Counseling - Family	15 Minutes	9	34.00	27.45	8399.70	
Mental Health Counseling - Group Telehealth	15 Minutes	4	1.00	16.20	64.80	
Mental Health Counseling - Individual	15 Minutes	24	82.75	27.45	54515.70	
Mental Health Counseling - Group	15 Minutes	11	130.00	16.20	23166.00	
Mental Health Counseling - Family Telehealth	15 Minutes	2	4.00	27.45	219.60	
Non-medical Transportation Total:						1703549.32
Non-medical Transportation	1 Way Trip	229	212.00	35.09	1703549.32	
Peer Mentorship Total:						58217.50
Peer Mentorship	15 minutes	4	2281.25	6.38	58217.50	
Personal Emergency Response Systems (PERS) Total:						141238.22
Personal Emergency Response Systems (PERS) - Install/Purchase	1 Time	58	1.00	109.79	6367.82	
Personal Emergency Response Systems (PERS)- Monthly Service	1 Month	223	10.00	60.48	134870.40	
Remote Support Total:						1897.20
Remote Support Technology	Per Purchase	9	1.00	57.40	516.60	
Remote Support	15 Minutes	2	295.00	2.34	1380.60	
Specialized Medical Equipment and Supplies/Assistive Devices Total:						71535.10

GRAND TOTAL:	76150733.76
Total Estimated Unduplicated Participants:	1113
Factor D (Divide total by number of participants):	68419.35
Average Length of Stay on the Waiver:	302

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Medical Equipment and Supplies/Assistive Devices	Per Purchase	91	10.00	78.61	71535.10	
Substance Abuse Counseling Total:						1095.62
Family	Hour	2	1.00	65.51	131.02	
Individual Telehealth	Hour	2	1.00	65.51	131.02	
Group	Hour	4	2.00	36.71	293.68	
Group Telehealth	Hour	4	1.00	36.71	146.84	
Family Telehealth	Hour	3	1.00	65.51	196.53	
Individual	Hour	3	1.00	65.51	196.53	
Supported Living Program Total:						57132096.90
Supported Living Program	Day	353	395.00	409.74	57132096.90	
Transition Setup Total:						9320.00
Transition Setup Expense	Per Transition	4	1.00	2000.00	8000.00	
Transition Setup Coordinator	15 Minutes	4	40.00	8.25	1320.00	
Transitional Living Program Total:						563089.80
Transitional Living Program	Day	4	195.00	721.91	563089.80	

GRAND TOTAL:	76150733.76
Total Estimated Unduplicated Participants:	1113
Factor D (Divide total by number of participants):	68419.35
Average Length of Stay on the Waiver:	302

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						1320053.73
Adult Day Tier 1	15 Minutes	47	710.84	7.44	248566.53	
Adult Day Tier 2	2+ Hours	92	140.00	83.19	1071487.20	
Day Treatment Total:						1157.91
Day Treatment	Day	1	13.00	89.07	1157.91	
Personal Care Total:						6486011.84
Personal Care (in person)	15 Minutes	245	3236.00	6.80	5391176.00	
Personal Care - Relative (in person)	15 Minutes	106	1624.00	6.36	1094835.84	
Personal Care Remote Supports	15 Minutes	0	0.00	0.01	0.00	
Respite Total:						82893.96
Respite - In-Home	15 Minutes	6	641.00	7.01	26960.46	
Respite - Nursing Facility	Day	7	42.00	190.25	55933.50	
Behavioral Management and Education Total:						187545.60
Behavioral Management and Education	30 Mins	5	2368.00	15.84	187545.60	
Consumer Directed Attendant Support Services Total:						8232360.20
Consumer Directed Attendant Support Services	15 minutes	126	9455.31	6.91	8232360.20	
Home Delivered Meals Total:						33537.60
Home Delivered Meals	Per Purchase	8	340.00	12.33	33537.60	
Home Modification Total:						211592.36
Home Modification	Per Project	20	2.17	4875.40	211592.36	
Independent Living Skills Training Total:						2625265.75
Independent Living Skills Training (Telehealth)	15 minutes	26	78.92	12.82	26305.61	

GRAND TOTAL:		84615770.26
Total Estimated Unduplicated Participants:		1294
Factor D (Divide total by number of participants):		65390.86
Average Length of Stay on the Waiver:	302	

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Independent Living Skills Training	15 Minutes	140	1448.05	12.82	2598960.14	
Mental Health Counseling Total:						103278.49
Mental Health Counseling - Individual Telehealth	15 Minutes	8	22.00	27.45	4831.20	
Mental Health Counseling - Family	15 Minutes	14	35.00	27.45	13450.50	
Mental Health Counseling - Group Telehealth	15 Minutes	5	1.00	16.20	81.00	
Mental Health Counseling - Individual	15 Minutes	25	82.75	27.45	56787.19	
Mental Health Counseling - Group	15 Minutes	12	143.00	16.20	27799.20	
Mental Health Counseling - Family Telehealth	15 Minutes	3	4.00	27.45	329.40	
Non-medical Transportation Total:						2208143.52
Non-medical Transportation	1 Way Trip	276	228.00	35.09	2208143.52	
Peer Mentorship Total:						72771.88
Peer Mentorship	15 minutes	5	2281.25	6.38	72771.88	
Personal Emergency Response Systems (PERS) Total:						169498.18
Personal Emergency Response Systems (PERS) - Install/Purchase	1 Time	62	1.00	109.79	6806.98	
Personal Emergency Response Systems (PERS)- Monthly Service	1 Month	269	10.00	60.48	162691.20	
Remote Support Total:						1897.20
Remote Support Technology	Per Purchase	9	1.00	57.40	516.60	
Remote Support	15 Minutes	2	295.00	2.34	1380.60	
Specialized Medical Equipment and Supplies/Assistive Devices Total:						78610.00

GRAND TOTAL:	84615770.26
Total Estimated Unduplicated Participants:	1294
Factor D (Divide total by number of participants):	65390.86
Average Length of Stay on the Waiver:	302

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Medical Equipment and Supplies/Assistive Devices	Per Purchase	100	10.00	78.61	78610.00	
Substance Abuse Counseling Total:						1161.13
Family	Hour	2	1.00	65.51	131.02	
Individual Telehealth	Hour	2	1.00	65.51	131.02	
Group	Hour	4	2.00	36.71	293.68	
Group Telehealth	Hour	4	1.00	36.71	146.84	
Family Telehealth	Hour	4	1.00	65.51	262.04	
Individual	Hour	3	1.00	65.51	196.53	
Supported Living Program Total:						62036274.96
Supported Living Program	Day	372	407.00	409.74	62036274.96	
Transition Setup Total:						9320.00
Transition Setup Expense	Per Transition	4	1.00	2000.00	8000.00	
Transition Setup Coordinator	15 Minutes	4	40.00	8.25	1320.00	
Transitional Living Program Total:						754395.95
Transitional Living Program	Day	5	209.00	721.91	754395.95	

GRAND TOTAL:	84615770.26
Total Estimated Unduplicated Participants:	1294
Factor D (Divide total by number of participants):	65390.86
Average Length of Stay on the Waiver:	302

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						1360282.18
Adult Day Tier 1	15 Minutes	48	710.84	7.44	253855.18	
Adult Day Tier 2	2+ Hours	95	140.00	83.19	1106427.00	
Day Treatment Total:						1157.91
Day Treatment	Day	1	13.00	89.07	1157.91	
Personal Care Total:						8486038.48
Personal Care (in person)	15 Minutes	293	3634.00	6.80	7240381.60	
Personal Care - Relative (in person)	15 Minutes	117	1674.00	6.36	1245656.88	
Personal Care Remote Supports	15 Minutes	0	0.00	0.01	0.00	
Respite Total:						98519.18
Respite - In-Home	15 Minutes	7	674.00	7.01	33073.18	
Respite - Nursing Facility	Day	8	43.00	190.25	65446.00	
Behavioral Management and Education Total:						225054.72
Behavioral Management and Education	30 Mins	6	2368.00	15.84	225054.72	
Consumer Directed Attendant Support Services Total:						9326796.82
Consumer Directed Attendant Support Services	15 minutes	141	9572.72	6.91	9326796.82	
Home Delivered Meals Total:						37729.80
Home Delivered Meals	Per Purchase	9	340.00	12.33	37729.80	
Home Modification Total:						222171.98
Home Modification	Per Project	21	2.17	4875.40	222171.98	
Independent Living Skills Training Total:						2795506.89
Independent Living Skills Training (Telehealth)	15 minutes	26	82.86	12.82	27618.90	

GRAND TOTAL:		93833788.41
Total Estimated Unduplicated Participants:		1504
Factor D (Divide total by number of participants):		62389.49
Average Length of Stay on the Waiver:	302	

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Independent Living Skills Training	15 Minutes	142	1520.45	12.82	2767888.00	
Mental Health Counseling Total:						93299.41
Mental Health Counseling - Individual Telehealth	15 Minutes	9	13.00	27.45	3211.65	
Mental Health Counseling - Family	15 Minutes	21	36.00	27.45	20752.20	
Mental Health Counseling - Group Telehealth	15 Minutes	6	1.00	16.20	97.20	
Mental Health Counseling - Individual	15 Minutes	26	50.07	27.45	35734.96	
Mental Health Counseling - Group	15 Minutes	13	157.00	16.20	33064.20	
Mental Health Counseling - Family Telehealth	15 Minutes	4	4.00	27.45	439.20	
Non-medical Transportation Total:						2862817.65
Non-medical Transportation	1 Way Trip	333	245.00	35.09	2862817.65	
Peer Mentorship Total:						87326.25
Peer Mentorship	15 minutes	6	2281.25	6.38	87326.25	
Personal Emergency Response Systems (PERS) Total:						203311.13
Personal Emergency Response Systems (PERS) - Install/Purchase	1 Time	67	1.00	109.79	7355.93	
Personal Emergency Response Systems (PERS)- Monthly Service	1 month	324	10.00	60.48	195955.20	
Remote Support Total:						1897.20
Remote Support Technology	Per Purchase	9	1.00	57.40	516.60	
Remote Support	15 Minutes	2	295.00	2.34	1380.60	
Specialized Medical Equipment and Supplies/Assistive Devices Total:						86471.00

GRAND TOTAL:	93833788.41
Total Estimated Unduplicated Participants:	1504
Factor D (Divide total by number of participants):	62389.49
Average Length of Stay on the Waiver:	302

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Medical Equipment and Supplies/Assistive Devices	Per Purchase	110	10.00	78.61	86471.00	
Substance Abuse Counseling Total:						1533.70
Family	Hour	3	1.00	65.51	196.53	
Individual Telehealth	Hour	3	1.00	65.51	196.53	
Group	Hour	5	2.00	36.71	367.10	
Group Telehealth	Hour	5	1.00	36.71	183.55	
Family Telehealth	Hour	5	1.00	65.51	327.55	
Individual	Hour	4	1.00	65.61	262.44	
Supported Living Program Total:						67127294.46
Supported Living Program	Day	391	419.00	409.74	67127294.46	
Transition Setup Total:						11650.00
Transition Setup Expense	Per Transition	5	1.00	2000.00	10000.00	
Transition Setup Coordinator	15 Minutes	5	40.00	8.25	1650.00	
Transitional Living Program Total:						804929.65
Transitional Living Program	Day	5	223.00	721.91	804929.65	

GRAND TOTAL:	93833788.41
Total Estimated Unduplicated Participants:	1504
Factor D (Divide total by number of participants):	62389.49
Average Length of Stay on the Waiver:	302