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:
Colorado's Home and Community Based Services Waiver for Children with Life-Limiting Illness

C. Waiver Number:CO.0450
Original Base Waiver Number: CO.0450.

D. Amendment Number:

E. Proposed Effective Date: (mm/dd/yy)
07/01/22
Approved Effective Date of Waiver being Amended: 07/01/20

2. Purpose(s) of Amendment

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

The purpose of this amendment is to:

-Updating the number of Single Entry Points from 22 to 21;
-Updating the Case Manager qualifications for individuals who conduct Level of Care eligibility determination screens and Person Centered Support Planning in order to expand the pool of individuals qualified to provide these services;
-Updating the prior approval/authorization flexibility to authorize access to services before the service plan revision is completed in times of emergency or when there is an urgent situation concerning the health and welfare of members;
-Updating the Critical Incident processes to include setting evacuations in the event an individual must evacuate their current setting;
-Updating Appendix H with minor revisions including clarifying language on sampling method, adding discussion on the new assessment tool and universal case management system, and correcting typos;
-Including language for the temporary increases to Home Modifications lifetime cap approved through the Appendix K;
-Updating the cost neutrality demonstration with adjustments on trends for utilizers, units per utilizer, and select rates due to new utilization data. The Department received lagged (or delayed) 372 reports for FY 2019-20 and has incorporated that data into this forecast; and
-Updating performance measures throughout the waiver application to streamline efficiencies in measuring assurance compliance.

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	
☒ Appendix A Waiver Administration and Operation	3, 4, QI PMs (A.3, A.4, A.5, A.6, A.14), a-ii, b-i
☒ Appendix B Participant Access and Eligibility	3a, 6c, QI PMs (B.a.1, B.c.1, B.c.2, B.c.3), a-ii, bi
☒ Appendix C Participant Services	QI PMs (C.a.2, C.a.6, C.b.1, C.b.4), a-ii, b-i
☒ Appendix D Participant Centered Service Planning and Delivery	1a, 1d, 2a, QI PMs (D.a.1, D.c.1, D.d.2, D.d.3, D.d.4, D.d.5, D.d.6, D.d.7), a-ii,
☐ Appendix E Participant Direction of Services	
☐ Appendix F Participant Rights	
☒ Appendix G Participant Safeguards	1b, QI PMs (G.a.3, G.a.5, G.a.6, G.b.2, G.b.5, G.b.7, G.b.8, G.d.3), a-ii, b-i
☒ Appendix H	1a-i, 1b-i, 1b-ii
☒ Appendix I Financial Accountability	QI PMs (I.a.1, I.a.2, I.a.4), a-ii, b-i
☒ 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*):

Colorado's Home and Community Based Services Waiver for Children with Life-Limiting Illness

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.0450
Draft ID: CO.014.03.04

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/20
Approved Effective Date of Waiver being Amended: 07/01/20

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 purpose of this waiver is to keep children with Life-Limiting Illnesses out of the hospital and in the home as much as possible. This is a Palliative Care waiver that allows children to begin receiving services early in their diagnosis and allows the family to continue to pursue curative treatments while receiving palliative care. It removes the requirement of a physician certification that death is expected within nine months. If curative treatments are provided along with palliative care, there can be an effective continuum of care throughout the life of the child. This waiver serves children from birth through 18 years of age who are Medicaid eligible and diagnosed with a life-limiting illness.

Children receiving services through the waiver can receive in-home Respite Care consisting of personal care, nursing or home health aid depending upon the condition of the child; Expressive Therapies such as creative art, music or play therapy; Palliative/Supportive Care such as pain and symptom management and care coordination; Massage therapy; Therapeutic Grief Support and Bereavement Services. Case management is an administrative function. Additionally, clients will have access to all Medicaid State Plan benefit services including Hospice and Home Health.

The Department oversees the administration of the waiver. County Departments of Human Services determine financial eligibility. Case Management Agencies (CMA) assess the level of care and target population criteria. The nurse at the Hospice or Home Health agency will be assessing the child for the medical care that each child may require based on the physician's orders and shall provide medical care coordination.

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 02/03/2022 through 03/04/2022:

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 02/03/2022 and 03/17/2022. 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 02/03/2022. 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 02/03/2022. 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 1570 Grant Street, 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: Johnson

First Name: Tracy

Title: Medicaid Director

Agency: Colorado Department of Health Care Policy & Financing

Address: 1570 Grant Street

Address 2:

City: Denver

State: **Colorado**

Zip: 80203

Phone: (303) 866-2993 **Ext:** ☐ **TTY**

Fax: (303) 866-4411

E-mail: Tracy.Johnson@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.

All CLLI waiver participants live in their family home. This waiver does not have active participants residing in facilities. Waiver participants may also receive services in the community and in their provider’s office.

The Colorado Department of Health Care Policy & Financing oversees the provider certification processes and ongoing oversight of provider compliance with all state standards. The Department assesses providers for ongoing compliance with the HCB Settings through two processes. First, provider certification visits and surveys, delegated to the Colorado Department of Public Health and Environment through an interagency agreement, document the interaction between providers and participants to monitor potential changes in provider-specific policies and service delivery processes. Secondly, the ongoing incident and complaint management systems described in Appendix G of the approved waiver ensure that the Department is notified of any potential changes to participants’ reception of services through waiver benefits.

Colorado 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. Colorado will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix I-1: Financial Integrity and Accountability:

Department reviewers and contractors utilize multiple regulation sources at the state and federal level to create review projects, as part of the Department's overall compliance monitoring of providers. As mentioned above, research and creation of annual work plans come from multiple sources, including reviewing fraud, waste, and abuse trends occurring locally and nationally, preliminary reviewing claims data, reviewing referrals and provider self-disclosures, and employing data analytics tools and algorithms to identify possible abnormalities. In accordance with 10 C.C.R. 2505-10 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 and abuse.
- Reviewing compliance with rules, manuals, and bulletins issued by the Department, board, or 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) and Current Dental Terminology (CDT).
- 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, under the HCBS Waivers Program Post Payment Review Contract, review projects will include whether providers are compliant with multiple HCBS Waiver programs. All Department reviewers and contractors are required to follow audit and recovery rules set forth in C.R.S. 25.5-4-301 and 10 C.C.R. 2505-10 Section 8.076.3.

For negotiated rates: As part of the Service Plan review and on-site 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.

The Department will operate an Electronic Visit Verification (EVV) system to document that a variety of HCBS services are provided to members. EVV will capture six points of data as required by the 21st Century Cures Act: individual receiving the service, attendant providing the service, service provided, location of service, date of service, and time that service provision begins and ends. The Department is implementing a hybrid or open EVV model. The state contracted 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 agency.

The Department is implementing EVV for federally mandated and additional services that are similar in nature and service delivery. HCBS waiver services impacted by EVV:

Respite (provided in the home or community)

The State EVV Solution and Data Aggregator, for alternate vendor data transfer, are currently available for use. Participation in EVV is voluntary until the Department mandates, estimated late summer 2020. The Department's Good Faith Effort Exemption request was approved on September 18, 2019.

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:

The 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 Department maintains an Interagency Agreement with the Colorado Department of Public Health and Environment (CDPHE). This agreement allows CDPHE to survey and investigate complaints against the following HCBS providers: Palliative/Supportive Care, Respite Care, Therapeutic Life-Limiting Illness Support, and Expressive Therapies. Once a provider has been surveyed by CDPHE, they are referred to the Department to obtain Medicaid Certification.

The Department contracts annually with 21 Single Entry Point (SEP) agencies serving 24 regions throughout Colorado. The SEP agencies are made up of 15 public County Departments of Human and Social Services, County Departments of Public Health, County Area Agencies on Aging, or County and District Nursing Services. The other six (6) SEPS are private, non-profit entities.

Single Entry Point (SEP) Case Management Agencies (CMAs) are contracted with the Department to provide case management services for HCBS clients. These services include HCBS waiver operational and administrative services, intake screening, case management, functional and disability determination, services planning, referral care coordination, utilization review, the prior authorization of waiver services within limits, and service monitoring, reporting, and follow-up.

A Single Entry Point (SEP) region may select a public county agency, including county depts. of social/human services, a county nursing service, an area agency on aging, public health, or a multi-county agency to serve as the SEP agency for that region. The SEP has 60 days prior to the effective date of a change in region designation or the expiration of the contract with the existing SEP agency.

In the event that a SEP region does not give the Dept. its selection within the 60 day period, the SEP agency for the region shall be selected by the Dept. through the competitive bidding process. Currently, 6 of the Single entry point contracts were bid through the competitive process.

The Department contracts with a Fiscal Agent to maintain the Medicaid Management Information System (MMIS), process claims, assist in the provider enrollment and 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 Department contracts with a Quality Improvement Organization (QIO) in order to consolidate long term care utilization management functions for waiver programs and Medicaid clients. For the Over Cost Containment (OCC) 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 an OCC review denial.

The QIO is responsible for the management of the Critical Incident Reports (CIR) for the HCBS-CLLI 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 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 QIO conducts desk reviews of case files from all twenty-four (24) SEPs.

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.

○ **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 15 non-state public agencies to act as CMAs throughout the state of Colorado to perform HCBS waiver operational and administrative services, case management, utilization review, and prior authorization of waiver services for CLLI 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 six (6) non-governmental, non-state, private, non-profit agencies to act as CMAs to perform HCBS waiver operational and administrative services, case management, utilization review, and prior authorization of waiver services. These six CMAs 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:

Colorado Department of Health Care Policy & Financing, Office of Community Living (OCL)

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 (IA) 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, investigated, and substantiated. The IA 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 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. In addition, the contract with the CMAs allows the Dept. to withhold funding and terminate a contract due to noncompliance. 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. 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 Benefits Utilization System (BUS) to audit client files and ensure that all components of the CMA contract have been performed according to necessary waiver requirements. The BUS is an electronic record used by each CMA to maintain client-specific data. Data includes client referrals, screening, Level of Care (LOC) assessments, individualized service plans, case notes, reassessment documentation, and all other case management activities. Additionally, the BUS is used to track and evaluate timelines for assessments, reassessments, and 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 Department has oversight of the Fiscal Agent and the QIO through different contractual requirements. Deliverable due dates include monthly, quarterly, and annual reports to ensure the vendor is 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.

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 RAC 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 RAC 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 percent (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	☒	☐	☐

Function	Medicaid Agency	Contracted Entity	Local Non-State Entity
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 CDPHE 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:

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

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: QIO	☒ **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.6 Number and Percent of Fiscal Intermediary service level agreements reviewed by the Dept demonstrating financial monitoring of the CLLI waiver N: # of Fiscal Intermediary service level agreements reviewed by the Dept demonstrating financial monitoring of the CLLI 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
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:

Fiscal Intermediary		
	☐ **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.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**

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.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):
Other
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:

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/IAs 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 CDPHE 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, and the 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, and 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 including provider enrollment, provider publication, and provider training. The Dept. requests ad hoc reports as needed to monitor any additional issues or concerns.

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.20
The monitoring of CMAs is completed by 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 the evaluation of need, service planning, participant monitoring, case reviews, complaint procedures, provision of participant choice, waiver expenditures, etc.

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.14, A.20
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, 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 theDept. 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 returns 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: In addition to annual review of CMAs, continuous reviews occur with the CDPHE and ACS allowing the department to gather data whenever there is an occurrence 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			☐
	☐	Disabled (Physical)			
	☐	Disabled (Other)			
☒ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☒	Medically Fragile	0	18	☐
	☐	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:

Medicaid-eligible children, through the age of 18 who have been diagnosed with a life-limiting illness and who are at risk of hospitalization within one month but for the availability of the waiver services. A life-limiting illness means a medical condition that, in the opinion of the medical specialist involved, has a prognosis of death that is highly probable before the child reaches adulthood. Conditions that are incurable, irreversible, and that usually result in death are considered as one criterion for eligibility for this waiver.

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:

Upon becoming eligible for the waiver clients, parents, guardians or legal representatives are advised that Children with Life-Limiting waiver services shall end upon the child reaching 19 years of age. A child who reaches the age of 19 and remains categorically eligible for Medicaid will be eligible for State Plan services, which include traditional hospice care. If the client is eligible for another HCBS waiver and space is available, the client will be enrolled in the waiver. The CMA case manager shall re-assess the client during his/her 18th year and notify the client and/or parents, guardians or legal representatives of other Medicaid benefits for which there is eligibility, the possibility of waiting lists for specific waivers, and how the client and family may be linked to the next service package when the client turns 19 years of age.

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)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

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:

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:

☐ **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	218
Year 2	195
Year 3	197
Year 4	200
Year 5	203

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	

Waiver Year	Maximum Number of Participants Served At Any Point During the Year

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:

This waiver provides for the entrance of all eligible persons. Individuals are enrolled based upon the date of the case manager's verification of financial eligibility, Medicaid eligibility, and certification that the individual meets the level of care and targeting 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**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [x] **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:

The maintenance needs allowance is equal to the individual's total income as determined under the post eligibility process which includes income that is placed in a Miller trust.

○ **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:

  The maintenance needs allowance is equal to the individual's total income as determined under the post eligibility process which includes income that is placed in a Miller trust.

- ○ **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) are responsible for performing level of care evaluations and reevaluations. The Dept. contracts annually with 24 Case Management Agencies (CMAs) serving 24 districts throughout Colorado.

- ( ) **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 Level of Care Eligibility Determination Screen (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.

The nurse at the hospice agency shall also collaborate with the CMAs for the medical component of the services the client may require in order for the client to be safely cared for in the home.

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:

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

Case management agencies perform a phone review with referred members to discuss the member's needs, supports, waiver options, and services available. Based on the member-provided information, the case management agency will discuss whether 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 child's parents or legal guardians are informed of the right to request a LOC Screen if they disagree with the CMA's determination.

Should the CMA determine that a LOC Screen is appropriate, the CMA:
• Verifies the applicant's current financial eligibility status,
• Refers the applicant to the county department of social services of the child'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 child resides and then documents follow-up upon 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.

Upon verification of the applicant's financial eligibility or verification that an application has been submitted, the CMA completes the LOC Screen.

Case managers are required to complete a reevaluation of the child within 12 months of the initial LOC Screen or the previous Continued Stay Review (CSR) evaluation. A reevaluation may be completed sooner if the child's condition changes or if required by program criteria, i.e., the child's condition improves and the waiver is no longer needed or the child's condition deteriorates and more services are needed to keep the child in the home. The reevaluation process is the same as the initial. CMAs may use phone or telehealth to engage in the development and monitoring of Person-Centered Support Plan (PCSP) 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):*

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 contains electronic client records and the timeframes for evaluation and re-evaluation. All CMAs are required to use the State's case management IT system. The annual program evaluation includes a review of a random sample to ensure assessments are being completed correctly and timely.

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:

CMAs are required to keep documentation retrievable electronically by utilizing the State's case management IT system. The database is housed at the Department and the documentation is accessible electronically to monitoring staff and program administrators.

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:
	☐ **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:

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 N: Number of new waiver participants whose eligibility was determined using the approved processes and instruments D: 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:
	☐ **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:

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 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 = 95% confidence level with +/- 5% margin of error
☒ **Other** Specify: CMA	☒ **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:
B.c.4 Number and percent of initial determinations in which the life limiting attestation was appropriately checked and signed by the physician. Numerator = Number of initial determinations with the life limiting attestation appropriately checked and signed by the physician Denominator = Total number of initial determinations

Data Source (Select one):
Other
If 'Other' is selected, specify:
State review of form

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:

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 (1) the state's case management system, the state's case management IT system, the Bridge, and (2) 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 only QI Review Tool data, and some use a combination of state's case management IT system and/or Bridge and QI Review Tool data). The Super Aggregate Report provides initial compliance outcomes for performance measures in the LOC sub-assurances and performance measures. To ensure the quality review process is completed accurately, efficiently and in accordance with federal standards, the Department has contracted with an independent QIO to complete the QI Review Tool for the annual CMA program case evaluations.

The case manager completes the LOC Screen to determine an individual's need for an 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 LOC start date; services cannot be received prior to the LTC start date; the assessment 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 assessment must comply with Department regulations and requirements. All LOC eligibility questions must be completed to determine the level of care. The Department uses the results provided by the QIO's 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, (prior to and within six months of the LTC start date.) The Department uses the QIO QI Review Tool results and the participant's state's case management IT system record to discover deficiencies for this performance measure.

B.c.4 Compliance with this performance measure requires that applicants through the age of 18 have been diagnosed with a life-limiting illness and are at risk of hospitalization within one month as evidenced in the Life-Limiting Attestation signed by the medical specialist. The Department reviews Life-Limiting Illness Attestation forms submitted during the assessment process to ensure the form is appropriately checked and signed by the physician.

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, B.c.4
The Department provides remediation training CMAs annually to assist with improving compliance with LOC performance measures and in completing LOC Screens. 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**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: Case Management Agencies (CMA)	☒ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: as warranted by nature of discovery and/or severity of incidence

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 LOC Screen and Person-Centered Care Planning process with their Case Manager (CM), 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 continued stay reviews (CSR).

The LOC Screen determines eligibility for an institutional level of care. If an individual is determined eligible, they are provided a choice between institutional or HCBS waiver services. If waiver services are chosen, the Person-Centered Care Planning process assesses which waiver(s) the client is eligible for based on both the level of care ad targeting criteria. The waiver(s) for which the client meets targeting criteria and their associated services are explained to the client and discussed relative to the client's service and support needs. Based on this assessment and discussion, the client and /or their legal representative choose the best waiver and service options for them and a PCSP is developed. 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. During this process, case managers also provide a choice of providers, notify clients of the right to select qualified providers, and to change providers at any time.

This information is documented and maintained by the Case Management Agency (CMA) in the “Service and Provider Choice” section of the client’s PCSP located in the state’s case management IT system.

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 in the Case Management Agency (CMA) and in the State's case management IT system at the Department.

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 reflect cultural considerations of clients by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient. Documents include a written statement in Spanish instructing clients on 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	**Respite Care**

Service Type	Service		
Extended State Plan Service	Bereavement Counseling		
Extended State Plan Service	Palliative/Supportive Care services		
Other Service	Expressive Therapy		
Other Service	Massage Therapy		
Other Service	Therapeutic Life Limiting Illness Support: Individual Counseling, Family Counseling, Group Counseling		

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):

Respite Care

HCBS Taxonomy:

Category 1: 09 Caregiver Support

Sub-Category 1: 09011 respite, out-of-home

Category 2: 09 Caregiver Support

Sub-Category 2: 09012 respite, in-home

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

Respite Care means services provided to an eligible client who is unable to care for himself/herself on a short term basis because of the absence or need for relief of those persons normally providing care. Respite Care under this waiver is provided in a private residence of the client/family's choice, whether that be the client's home or the home of the caregiver and may be provided by different levels of providers depending upon the needs of the client. Respite care may be provided in the community or in an approved respite center location. A respite center location is a respite care facility. An individual would be responsible for any room and board costs for the time spent in a respite care facility.

Respite Care may be provided by a skilled or unskilled provider. A skilled respite provider would be either a licensed RN/LPN or CNA. Skilled respite is for clients with ongoing medical needs that can only be provided by an RN/LPN or CNA (i.e. suctioning).
Unskilled respite is for clients that will not have any medical needs that will need to be attended to (such as a G-tube feeding). This includes the possibility of the need for skilled/medical intervention.

An individual would be responsible for any room and board costs for the time spent in a respite care facility.

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

Respite Care may be provided for up to a maximum of 30 days per certification period.
Respite Care services and State Plan nursing, home health aide, or private-duty nursing services shall not be provided at the same time. Respite Care does not diminish services a client is entitled to under Early Periodic Screening, Diagnosis, and Treatment, however it will not duplicate those services.

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	Hospice
Agency	Home Health Agency
Agency	Personal Care Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Care

Provider Category:
Agency
Provider Type:

Hospice

Provider Qualifications
License *(specify)*:

Hospice agency must be a licensed Medicare/Medicaid hospice provider in Colorado.

Certificate *(specify):*

Medicare/Medicaid Certified as a Medicaid provider of Hospice services. 10 C.C.R. 2505-10, Section 8.550.

Other Standard *(specify):*

Hospice Agencies may provide skilled or unskilled respite. All skilled providers employed by a hospice agency must have the appropriate license or certification as required by the Department of Regulatory Agencies. Skilled providers must be a licensed RN/LPN or CNA.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Environment, Health Facilities and Emergency Section Division

Frequency of Verification:

Department of Public Health and Environment, Health Facilities and Emergency Services Division. According to survey cycle, at least every 5 years for Hospice agencies.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Care

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Department of Public Health and Environment, Health Facilities and Emergency Section Division is currently licensing all home health providers in the state of Colorado
Medicare/Medicaid Certified. Certified as a Medicaid provider of home health State Plan benefits. 10 C.C.R. 2505-10, Section 8.520.

Certificate *(specify):*

All Skilled home health agencies in Colorado must be certified by Medicare prior to be certified by the Department of Health Care Policy and Financing
Medicare/Medicaid Certified. Certified as a Medicaid provider of home health State Plan benefits. 10 C.C.R. 2505-10, Section 8.520.

Other Standard *(specify):*

Home Health Agencies may provide skilled or unskilled respite. All skilled providers employed by a home health agency must have the appropriate license or certification as required by the Department of Regulatory Agencies. Skilled providers must be a licensed RN/LPN or CNA.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Environment, Health Facilities and Emergency Section Division

Frequency of Verification:

Home Health Agency Department of Public Health and Environment, Health Facilities and Emergency Services Division. According to survey cycle mandated by the Centers for Medicare and Medicaid Services.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Care

Provider Category:
Agency
Provider Type:

Personal Care Provider

Provider Qualifications
License *(specify):*

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, Section 8.489.

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:

Department of Public Health and Environment, Health Facilities and Emergency Section 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 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:

Extended State Plan Service

Service Title:

Bereavement Counseling

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
10 Other Mental Health and Behavioral Services	10060 counseling
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Counseling provided to the participant and/or family members in order to guide and help them cope with the participant's illness and the related stress that accompanies the continuous, daily care required by a terminally ill child. Enabling the participant and family members to manage this stress improves the likelihood that the child with a life-threatening condition will continue to be cared for at home, thereby preventing premature and otherwise unnecessary institutionalization. Bereavement activities and opportunities for dialog offer the family a mechanism for expressing emotion and asking questions about death and grieving in a safe environment thereby potentially decreasing complications for the family after the child dies. Bereavement counseling is initiated and billed while the child is on the waiver but may continue after the death of the child for a period of up to one year.

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:

Bereavement services are billable one time for a flat rate. The service may be billed once the family has shown interest in receiving the service and prior to the child's death. Providers are required to provide up to one year of bereavement counseling following the death of the waiver participant. A Master- prepared Social Worker, Counselor, Licensed Psychologist, non-denominational Chaplain/Spiritual Care Counselor, or a board-certified Music Therapist shall be the direct provider for this service and acuity level is determined by a professional assessment of need.

When available and appropriate, Private Health Coverage and/or State Plan services will be utilized prior to waiver services for the child or family.

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	Hospice
Agency	Home Health Agency
Individual	Individual Therapist
Agency	Medicaid Enrolled Provider

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Bereavement Counseling

Provider Category:

Agency

Provider Type:

Hospice

Provider Qualifications

License *(specify):*

Hospice agency must be a licensed Medicare/Medicaid hospice provider in Colorado.

Certificate *(specify):*

Hospice agency must be a licensed Medicare/Medicaid hospice provider in Colorado.

Other Standard *(specify):*

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

•HIPAA compliant platforms;

•Client support given, when needed, to 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 the choice in the member's service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Environment, Health Facilities and Emergency Section Division

Frequency of Verification:

Department of Public Health and Environment, Health Facilities and Emergency Services Division. According to survey cycle, at least every 5 years.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Bereavement Counseling

Provider Category:
Agency
Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Department of Public Health and Environment, Health Facilities and Emergency Section Division is currently licensing all home health providers in the state of Colorado.

Certificate *(specify):*

All Skilled home health agencies in Colorado must be certified by Medicare prior to be certified by the Department of Health Care Policy and Financing
Medicare/Medicaid Certified. Certified as a Medicaid provider of home health State Plan benefits. 10 C.C.R. 2505-10, Section 8.520.

Other Standard *(specify):*

Providers for the Telehealth service delivery option must demonstrate policies and procedures that include:
•HIPAA compliant platforms;
•Client support given, when needed, to 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 the choice in the member's service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Environment, Health Facilities and Emergency Section Division

Frequency of Verification:

Department of Public Health and Environment, Health Facilities and Emergency Services Division. According to survey cycle mandated by the Centers for Medicare and Medicaid Services (CMS); at least every 5 years.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Bereavement Counseling

Provider Category:
Individual
Provider Type:

Individual Therapist

Provider Qualifications

License *(specify):*

Individuals providing bereavement counseling shall hold any of the following licenses LCSW, LPC, LSW, LISW, Licensed Psychologist, Individual Licensed by State of Colorado, and/or Licensed individual.
Individuals providing art or play therapy shall hold any of the following licenses: LCSW, LPC, LSW, LISW, Licensed Psychologist, Non-denominational/Spiritual/Bereavement counselor, individual licensed by the State of Colorado and/or licensed individual.

Certificate *(specify):*

Individuals providing music therapy must hold a Bachelor's, Master's, or Doctorate in Music Therapy and maintain certification from the Certification Board for Music Therapists.

Non-denominational/Spiritual/Bereavement Counselor/Chaplain certified by appropriate associations.

Other Standard *(specify):*

Individual and Family Grief Loss or Bereavement counseling experience, pediatric/adolescent counseling experience of one year.

Providers for the Telehealth service delivery option must demonstrate policies and procedures that include:
•HIPAA compliant platforms;
•Client support given, when needed, to 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 the choice in the member's service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Colorado Department of Regulatory Agencies and Medicaid Fiscal Agent

Frequency of Verification:

All Individual provider qualifications are verified by the Department's Fiscal Agent upon initial enrollment and in a revalidation cycle; at least every 5 years.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Bereavement Counseling

Provider Category:

Agency

Provider Type:

Medicaid Enrolled Provider

Provider Qualifications

License *(specify):*

Individuals providing bereavement counseling shall hold any of the following licenses: LCSW, LPC, LSW, LISW, Licensed Psychologist, Individual Licensed by State of Colorado and/or Licensed individual.

Individuals providing art or play therapy shall hold any of the following licenses: LCSW, LPC, LSW, LISW, Licensed Psychologist, Non-denominational/Spiritual/Bereavement counselor, individual licensed by the State of Colorado and/or licensed individual.

Certificate *(specify):*

Individuals providing music therapy must hold a Bachelor's, Master's, or Doctorate in Music Therapy and maintain certification from the Certification Board for Music Therapists.
Non-denominational/Spiritual/Bereavement Counselor/Chaplain certified by appropriate associations.

Other Standard *(specify):*

At least one year of experience in the provision of art/play therapy or music therapy to pediatric/ adolescent clients.

Providers for the Telehealth service delivery option must demonstrate policies and procedures that include:
•HIPAA compliant platforms;
•Client support given, when needed, to 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 the choice in the member's service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

HCPF, CDPHE and the Department's Fiscal gent

Frequency of Verification:

All agency provider qualifications are verified by the Medicaid's Fiscal Agent upon initial enrollment and in a revalidation cycle; at least every 5 years. Additionally, an agency survey is completed by CDPHE according to the survey cycle.

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:

Extended State Plan Service

Service Title:

Palliative/Supportive Care services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05010 private duty nursing
Category 2:	**Sub-Category 2:**
11 Other Health and Therapeutic Services	11010 health monitoring
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Palliative care is specialized medical care for people with life-limiting illnesses. This type of care focused on providing clients with relief from the symptoms, pain, and stress of serious illness, whatever the diagnosis. For the purpose of this waiver, Palliative Care includes care coordination and pain and symptom management. The services are provided by a Hospice or Home Care Agency that has received additional training in palliative care concepts such as adjustment to illness, advance care planning, symptom management, and grief/loss. Palliative/Supportive Care is care provided to manage, control, and alleviate symptoms such as pain, nausea, discomfort, and anxiety related to the life-limiting diagnosis. Palliative/Supportive Care differs from State Plan Home Health benefit because the providers are required to have end of life care experience and/or training.

Care Coordination includes the development and implementation of a care plan, home visits for regular monitoring of the health and safety of the client and central coordination of medical and psychological services. The Care Coordinator will organize the multifaceted array of services. This approach will enable the client to receive all medically necessary care in the community with the goal of avoiding institutionalization in an acute care hospital. Additionally, a key function of the Care Coordinator will be to support families with the majority of the responsibility, otherwise placed on the parents, for condensing, organizing, and making accessible to providers, critical information that is related to care and necessary for effective medical management. The activities of the Care Coordinator will allow for a partnership between the care coordinator and the parents to better simplify and coordinate the system of care.

Administrative activities (specifically utilization management; i.e. review and authorization of service requests, level of care determinations, and waiver enrollment) are provided by the case manager at the CMA. These activities are not waiver services.

Pain and symptom management is defined as a pediatrician home visit or nursing care in the home by a registered nurse to manage the client's symptoms and pain. Management includes regular, ongoing pain and symptom assessments to determine the efficacy of the current regimen and available options for optimal relief of symptoms. Management also includes as-needed visits to provide relief of suffering, during which, nurses assess the efficacy of current pain management and modify the regimen if needed to alleviate distressing symptoms and side effects using pharmacological, non-pharmacological and complementary/supportive therapies.

Telehealth is an allowable mode for delivering Care Coordination. 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:

No limits on the number of services but documentation needs to cover the medical necessity of visits.

When a child is first diagnosed with the illness, the child and family might need a significant amount of Palliative/Supportive Care that may taper off during the treatment phase when the child has some improvement or remission of symptoms. As the child's health deteriorates, supportive services may be required at an intensive level.

Pediatrician home visits are billed as a component of the waiver service and cannot be billed separately as a physician visit.

Palliative/Supportive Care and State Plan home health or hospice benefits may not be provided at the same time. State plan services should be exhausted prior to accessing Palliative/Supportive Care as via the waiver.

Reimbursement for Telehealth services is limited to enrolled Colorado Medicaid providers and excludes the purchasing or installation of telehealth equipment or technologies.
Telehealth may not be used to provide the pain and symptom management service.

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	Hospice agency
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Palliative/Supportive Care services

Provider Category:

Agency

Provider Type:

Hospice agency

Provider Qualifications

License *(specify):*

Hospice agency must be a licensed Medicare/Medicaid hospice provider in Colorado.

Certificate *(specify):*

Medicare/Medicaid Certified as a Medicaid provider of Hospice services. 10 C.C.R. 2505-10, Section 8.550.

Other Standard *(specify):*

Providers for the Telehealth service delivery option must demonstrate policies and procedures that include:
•HIPAA compliant platforms;
•Client support given, when needed, to 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 the choice in the member's service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Department of Public Health and Environment, Health Facilities and Emergency Services Division. According to survey cycle, at least every 5 years for Hospice agencies.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Palliative/Supportive Care services

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Department of Public Health and Environment, Health Facilities and Emergency Section Division is currently licensing all home health providers in the state of Colorado

Certificate *(specify):*

All Skilled home health agencies in Colorado must be certified by Medicare prior to be certified by the Department of Health Care Policy and Financing
Medicare/Medicaid Certified.Certified as a Medicaid provider of home health State Plan benefits. 10 C.C.R. 2505-10, Section 8.520.

Other Standard *(specify):*

Providers for the Telehealth service delivery option must demonstrate policies and procedures that include:
•HIPAA compliant platforms;
•Client support given, when needed, to 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 the choice in the member's service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Environment, Health Facilities and Emergency Section Division

Frequency of Verification:

Home Health Agency Department of Public Health and Environment, Health Facilities and Emergency Services Division. According to survey cycle mandated by the Centers for Medicare and Medicaid 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:

Expressive Therapy

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11130 other therapies
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

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

Expressive Therapy means the provision of creative art, music, or play therapy which gives children the ability to creatively and kinesthetically express their medical situation. Expressive therapy functions as the interface between the mind and the body. These therapies are based on the theory that creative activity improves the capacity of the body to heal. Therapies may include book writing, painting, music therapy, and scrapbook making. The use of these therapies can decrease a client's feelings of isolation, improve communication skills, decrease emotional suffering due to health status, and develop coping skills. Expressive therapy is an activity that is not for recreation but related to the care and treatment of the patient's disabling health problems.

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:

Expressive Therapy is limited to 39 hours per certification period.

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	Home Health Agency
Individual	Individual Therapist
Agency	Hospice Agency
Agency	Medicaid Enrolled Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Expressive Therapy

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Department of Public Health and Environment, Health Facilities and Emergency Section Division is currently licensing all home health providers in the state of Colorado.

Certificate *(specify):*

Medicare/Medicaid Certified.Certified as a Medicaid provider of home health State Plan benefits. 10 C.C.R. 2505-10, Section 8.520.

Other Standard *(specify):*

The individuals employed by the agency utilizing music therapy must hold a Bachelor's, Master's or Doctorate in Music Therapy and maintain certification from the Certification Board for Music Therapists. The individuals employed by the agency utilizing art or play therapy shall hold any of the following licenses: LCSW, LPC, LSW, LISW, Licensed Psychologist, Non-denominational/Spiritual/Bereavement Counselor. All individuals providing Expressive Therapy must have at least one year of experience in provision of art/play therapy or music therapy to pediatric/adolescent clients.

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

•HIPAA compliant platforms;

•Client support given, when needed, to 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 using 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 the choice in the member's service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Environment, Health Facilities and Emergency Section Division

Frequency of Verification:

Department of Public Health and Environment, Health Facilities and Emergency Services Division. According to the survey cycle mandated by CMS.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Expressive Therapy

Provider Category:

Individual

Provider Type:

Individual Therapist

Provider Qualifications

License *(specify):*

Providers utilizing art or play therapy shall hold any of the following licenses: LCSW, LPC, LSW, LISW, Licensed Psychologist, Non-denominational/Spiritual/Bereavement Counselor
Individual Licensed by the State of Colorado and/or Licensed individual.

Certificate *(specify):*

Providers utilizing music therapy must hold a Bachelor's, Master's or Doctorate in Music Therapy and maintain certification from the Certification Board for Music Therapists.

Other Standard *(specify):*

At least one year of experience in provision of art/play therapy or music therapy to pediatric/adolescent clients.

Providers for the Telehealth service delivery option must demonstrate policies and procedures that include:
•HIPAA compliant platforms;
•Client support given, when needed, to 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 using 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 the choice in the member's service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

HCPF and Medicaid Fiscal Agent

Frequency of Verification:

All Individual provider qualifications are verified by the Department's Fiscal Agent upon initial enrollment and in a revalidation cycle; at least every 5 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Expressive Therapy

Provider Category:

Agency

Provider Type:

Hospice Agency

Provider Qualifications

License *(specify):*

Hospice agency must be a licensed Medicare/Medicaid hospice provider in Colorado.

Certificate *(specify):*

Medicare/Medicaid Certified as a Medicaid provider of Hospice services. 10 C.C.R. 2505-10, Section 8.550.

Other Standard *(specify):*

The individuals employed by the agency utilizing music therapy must hold a Bachelor's, Master's or Doctorate in Music Therapy and maintain certification from the Certification Board for Music Therapists. The individuals employed by the agency utilizing art or play therapy shall hold any of the following licenses: LCSW, LPC, LSW, LISW, Licensed Psychologist, Non-denominational/Spiritual/Bereavement Counselor. All individuals providing Expressive Therapy must have at least one year of experience in provision of art/play therapy or music therapy to pediatric/adolescent clients.

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

•HIPAA compliant platforms;
•Client support given, when needed, to 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 using 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 the choice in the member's service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Environment, Health Facilities and Emergency Section Division

Frequency of Verification:

Department of Public Health and Environment, Health Facilities and Emergency Services Division. According to survey cycle, at least every 5 years for hospice agencies.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Expressive Therapy

Provider Category:
Agency
Provider Type:

Medicaid Enrolled Provider

Provider Qualifications

License *(specify):*

Individuals providing art or play therapy shall hold any of the following licenses: LCSW, LPC, LSW, LISW, Licensed Psychologist, Non-denominational/Spiritual/Bereavement counselor, individual licensed by the State of Colorado and/or licensed individual.

Certificate *(specify):*

Individuals providing music therapy must hold a Bachelor's, Master's, or Doctorate in Music Therapy and maintain certification from the Certification Board for Music Therapists.

Other Standard *(specify):*

At least one year of experience in the provision of art/play therapy or music therapy to pediatric/ adolescent clients.

Providers for the Telehealth service delivery option must demonstrate policies and procedures that include:
•HIPAA compliant platforms;
•Client support given, when needed, to 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 using 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 the choice in the member's service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

HCPF, CDPHE and the Department's Fiscal Agent

Frequency of Verification:

All agency provider qualifications are verified by the Medicaid's Fiscal Agent upon initial enrollment and in a revalidation cycle; at least every 5 years. Additionally, an agency survey is completed by CDPHE according to the survey cycle.

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:

Massage Therapy

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11130 other therapies
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Massage therapy shall only be used for the treatment of conditions or symptoms related to the client's illness. This service is only available from a provider who is licensed, certified, registered and/or accredited by an appropriate national accreditation association in that profession and the intervention is related to an identified medical need. Massage therapy is the physical manipulation of muscles to ease muscle contractures, spasms, extension, muscle relaxation, and muscle tension.

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

Limited to 24 hours per certification period.

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	Individual Therapist
Agency	Home Health

Provider Category	Provider Type Title
Agency	Hospice
Agency	Medicaid Enrolled Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Massage Therapy

Provider Category:
Individual
Provider Type:

Individual Therapist

Provider Qualifications
License *(specify):*

The service to be delivered shall meet all applicable state licensing requirements for the performance of the support or service being provided. Massage Therapy providers shall have an approved license with the Office of Massage Therapy Licensure through the Department of Regulatory Agencies.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:

HCPF and Medicaid Fiscal Agent

Frequency of Verification:

All Individual provider qualifications are verified by the Department's Fiscal Agent upon initial enrollment and in a revalidation cycle; at least every 5 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Massage Therapy

Provider Category:
Agency
Provider Type:

Home Health

Provider Qualifications
License *(specify):*

Department of Public Health and Environment, Health Facilities and Emergency Section Division is currently licensing all home health providers in the state of Colorado.

Certificate *(specify):*

Medicare/Medicaid Certified. Certified as a Medicaid provider of home health State Plan benefits. 10 C.C.R. 2505-10, Section 8.520.

Other Standard *(specify):*

The individuals employed by the agency must be a massage therapist and meet all applicable state licensing requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

HCPF and Department of Public Health and Environment, Health Facilities and Emergency Section Division.

Frequency of Verification:

Department of Public Health and Environment, Health Facilities and Emergency Services Division. According to the survey cycle mandated by CMS.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Massage Therapy

Provider Category:

Agency

Provider Type:

Hospice

Provider Qualifications

License *(specify):*

Hospice agency must be a licensed Medicare/Medicaid hospice provider in Colorado.

Certificate *(specify):*

Medicare/Medicaid Certified as a Medicaid provider of Hospice services. 10 C.C.R. 2505-10, Section 8.550.

Other Standard *(specify):*

The individuals employed by the agency must be a massage therapist and meet all applicable state licensing requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Environment, Health Facilities and Emergency Section Division.

Frequency of Verification:

Department of Public Health and Environment, Health Facilities and Emergency Services Division. According to survey cycle, at least every 5 years for Hospice agencies.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Massage Therapy

Provider Category:

Agency

Provider Type:

Medicaid Enrolled Provider

Provider Qualifications

License *(specify):*

Individuals shall meet all applicable state licensing requirements for the performance of the support or service being provided. Massage Therapy providers shall have an approved license with the Office of Massage Therapy Licensure through the Department of Regulatory Agencies.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

HCPF, CDPHE, and the Department's Fiscal Agent

Frequency of Verification:

All agency provider qualifications are verified by the Medicaid's Fiscal Agent upon initial enrollment and in a revalidation cycle; at least every 5 years. Additionally, an agency survey is completed by CDPHE according to the survey cycle.

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:

Therapeutic Life Limiting Illness Support: Individual Counseling, Family Counseling, Group Counseling

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
10 Other Mental Health and Behavioral Services	10060 counseling
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Therapeutic Life-Limiting Illness Support is grief/loss or anticipatory grief counseling/support provided by a Licensed Clinical Social Worker (LCSW), Licensed Social Worker (LSW) Licensed Professional Counselor (LPC), Licensed Psychologist or non-denominational Chaplain/Spiritual Care counselor with experience working with clients with life-limiting illnesses and their families and according to hospice industry established practice guidelines. Support is intended to help the child and family in the disease process.

Therapeutic Life-Limiting Illness Support has three components: Individual Counseling, Family Counseling, and Group Counseling.

Individual Counseling is provided to the client to decrease emotional suffering due to health status and develop coping skills. Enabling the participant to manage this stress improves the likelihood that the child with a life-threatening condition will continue to be cared for at home, thereby preventing premature and otherwise unnecessary institutionalization. Support will include but is not limited to attending physician visits, attending hospital discharge planning meetings, connecting the family with community resources such as funding or transportation, etc.

Family Counseling is provided to the family/caregiver to alleviate the feelings of devastation and loss related to a diagnosis and prognosis for a limited lifespan, surrounding the failing health status of the client, and the impending death of a child. Support is provided to the family members in order to guide and help them cope with the client's illness and the related stress that accompanies the continuous, daily care required by a terminally ill child. Enabling the family members to manage this stress improves the likelihood that the child with a life-threatening condition will continue to be cared for at home, thereby preventing premature and otherwise unnecessary institutionalization. Support will include but is not limited to attending physician visits, attending hospital discharge planning meetings, connecting the family with community resources such as funding or transportation, etc.

Group Counseling may be provided to multiple clients on the waiver at the same time to decrease emotional suffering due to health status and develop coping skills.

Telehealth is an allowable mode for delivering for 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:

Therapeutic Life-Limiting Illness Support is limited to 98 hours every 365 days based on the date the client entered the program. Therapeutic Life-Limiting Illness Support will be provided according to the assessment of the client in the continuum of care after a diagnosis of a life-limiting illness or condition. When a child is first diagnosed with the illness, the child and family might need a significant amount of anticipatory grief/loss counseling that may taper off during the treatment phase when the child has some improvement or remission of symptoms. As the child's health deteriorates, supportive services may be required at an intensive level.

When available and appropriate, State Plan services will be utilized prior to waiver services for the child or family.

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	Medicaid Enrolled Provider
Individual	Individual Therapist
Agency	Home Health agency
Agency	Hospice agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Therapeutic Life Limiting Illness Support: Individual Counseling, Family Counseling, Group Counseling

Provider Category:

Agency

Provider Type:

Medicaid Enrolled Provider

Provider Qualifications

License *(specify):*

Services must be provided by licensed, certified, and/or registered individuals operating within the applicable scope of practice in the state of Colorado: LCSW, LPC, LSW, LISW, Licensed Psychologist.

Certificate *(specify):*

Individuals with non-denominational/ Spiritual/Bereavement, Counselor/Chaplain certified by appropriate associations.

Other Standard *(specify):*

Individual and Family Grief Loss or Bereavement counseling experience, pediatric/adolescent counseling experience of one year.

Providers for the Telehealth service delivery option must demonstrate policies and procedures that include:
•HIPAA compliant platforms;
•Client support given, when needed, to 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 using 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 the choice in the member's service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

HCPF, CDPHE and Medicaid's Fiscal Agent

Frequency of Verification:

All agency provider qualifications are verified by Medicaid's Fiscal Agent upon initial enrollment and in a revalidation cycle; at least every 5 years. Additionally, an agency survey is completed by CDPHE according to the survey cycle.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Therapeutic Life Limiting Illness Support: Individual Counseling, Family Counseling, Group Counseling

Provider Category:

Individual

Provider Type:

Individual Therapist

Provider Qualifications

License *(specify):*

LCSW, LPC, LSW, LISW, Licensed Psychologist,
Individual Licensed by State of Colorado and/or Licensed individual

Certificate *(specify):*

Non-denominational/Spiritual/Bereavement Counselor/Chaplain certified by appropriate associations.

Other Standard *(specify):*

Individual and Family Grief Loss or Bereavement counseling experience, pediatric/adolescent counseling experience of one year.

Providers for the Telehealth service delivery option must demonstrate policies and procedures that include:
•HIPAA compliant platforms;
•Client support given, when needed, to 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 using 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 the choice in the member's service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

HCPF and Medicaid's Fiscal Agent

Frequency of Verification:

All Individual provider qualifications are verified by the Department's Fiscal Agent upon initial enrollment and in a revalidation cycle; at least every 5 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Therapeutic Life Limiting Illness Support: Individual Counseling, Family Counseling, Group Counseling

Provider Category:

Agency

Provider Type:

Home Health agency

Provider Qualifications

License *(specify):*

Department of Public Health and Environment, Health Facilities and Emergency Section Division is currently licensing all home health providers in the state of Colorado.
Services must be provided by licensed, certified, and/or registered individuals operating within the applicable scope of practice.

Certificate *(specify):*

All Skilled Home Health agencies in Colorado must be certified by Medicare prior to being certified by the Department of Health Care Policy and Financing.
Medicare/Medicaid Certified. Certified as a Medicaid provider of home health State Plan benefits. 10 C.C.R. 2505-10, Section 8.520.

Other Standard *(specify):*

Providers for the Telehealth service delivery option must demonstrate policies and procedures that include:
•HIPAA compliant platforms;
•Client support given, when needed, to 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 using 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 the choice in the member's service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Environment, Health Facilities and Emergency Section Division

Frequency of Verification:

Department of Public Health and Environment, Health Facilities and Emergency Services Division. According to the survey cycle mandated by CMS.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Therapeutic Life Limiting Illness Support: Individual Counseling, Family Counseling, Group Counseling

Provider Category:

Agency

Provider Type:

Hospice agency

Provider Qualifications

License *(specify):*

Hospice agency must be a licensed Medicare/Medicaid hospice provider in Colorado.

Services must be provided by licensed, certified, and/or registered individuals operating within the applicable scope of practice.

Certificate *(specify):*

Medicare/Medicaid Certified as a Medicaid provider of Hospice services. 10 C.C.R. 2505-10, Section 8.550.

Other Standard *(specify):*

Providers for the Telehealth service delivery option must demonstrate policies and procedures that include:
•HIPAA compliant platforms;
•Client support given, when needed, to 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 using 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 the choice in the member's service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Environment, Health Facilities and Emergency Section Division

Frequency of Verification:

Department of Public Health and Environment, Health Facilities and Emergency Services Division. According to the survey cycle, at least every 5 years.

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:

21 CMAs provide case management services throughout the state. The State assures that this waiver will be compliant with all applicable regulations related to case management as determined by CMS. Any amendments required to achieve such compliance will be submitted to CMS at least 90 days in advance of that date.

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):

It is policy for participants in Certified Nurses Aide state-approved educational programs to have Colorado Bureau of Investigation (CBI) background investigations when they are admitted to the program. Health care agencies and other independent training sites in Colorado that provide these educational programs require applicants for Certified Nurses Aide to comply. Compliance with the requirement for a state background check is monitored by the Department of Regulatory Agencies for Certification of Nurses Aides. CBI background checks register arrests for crimes relevant to vulnerable populations such as child abuse, domestic violence, assault and battery, and violent crime felony arrests. Prosecution may be checked through the criminal justice system.

Hospice agencies usually complete background checks on nurses, therapists, and counselors when they hire these professionals though there is no state regulation requirement.
Home Health Agencies, as of July 1, 2009, are now licensed by the Colorado Department of Public Health and Environment (CDPHE) and are required to perform background checks on all employees are indicated in 6 CCR 1011-1 Section 6.3

Per state statute, §26-3.1-111 C.R.S., employers must request a Colorado Adult Protective Services (CAPS) data check from the CAPS check unit before hiring new employees who will provide direct care to at-risk adults. CDPHE will verify the completion of these screenings at the time of the survey.

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):

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- ◉ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**

○ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

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.*

The State makes payment to legally responsible individuals for furnishing personal care or similar services. The personal care or similar services for which such payment may be made to legally responsible individuals; the legally responsible individuals who may furnish such services, State policies that specify the extraordinary circumstances when such payments may be authorized, and the controls that are employed to ensure that payments are made only for services rendered:
Payment to relatives may be made for personal care under the Respite Service. Relatives shall be defined as all persons related to the client by virtue of Blood, Marriage, Adoption or common law.
Payments to relatives are only for the extraordinary care that is beyond that which would ordinarily be provided to a child of the same age and development stage. The Department has instructed its Case Management Agencies that extraordinary care are activities that a parent or guardian would not normally provide as a part of a normal household routine. Additionally, extraordinary care shall only be provided by a legally responsible individual when it is necessary to ensure the health and welfare of the individual and to avoid institutionalization. Allowing a client to receive Personal Care 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.

The services for the Respite Care are made under the Home Health agency or Personal Care provider agency that employs the relatives as a Certified Nurses Aide after meeting all the requirements to be hired as a caregiver through the agency.

Payments for services rendered are delivered to the relative as a part of the employment relationship with the Home Health agency or personal care provider. The Department contracts with the Colorado Department of Public Health and Environment to license and survey agencies administering personal care or similar services. This includes a review of the service hours billed, documentation of tasks performed, and agency documentation of their oversight of their employee.

☐ **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.*

◉ **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.

Payment is not made directly to relatives for Respite Services. Relatives providing Respite shall be employees of a Certified Medicaid Agency and can be qualified to provide the service. Services provided by relatives for Respite are only for the extraordinary care that is beyond that which would ordinarily be provided to a child of the same age and developmental stage. The CMA case manager assessment utilizing the ULTC100.2 tool and the Service Plan determines that the care is extraordinary. All Respite services are prior authorized by the CMA Case manager. Respite care is limited to 30 days per year. The Department monitors this benefit through the CMA case management annual review, by MMIS claims adjudication and post-payment review of records, and agency surveys to ensure that controls are in place and 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:

Under the Department's rules, any provider can apply to enroll. Applications for each provider type are available on-line or by calling the Fiscal Agent. Providers who apply to become certified Home and Community-Based Services providers for Respite Services and Palliative/Supportive Care Services will be surveyed by the Department of Public Health and Environment-Health Facilities and Emergency Services Division (to ensure compliance with all applicable rules.

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 Number and percent of waiver providers, by type, that met licensing standards or certification requirements at time of scheduled or periodic recertification survey N: Number of licensed/certified waiver providers, by type, that met licensing standards or cert requirements at time of scheduled or periodic recert survey D: Total waiver providers, by type, surveyed during perf 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**	☐ **Other**

	Ongoing	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 performance period, by type, that have the required professional licensure or certification prior to serving waiver participants N: Number of newly enrolled waiver providers, by type, that have the required professional licensure or certification prior to serving waiver participants D: Total number of newly enrolled waiver providers by type

Data Source (Select one):
Other
If 'Other' is selected, specify:
CDPHE Survey Reports

Responsible Party for data	**Frequency of data collection/generation**	**Sampling Approach** *(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: 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 waiver providers, by type, that continually meet waiver provider standards N: Number of non-surveyed waiver providers, by type, that meet waiver provider standards D: Total number of non-surveyed 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:

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 providers that initially and continually meet waiver requirements N: Number of non-surveyed providers that initially and continually meet waiver requirements D: Total number of initial and ongoing non-surveyed 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 = 95% confidence level with a +/- 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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **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 CLLI waiver providers who meet Department waiver training requirements N: Number of surveyed CLLI waiver providers who meet Department waiver training requirements D: Total number of surveyed waiver providers

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:

CDPHE		
	☐ **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.c.2 Number and percent of CLLI waiver non-surveyed providers who meet department training requirements in accordance with state requirements and the approved waiver N: Number of CLLI waiver non-surveyed providers who meet Department training requirements in accordance with state requirements and the approved waiver D: Total CLLI 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**

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:

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 interested in providing HCBS services 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, 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 licenses are verified by the fiscal agent upon initial enrollment and in a revalidation cycle; at least every five years. Data reports verifying required 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 licensed/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.1
The Department reviews the waiver provider qualifications. The fiscal agent enrolls providers in accordance 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.4
The Department reviews the waiver provider qualifications at the time of the initial application. 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. Data reports verifying non-licensed/non-certified providers initially 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.c.1
DPHE 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 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 noncompliance 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 health and welfare of participants receiving services is 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 noncompliance 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 health and welfare of participants receiving services is 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.4
If areas of noncompliance 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. Applications for providers that do not remediate deficiencies are denied enrollment in the program.

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.

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:

Case managers working for the CMA shall have a degree of Bachelor of Arts or Bachelor of Science in the Human Services field. The majority of case managers have a Bachelor of Sociology or Psychology. Some case managers possess a Master of Social Work. Case managers will receive specialized training for the waiver target population as described in Appendix B-6-c: Qualifications of Individual Performing Initial Evaluation.

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:*

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.

Clients and/or parents, guardians, or legal representatives may choose among qualified providers and services. The case manager will advise the client and/or parents, guardians, or legal representative of the range of services and supports for which the client is eligible in advance of PCSP development. 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 parents, guardians, or legal representatives are informed they have the authority to select and invite individuals of their choice to actively participate in the care planning process.

The nurse of the Hospice Agency shall collaborate with the CMA case managers for the medical component in the planning of the services for the care of the client that may be required in order for care to be safely delivered in the home.

When scheduling to meet with the client and or child's parents and/or legal guardian the case manager makes reasonable attempts to schedule the meeting at a time convenient for all participants. In addition, the client and /or child's parents and/or legal guardian have the authority to select and invite individuals of their choice to actively participate in the PCSP process. Case managers develop emergency back-up plans with the client and /or child’s parents and/or legal guardian during the PCSP process and document the plan on the PCSP. The client must be seen at the time of the initial evaluation and at the redetermination to ensure that the client is in the home. CMAs may use phone or telehealth to engage in the development and monitoring of PCSP when there is a documented safety risk to the case manager or client, including public health emergencies as determined by state and federal government.

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.

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 service plan [10 C.C.R. 2505-10, Section 8.390]. The case manager meets with the child, the client's parents, and/or legal guardian to complete a Level of Care Eligibility Determination Screen (LOC Screen) of the client's needs in the client's residence. CMAs may use phone or telehealth to engage in the development and monitoring of person-centered plans when there is a documented safety risk to the case manager or client, including public health emergencies as determined by state and federal government

When scheduling to meet with the client and /or client's parents and/or legal guardian the case manager makes reasonable attempts to schedule the meeting at a time convenient for the client, the client's parents, and/or legal guardian to complete a LOC Screen of the client's needs. The client's parents and/or legal guardian have the authority to select and invite individuals of their choice to actively participate in the LOC Screen process. The client's parents and/or legal guardian provide the case manager with information about the client's medical status, needs, preferences, and goals. In addition, the case manager obtains diagnostic and health status information from the client's medical provider, and collateral information from agencies providing services to the client and determines the level of care using the state-prescribed LOC Screen instrument. The case manager works with the client's parents and/or legal guardian to identify risk factors and addresses risk factors with appropriate parties.

Once the PCSP is developed, options for services and providers are explained to the client and /or the client's parent or guardian by the case manager. The client's parents and/or legal guardian are required to access services through other sources such as State Plan benefits and EPSDT services when available before accessing waiver benefits. The case manager arranges and coordinates services documented in the PCSP. Services requiring a skilled assessment, such as skilled nursing or home health aide (Certified Nurses Aide) are determined and referrals are made to the appropriate providers of the client and /or client's parents and/or legal guardian choice. The PCSP defines the type of services, frequency, and duration of the services needed. The PCSP documents that the client and/or the client's parents or guardian has been informed of the choice of providers and documents that the client and /or client's parents, or legal guardian has chosen to have services provided in the community or in a hospital. The PCSP is completed within 15 working days of the client being determined eligible for CLLI services. CLLI services begin when all criteria are met which includes program and financial. 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 PCSPs created by the case management with the client's parents and/or legal guardian are signed by the client's parents and/or legal guardian and maintained in the case management record.

The client and /or client's parents and/or legal guardian may contact the case manager for on-going case management such as assistance in coordinating services, conflict resolution, or crisis intervention, as needed.

The case manager reviews the LOC Screen and PCSP with the client and /or the client's parents or legal guardian every six months. The review is conducted over the telephone or at the client's place of residence, place of service, or another appropriate setting as determined by the client's needs. This review includes obtaining information concerning the client and/or client's parents or legal guardian's satisfaction with the services provided, informal assessment of changes in client's function, service effectiveness, service appropriateness, and service cost-effectiveness. If complaints are raised by the client and /or client's parents or legal guardian, the case manager will document the complaint on the CMA's complaint log and assist the client and /or client's parent or guardian to resolve the complaint.

The case manager is required to complete a face-to-face reevaluation at the client and/or client's parents or legal guardian's residence within 12 months of the initial or previous evaluation. A reevaluation shall be completed sooner if the client's condition changes.

Upon Department approval, the annual evaluation 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.).

During an emergency situation, the Department may authorize members to receive services prior to completing the initial or revision to the service plan when there is a documented safety risk to the case manager or client, including public health emergencies as determined by state and federal government. The initial service plan will then be completed within 30 days of the member receiving services.

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 care planning process during a face-to-face interview in the client's home and are documented on the care plan form. This population is particularly at risk for anticipatory grief, isolation from peers, depression and parental distress, and/or burnout related to the life-limiting diagnosis and physical condition of the client. Clients are eligible for the waiver due to their risk of institutionalization. The waiver service package will help to mitigate crises in these risk areas by making Respite, Counseling, Palliative/Supportive Care, and Expressive Therapy services available. Individual/Caregiver Counseling would help to mitigate the risk of isolation and encourage open dialog between clients and family caregivers for the purpose of expressing and overcoming feelings of grief and distress. Expressive Therapy allows the client to express feelings through art, music, and play safely and effectively. Respite services would mitigate parental distress and burnout by providing caregivers with a period of relaxation free from caregiving duties. Palliative/Supportive Care provides comfort and palliation of distressing symptoms including anxiety related to the life-limiting diagnosis. Case managers evaluate the risk level of the clients and the family or caregiver with whom they reside at the initial assessment interview, quarterly, and annually. Referrals to appropriate agencies such as Child Protection Services are made immediately when the client is at risk for physical abuse, mental abuse, neglect, or exploitation. An emergency back-up plan is developed with the client and family/caregiver with physician input at the time of the initial assessment in the event that scheduled services are unable to be provided or caregivers are unable to provide the necessary care due to unforeseen circumstances, absence, or injury. The contingency plan within the Service Plan is a description of what services or supports will be implemented in assessing risk and mitigation and is tailored to the client’s specific needs. These back-up arrangements could include additional services or other supports such as family members or family friends. The contingency plan is developed during the service planning process in the client’s home with the client, family, and caregivers. The case manager discusses with the family what additional supports/services would be needed and what arrangements have already been made. This information is then recorded in a section of the PCSP.

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.

Each CMA is required to provide clients with free choice of all qualified providers in an accessible format based on the client's needs. CMAs have developed individual methods for providing choice to their clients. In order to ensure that clients continue to exercise 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 free choice of providers.

All CLLI services are available statewide. In areas of the state where enrolled clients reside, there is a choice among qualified providers. Due to the nature of this waiver, it is unpredictable to forecast where the need for services may arise. Accordingly, the Department is working to bolster capacity for when these situations occur and has put together information to outreach qualified providers who are already providing other HCBS services in those areas in order to ensure statewide access exists.

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 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 support plans is reviewed for accuracy, appropriateness, and compliance with regulations at 10 C.C.R. 2505-10, Section 8.390.

The person-centered support plans 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:

All PCSP are entered into the State's case management system, the State's case management IT system. The State's case management IT system is an electronic system that stores all case manager-entered information, such as the LOC Screen and PCSP, indefinitely. All PCSP are maintained for a minimum of three years.

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 face-to-face for PCSP development. When scheduling to meet with the client and/or 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 contact the client (at a minimum by phone) quarterly to ensure the person-centered 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. CMAs may use phone or telehealth to engage in the development and monitoring of PCSP when there is a documented safety risk to the case manager or client, including public health emergencies as determined by state and federal government.

Participant's exercise of free choice of providers:

Each CMA is required to provide clients with free choice of qualified providers. Some services and/or providers that are available in one part of the State may not be available in other areas of the State. CMAs have developed individual methods for providing choice to their clients. In order to ensure that clients continue to exercise 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 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.

Participant access to non-waiver services in the PCSP, including health services: The Department PCSP includes a section for health services and other non-waiver services.

Methods for prompt follow-up and remediation of identified problems:
Clients are provided with this information during the initial and annual support planning process using the "Client Roles and Responsibilities" and the "Case Manager Roles and Responsibilities" form. The form provides information to the client about the following, but not limited to, case management responsibilities:

•Assists with coordination of needed services;
•Communicate with the service providers regarding service delivery and concerns;
•Review and revise services as necessary; and
•Notifying clients regarding a change in 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's case management IT system.

During an emergency situation, the Department may authorize members to receive services prior to completing the initial or revision to the service plan when there is a documented safety risk to the case manager or client, including public health emergencies as determined by state and federal government. The initial service plan will then be completed within 30 days of the member receiving services.

Methods for systematic collection of information about monitoring results that are compiled, including how problems identified during monitoring are reported to the state:
CMAs are contractually obligated to conduct annual internal programmatic reviews. As specified in the QIS, the Department will require the CMA to conduct its 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. The Department requires that each CMA complete a specified number of client reviews as determined by the sampling methodology detailed in the QIS.

Evidentiary information supporting the CMA's internal programmatic reviews is submitted to the Department. Department staff then reviews a portion of each CMA's internal programmatic reviews using the sampling methodology described in the QIS. The Department staff compare information submitted by the CMA to state's 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 Person-Centered 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.

Costs are also monitored by Department staff reviewing 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:*

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 # and % of waiver participants in a rep sample whose Person-Centered Support Plan (PCSP) address the needs identified in the Level of Care Screen (LOC Screen) and determination N:# of participants in the sample whose PCSPs address the needs identified in the LOC screen & determination D:Total # of waiver participants in the sample

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% with a +/- 5% margin of error
☒ **Other** Specify: QIO	☒ **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:
D.a.2. Number and percent of waiver participants in a representative sample whose PCSPs address the waiver participant's personal goals N: Number of waiver participants in the sample whose PCSPs address the waiver participant's personal goals D: Total number of waiver participants in the sample

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:

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:
D.a.3 Number and percent of waiver participants in a representative sample whose PCSPs address identified health and safety risks through a contingency plan N: Number of waiver participants in the sample whose PCSPs address health and safety risks through a contingency plan D: Total number of waiver participants in the sample

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% with a +/- 5% margin of error
☒ **Other** Specify: QIO	☒ **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 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 in a representative sample whose PCSPs were revised, as needed, to address changing needs N: Number of waiver participants in the sample whose PCSPs were revised, as needed, to address changing needs D: Total number of participants in the sample who received a revision to their PCSP to address changing needs

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: QIO	☒ **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:

Performance Measure:
D.c.2. Number and percent of waiver participants in a representative sample with a prior PCSP that was updated within one year N: Number of waiver participants in the sample with a prior PCSP and whose PCSP start date is within one year of the prior PCSP start date D: 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 with a +/- 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:

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 in a rep sample whose scope and type of services are delivered as specified in the PCSP N: # of waiver participants in a rep sample 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:
	☐ **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 in a rep sample whose amount of services is delivered as specified in the PCSP N: # of waiver participants in a rep sample whose amount of services is 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:
	☐ **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:
D.d.5 Number and Percent of waiver participants in a rep sample whose frequency and duration of services are delivered as specified in the service plan N: # of waiver participants in a rep sample whose frequency and duration of services are delivered as specified in the service plan 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:
	☐ **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:

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 in a representative sample whose PCSPs document a choice between/among HCBS waiver services and qualified waiver service providers N: Number of waiver participants in the sample whose PCSPs document a choice between/among HCBS waiver services and qualified waiver service providers. D: 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:
	☐ **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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **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 Service Planning assurance and performance measures. The Super Aggregate Report is a custom report consisting of two parts: (1) data pulled directly from the state's case management system, the state's case management IT system and the Bridge, and (2)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 only QI Review Tool 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 service planning sub-assurances and performance measures. An independent QIO completes the QI Review Tool for the annual CMA program case evaluations

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 ULTC assessment. If a participant scores one 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 QIO reviewers use the BUS 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 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.

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 QIO 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 PCSP 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 assessment and care plan process are available for signature through digital or wet signatures based on the member's preference. 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.

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.2-5
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.2-5, D.e.1
The Department provides comprehensive remediation training for CMAs annually to assist with improving compliance with service planning performance measures and in developing future 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, 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 if a statewide root cause for deficiencies exists. 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)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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 CMA case manager notifies clients or their legal representative in writing when a denial of eligibility for the waiver occurs or services under the waiver are denied or reduced. Written notice of client appeal rights is included in the notice of adverse action and mailed using a Department approved form and/or a prior authorization request for services denial letter is generated by the fiscal agent that includes the appeal rights and instructions on how to file an appeal. The CMA is required to provide information to the client and/or parents, guardians or legal representative who applies for or receives publicly funded benefits regarding the right to request a fair hearing as set forth in 10 CCR 2505-10, Sections 8.393.15 and 8.393.28 et seq. See also recipient appeals rule, 10 C.C.R. 2505-10, Section 8.057.

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 the applicant and/or client defining the proposed action and information on appeal rights. The process and procedures for requesting a fair hearing with the State Office of Administrative Courts are listed on the reverse side of the notice. The notice includes language that instructs the client that they may receive assistance with the appeal process from any person of their choice, the Office of Administrative Courts, or the local Legal Aide Office. CMA case managers are also required to assist applicants and/or clients in developing a written request for an appeal if the client requests that they do so and the client is unable to complete one on their own. Appeal rights are also included in the Long Term Care Plan Information form.

Notification- Participants are notified of adverse action through the issuance of a written form entitled the Long Term Care Waiver Program Notice of Action (LTC 803 Form). The LTC 803 form informs the participant that waiver services will not be discontinued during the appeal process if the participant files an appeal on or prior to the effective date of the action. The CMA is required to generate the LTC 803 Form utilizing the Benefits Utilization System (BUS) and mail it to the participant at least ten (10) days before the date of the intended action. Participants are also provided a copy of the brochure "A Guide to Getting a Fair Medicaid Hearing" at the time notification is provided. HCPF rules and regulations regarding notification are located at 10 CCR 2505-10 8.057.2.

The case manager reviews this form with the client and/or authorized representative at the time of initial assessment and reassessment. The client and/or child's parents or legal guardians sign this form and a copy is provided to the client and/or parents, guardian,s or legal representative.

Client appeal rights are maintained on a Notice of Action in the BUS. Case managers are instructed to send a Notice of Action whenever there is a change or reduction/suspension, termination, or denial of provider choice in services or when a client has been denied CLLI services due to functional ineligibility. This documentation is maintained at the CMAs. The 803 forms completed are available for the case manager and case manager supervisor signature through digital or wet signatures.

If a client and/or child's parents or legal guardians submit an appeal within the required time frame, the client and/or child's parents or legal guardians may choose to continue receiving CLLI waiver services. The continuation of services is available under the condition that if the client's appeal is lost, the client and/or child's parents or legal guardians may be financially liable for services rendered.

Clients who have not received CLLI 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. The annual Administrative Review conducted by the Department requires CMAs to report their methods for community referrals.

Every Medicaid action that is appealed with the Office of Administrative Courts (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 if they disagree with it. 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, affirming, reversing, or remanding 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:

Colorado Department of Public Health and Environment, Health Facilities and Emergency Services Division and the CMAs

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, Health Facilities and Emergency Services Division (CDPHE). This hotline is set up for complaints about care provided, fraud, abuse, and misuse of personal property. CDPHE evaluates the complaint and initiates an investigation. Depending upon the nature of the complaint and the risk to the client's health and welfare, the investigation is started within 24 to 72 hours. Investigations may lead to targeted surveys or full surveys at 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. In addition, CMAs maintain a log system for complaints and grievances and either resolve the problem themselves or refer to the appropriate oversight agency. The Department reviews the complaint/grievance process through Case Management Agency contract deliverables in order for the case managers to better inform their clients, family members, and/or advocates on how to file a complaint outside the case management entity. A second critical incident 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.

The information on the nature of the complaints is forwarded to the Department in reports that are reviewed and analyzed in order to discover trends, plan training, or initiate changes in the regulations to address situations that might lead to a complaint.

25-3-109 C.R.S., Subparts (1), (3), (7), and (8), (2005).
42 C.F.R. Chapter IV, Section 484.10(f)
State laws, regulations, and policies referenced in the description are available through the operating agency or Medicaid Office.

The client/child's parents or legal guardian is informed that the filing of a grievance is not a prerequisite or substitute for a fair hearing and this is to be done by the case manager.

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 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 critical incidents, as used by the Department are as follows:

Death:
•Unexpected or expected

Mistreatment/Abuse/Neglect/Exploitation:

• Abuse or child abuse or neglect means an act or omission in one of the following categories that threatens the health and welfare of a child:
• Any case in which a child exhibits evidence of skin bruising, bleeding, malnutrition, failure to thrive, burns, fracture of any bone, subdural hematoma, soft tissue swelling, or death and either: Such condition of death is not justifiably explained; the history given concerning such condition is at variance with the degree or type of such condition or death, or the circumstances indicate that such condition may not be the product of an accidental occurrence;
• Any case in which a child is subjected to unlawful sexual behavior as defined in section 16-22-102(9), C.R.S;
• Any case in which a child is a child in need of services because the child's parents, legal guardians, or custodian fails to take the same actions to provide adequate food, clothing, shelter, medical care, or supervision that a prudent parent would take.
• Any case in which a child is subjected to emotional abuse. Emotional abuse means an identifiable and substantial impairment of the child's intellectual or psychological functioning or development or a substantial risk of impairment of the child's intellectual or psychological functioning or development.
• Any act or omission described in section 19-3-102 (1)(a), (1)(b), or (1)(c), C.R.S.
• Any case in which, in the presence of a child, or on the premises where a child is found, or where a child resides, a controlled substance, as defined in section 18-18-102(5), C.R.S, is manufactured or attempted to be manufactured
• Any case in which a child is born affected by alcohol or substance exposure, except when taken as prescribed or recommended and monitored by a licensed health care provider, and the newborn child's health or welfare is threatened by substance use;
• Any case in which a child is subjected to human trafficking of a minor for involuntary servitude, as described in section 18-3-503, or human trafficking of a minor for sexual servitude, as described in section 18-3-504(2)

• In all cases, those investigating reports of child abuse shall take into account accepted child-rearing practices of the culture in which the child participates including, but not limited to, accepted work-related practices of agricultural communities. Nothing in this subsection (1) shall refer to acts that could be construed to be a reasonable exercise of parental discipline or to acts reasonably necessary to subdue a child being taken into custody pursuant to section 19-2-502 that are performed by a peace officer, as described in section 16-2.5-101, C.R.S., acting in the good faith performance of the officer's duties.

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 which results in harm or an adverse effect that necessitates medical care.

Lost or Missing Person:

•A person is not immediately found, found; their safety is at serious risk or there is 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:
•An individual is residing in unsafe living conditions due to a natural event (such a fire or flood) or environmental hazard (such as infestation) and is at risk of eviction or homelessness.

Oversight is provided by the Department, Department of Public Health and Environment (CDPHE), or the Department of Human Services (DHS).

Critical incidents that involved alleged child mistreatment, abuse, neglect or exploitation, unexpected death or disability and, misuse of personal property are to be reported immediately (as soon as the incident is reported or discovered) to the county department of human services, child protective unit in the county that the child resides and/or to the local law enforcement agency as required in 10 CCR 2505-10, Section 8.393.2. Case managers are required to document any report made to a protective services unit in the BUS log notes within 24 hours of the report and are required to provide and document follow up within three days. CMAs are required to report to the county departments as soon as an allegation of abuse or neglect is reported or discovered. Case managers report critical incidents to Department staff using the Critical Incident Reporting System (CIRS) accessible through the BUS.

All county departments of social services are required to use the Colorado Child 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 Child's Protection Program.

CMAs are responsible for follow up with appropriate individuals and/or agencies in the event any issues or complaints have been presented by the client or others. The child's parent and/or legal guardian are informed at the time of initial assessment and reassessment to notify the case manager if there are changes in their care needs and/or problems with services.

CMAs complete a critical incident report using the BUS to document initial reports and subsequent case management follow up. The Department contracts with a QIO to review all critical incident reports for appropriate case management documentation, mandatory reporting, and follow-up activities to ensure the health, safety, and welfare of our members. The QIO notifies the Department through monthly, quarterly, and annual reporting of all critical incidents. The Department also receives immediate escalation from the QIO when a critical incident report involves mistreatment, abuse, neglect, and exploitation that places an individual or multiple individuals at serious risk which requires immediate action and notification of appropriate authorities.

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. During an emergency situation, the Department may authorize members to receive services prior to completing the initial or revision to the service plan when there is a documented safety risk to the case manager or client, including public health emergencies as determined by state and federal government. The initial service plan will then be completed within 30 days of the member receiving 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.

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.

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.

A child's parents and/or legal guardian are informed of the case management agency's complaint policy by the case manager. The Department has developed Policies and Procedures for the Critical Incident Reporting System. Resources are also available to clients and case managers about emergency backup and safety and prevention strategies.

Case management agencies are required to report to the county departments, Child Protective Services by phone as soon as an allegation of mistreatment, abuse, neglect, or exploitation is reported, suspected, or discovered by the case manager.

Information regarding what qualifies as a critical incident is provided to the child's parents or legal guardian at the initial assessment and annually thereafter. A child's parents and/or legal guardian are encouraged to report critical incidents to their provider(s), case manager, Child Protective Services, 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.

The Department has developed educational materials that are distributed by case managers to clients and/or client representatives at the initial and annual assessments. This information includes a list of client roles and responsibilities, case management roles, and how to file a complaint or appeal outside the CMA system.

Case managers document if mistreatment, abuse, neglect, or exploitation is suspected during the initial and annual evaluation 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.

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.

CMAs complete a critical incident report using the BUS to document initial reports and subsequent case management follow up. The Department contracts with a QIO to review all critical incident reports for appropriate case management documentation, mandatory reporting and follow up activities to ensure the health, safety, and welfare of our members. The QIO notifies the Department through monthly, quarterly and annual reporting of all critical incidents. The Department also receives immediate escalation from the QIO when a critical incident report involves mistreatment, abuse, neglect and exploitation which place an individual or multiple individuals at serious risk which require immediate action and notification of appropriate authorities. Critical incidents are required to be reported by licensed home health care agencies, personal care and homemaker agencies, and CMAs. Oversight is provided by the Department, CDPHE, or the Department of Human Services (DHS). The response to a critical incident is unique to the type of critical incident as well as who the critical incident involved.

The Department contracts with a QIO vendor to review all critical incidents. The QIO vendor provides monthly, quarterly, and annual reports to the Department regarding Critical Incident Report trends. The Department also reviews all critical incidents escalated to the Department following review by the QIO in which the incident results in serious risk of harm to an individual or results in criminal charges against a provider or caregiver. Below is a list of possible critical incidents, as well as who is responsible for follow up:

•Incidents involving surveyed providers (i.e. respite providers and home health providers) must be reported to the Department and CDPHE and are responded to by CDPHE;

Incidents involving non-surveyed providers (CMAs) must be reported to the Department and are responded to by the Department;

•Incidents involving mistreatment, abuse, neglect, or exploitation shall be reported to the County Department of Social Services and are responded to by the county; and

•All other incidents are responded to by the Department.

A Complaint system is maintained by the Colorado Department of Public Health and Environment - Health Facilities and Emergency Services Division (CDPHE-HFEMS). This system is accessible through the internet, email, phone, or facsimile for all complaints.

CDPHE investigates complaints about all health provider entities regulated by the CDPHE-HFEMS and that fall under the Public Health Survey jurisdiction. Complaints include quality of care, patient/resident rights, and building and equipment safety. Complaints are reviewed and prioritized based on actual or potential patient/resident harm. Complaint investigations are conducted either on-site or off-site depending on the nature of the complaint and typically include interviews with staff and/or patients/residents and a review of medical records/patient charts.

In addition to complaint investigations, all healthcare entities licensed or surveyed by Public Health jurisdiction are required to self-report incidents and occurrences to CDPHE-HFEMS Division within 24 hours or one(1) business day. Reportable occurrences include unexplained death, brain injury, life-threatening complications or errors from transfusion or anesthesia, severe burns, missing persons, physical/sexual abuse, neglect, misappropriation of property, diverted drugs, and malfunction or misuse of equipment. CDPHE survey jurisdiction will review and evaluate all reported occurrences and cite deficiencies where it finds violations of health-facility or licensing regulation. Occurrence data is made available to the public on the DPHE website at http://www.colorado.gov/pacific/cdphe/home-care-agencies-consumer-resources

The Department maintains an Interagency Agreement with CDPHE-HFEMS for the management of health facility licensure, survey, and certification. CDPHE provides the Department with monthly reports of information about the type of complaints or occurrence reported, nature of complaints or occurrences, investigation details and their outcome. These reports include the source of the complaint or occurrence, when the complaint or occurrence was investigated, and the investigation findings. From these reports, the Department staff can trend critical incidence and complaints. Once a complaint has been made or occurrences reported, investigations may lead to targeted surveys or full surveys of the agency involved. Where deficiencies are cited, agencies must submit and execute an approved plan of correction to CDPHE in order to maintain licensure.

CDPHE maintains an informational tool that is available to the child’s parents and/or legal guardian at www.colorado.gov/pacific/cdphe/home-car-agencies-consumer-resources, that will provide them with the results of the

provider complaints and investigations.

CMAs must maintain a log system for complaints and grievances. Issues must be resolved internally or referred to the appropriate oversight agency as required by 25-1-124 and 23-3-109 (1), (3), (7), (8) CRS 2005, 200. 42 CFR Chapter IV, Section 484.10(f).

The information packet developed by the Department is 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, information describing the Critical Incident Reporting System. Clients will be encouraged to report critical incidents to their provider(s), case manager and/or any other client advocate. The information packet includes what types of incidents to report and to whom the incident should be reported.

State laws, regulations, and policies referenced in the description are available through the operating or Medicaid Office.

The Department defines substantiated mistreatment, abuse, neglect, and exploitation as those allegations in which a report is made to law enforcement and/or protective services, an investigation was completed, and that credible evidence of mistreatment, abuse, neglect, or exploitation exists.

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 currently receives all monthly complaint reports from CDPHE for 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 was investigated, and the investigation findings. From these reports, Department staff can trend critical incidences or request to see a copy of the individual report on the complaint or occurrence from CDPHE.

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 the assignment of levels of priority to Critical Incidents Types to determine the most effective order in which to process each report:
1.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 needing immediate attention and housing to ensure health and safety.
- Death under suspicious circumstances that needs investigation, involves mistreatment, and/or 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 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 the 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.
- It should also be noted that Critical Incidents vary and priority level may be subjective. This is also not an all-inclusive list due to variance in events.
- Any CIR in which there is media coverage or involvement.

2.MEDIUM PRIORITY: those Critical Incidents that may have some immediate follow up documented, but still need some sort of actions 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.

3.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.

In instances whereupon review of the complaint or occurrence 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. During annual CMA monitoring, critical incident and complaint procedures are reviewed as a part of the Administrative evaluation.

In an effort to better monitor case management agencies' compliance with this requirement, the Waiver Administrator has conducted a parent/legal guardian survey that is administered to the child’s parents and or legal guardian annually. The surveys are distributed to every CLLI child’s parents and or legal guardian. The surveys identify client satisfaction with waiver services, case management services, Medicaid and other medical services, etc. Future surveys will also inquire whether or not the child’s parents and or legal guardian were provided choices, including but not limited to: a choice in waiver services, LTC service delivery (HCBS Waiver or institution), qualified providers, participation in service planning, etc. The child’s parents and or legal guardian will also be asked whether or not they received a list of client rights and responsibilities, complaint procedures, critical incident reporting guidelines, and contingency options.

Survey results will be analyzed, tracked and trended each year and the case management agency and improvements will be implemented.

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:

CDPHE surveys for use of restraints in home health agencies and hospice agencies.

○ **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).

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:

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:

CDPHE surveys for use of restraints in home health agencies and hospice agencies.

○ **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.

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:

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:

CDPHE surveys for unauthorized use of seclusion in home health agencies and hospice agencies.

○ **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.

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.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

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).

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:

(b) Specify the types of medication errors that providers are required to *record:*

(c) Specify the types of medication errors that providers must *report* to the state:

○ **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.

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 or guardian in a rep sample who received info/education on how to identify & report abuse, neglect, exploitation (ANE) & other critical incidents (CI) N: #of wvr participants &/or family/guardian in the smpl documented to have rcvd info/ed on how to identify & report ANE & other CI D: Total # of wvr participants &/or family/guardian in the sample

Data Source (Select one):
Other
If 'Other' is selected, specify:
Benefits Utilization 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 a +/- 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**

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

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 and percent 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**
☐ **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** 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:

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 on identified trends in critical incidents provided to CMAs D: Total number of annual reports required for CMAs

Data Source (Select one):
Other
If 'Other' is selected, specify:
Critical Incident Reports and BUS 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:
BUS 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**

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 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.7 # and % of providers surveyed during the performance period (PP) that met the Depts policies and procedures for prohibition of restrictive interventions for all waiver participants N:# of pvdrs surveyed during the PP that met Dept's policies and procedures for the prohibition of restrictive interventions for all wvr participants D: Total # of pvdrs surveyed during the PP

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: DPHE	☒ **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):*

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 N: The number of participants who had a medical claim in the past 12 months D: The total number of participants in the sample

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:
	☐ **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. 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 CIRS and follow up on each 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 the 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 the 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 CDPHE and are responded to by DPHE. A 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 if warranted. The investigation begins within 24-72 hours 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 training. Training records of preventative strategies training are maintained by the Dept.

G.b.3
The Dept. examines data for specific trends which include individuals that have multiple CIRs and 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
Data from root cause identified trends reduced as a result of systemic intervention are tracked and analyzed by the

CIR Team on a monthly and quarterly basis including through mortality review committee.

G.c.7
The Department monitors the prohibition of restrictive interventions through the CIRS and provider survey reports. These incidents receive additional scrutiny by the Department staff that includes a review of the original written incident report to ensure the prohibited use of a restrictive intervention has been discontinued. CIRS monitoring operates on a daily/continuous basis.
Oversight and discovery of the prohibition of restrictive interventions are completed through the review of complaints regarding services and supports, and by conducting surveys of CMAs by Department staff and of providers by CDPHE.

Providers must demonstrate during the survey process that they have met requirements for the prohibition of 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 BUS 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 CMA Administrator and reported in the individual's annual report of findings. CMAs deficient in completing accurate and required CIRs will receive technical assistance 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.
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 or by nature of the compliance issue. For issues or problems that arise at any other time throughout the year, technical assistance may be provided to the 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 on-going referrals and complaints to ensure that a resolution is reached, and the participant's health and safety have been maintained.

G.a.1
The Dept. provides remediation training CMAs annually to assist with improving compliance with this measure. The remediation process includes a standardized template for individual CMA Corrective Action Plans (CAPs) to ensure all the essential elements, including root-cause analysis, are addressed in the CAP. 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 for implementing the actions, and timeframes and a date for completion. The Dept. reviews the CAPs and either accepts them or requires additional remedial action. The Dept. follows up with each individual CMA quarterly to monitor the progress of the action items 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 a formal request for response, technical assistance, Dept. investigation, the 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-up will receive technical assistance 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 whereupon 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, G.c.7
The Dept. utilizes this information to develop statewide training, determine the need for individual agency technical assistance for case management and service provider agencies. In addition, the Dept. utilizes this information to identify 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 and Services Management Division to address and determine what additional remediation/improvement strategies need to be implemented.

G.c.7
CDPHE notifies the agencies of deficiencies and determines the appropriate remedial actions: training, technical assistance, Plan of Correction, and/or license revocation.

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 of incident 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 Improvement Strategy (QIS) encompasses all services provided in the CLLI waiver. The waiver specific requirements and assurances are included in the appendices.
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 unit 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 state's case management IT system. Work groups form as necessary to discuss prioritization and selection of system design changes.
Discovery and Remediation Information:
The Department maintains oversight over the (specify waiver) waiver in its 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 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 total population of waiver participants. The results obtained reflect systemic performance to ensure the waiver 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.
To ensure the quality review process is completed accurately, efficiently, and in accordance with federal standards, the Department contracts 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 Office of Community Living's Waiver Administration and Compliance Unit will review the QIS and its deliverables with management on a quarterly basis and will provide updates to CMS when appropriate. 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 will take 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) Under 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.

Single Entry Points (SEPs) are subject to the audit requirements within 2 CFR Part 200 for all Medicaid administrative payments. To ensure compliance with components detailed in the OMB Uniform Guidance, SEPs 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. The Department is responsible for overseeing the performance of the SEPs, reviewing the Single Audits of all SEPs 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 and Entities (LEIE), the System for Award Management (SAM), the Medicare Exclusion Database (MED), the Medicare for Cause Revocation Filed (MIG), 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 Dept monitors the action of licensing boards to ensure Medicaid providers are in good standing.

Claims are submitted to the Dept'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 prior to 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 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. The Department specifies requirements for providers that are then surveyed and certified by CDPHE. In order 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 the 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 no more than a 5 percent margin of error; however, the sample may be greater than the 95 percent confidence level with no more than 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 in accordance with 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 reviews and the RAC utilize 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. In accordance with 10 C.C.R. 2505-10 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 and abuse.*
- *Reviewing compliance with rules, manuals, and bulletins issued by the Department, board, or 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) and Current Dental Terminology (CDT).*
- *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, with regard to 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 set forth in C.R.S. 25.5-4-301 and 10 C.C.R. 2505-10 Section 8.076.3.

All reviews that are conducted will be desk reviews, however, the Department and its vendors are required to conduct on-site reviews as required under Colorado regulation. Under 10 C.C.R. 2505-10 Section 8.076.2.E., providers are given the option of an inspection or reproduction of the records by the Department or its designees at the providers' site. 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 set forth in 10 C.C.R. 2505-10 Section 8.076.3.

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 in a representative sample coded and paid according to the reimbursement methodology in the waiver N: Number of waiver claims in the sample coded and paid according to the reimbursement methodology in the waiver D: Total number of paid waiver claims in the 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:*
	☐ ***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 within a representative sample with adequate documentation that services were rendered. N: Number of claims in the sample

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:*
	☐ ***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***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☐ ***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 waiver application N: Number of claims paid where the rate is consistent with the approved rate methodology in the waiver application D: Total number of paid waiver claims in the 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:*
	☐ ***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:
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:*
	☐ ***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 several 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. Finally, 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 during its survey.

All waiver services included in the participant's service 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 elements above, the MMIS is configured to check for PARs that match 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 are pulled and analyzed from the MMIS.

I.a.1
This performance measure ensures that claims paid for waiver services have utilized the correct coding for each waiver services offered. 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 Department utilizes the client's PAR as documentation of services rendered. Case managers monitor service provision to ensure that services are being provided according to the service plan. Case managers inform the Department of discrepancies between a provider's claim and what the participant reports have occurred or if the participant reports that the provider is not providing services according to the service 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 Fee Schedule portion of 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 Division staff review the rate adjustments to confirm 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.*

Waiver administrators coordinate with the Department's Claims Systems and Operations Division staff to 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.

The Benefits and Services Management Division (BSM) 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 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
The BSM 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:*

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
	as needed based on severity of occurrence 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 Department's methodology for calculating home and community-based services (HCBS) rates identifies all factors necessary to provide services and the accessibility of the service through research, facility site visits, and feedback from stakeholders. The rate methodology for these services was last reviewed in 2017. The expected price of factors identified as necessary to provide the service to Medicaid clients are determined and calculated. The factors considered in the determination of fee-for-service waiver rates for Expressive Therapy, Massage therapy, Palliative Supportive Care Services: Care Coordination, Pain, and Symptom Management; Respite Care (unskilled, skilled CNA, skilled RN); Therapeutic Life-Limiting Illness Support: Individual, Family/Caregiver, and Group Counseling; and Bereavement Services are as follows:

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 equivalency required for the delivery of the services. Finally, collaboration with policy staff ensures the salaried positions, wages, and required hours conform to the program or service design.

B. 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, and utility expenses.

C. Administrative Expense Expectations:
Identifies computer, software, office supply costs, and the total number of employees to determine administrative and operating costs per employee of providing services.

D. 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.

Indirect and Direct Care requirement corresponds to the total wages, taxes, and benefits required to provide the service to a client. The total dollar amount is determined for all indirect and direct care positions for a specified period of time (typically annual). The Facility, Administrative, and Capital Overhead expenses are calculated based on the average market price for each of the components included. The components in each of the factors are totaled resulting in an annual total cost for Facility, Administrative, and Capital Overhead. Prior to adding the direct and indirect care costs to the costs of the additional factors, the Facility, Administrative, and Capital Overhead costs are first reduced to per-employee costs and then multiplied by the percentage of FTE required to serve one client for one full year. Thus, the final result is the total cost per client per year. The results for each factor are added to the total indirect and direct care costs. After summing each of the per client per year factor costs with indirect and direct care costs, the result is divided by the total number of direct care units per year to determine an hourly rate. From here the rate is easily reduced to a lower unit rate, such as 15-30 minutes, or can be easily increased for a higher unit rate, such as 2 hours to a full day.

EX: Direct and Indirect Care for one client for one year $3000.00
Facility $20,000.00
Administration $7000.00
Capital Overhead $0.00

The total number of direct and indirect care hours to serve one client = 28 hours

To determine % of FTE required to serve one client 28 hours/ annual hours=%FTE
The % FTE represents the proportion of the cost to serve a client annually, thus a cost per client
Direct and Indirect Care for one client for one year $3,000.00
Facility +($20,000.00%FTE)*
Administration +($7,000.00%FTE)*
Capital Overhead +($0.00%FTE)*
Total Annual Cost for one client $3,450.00/Direct Care Units=$ per hour

Room and Board are not included in the development of HCBS rates.

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 which also include measures of efficiency and economy in order 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.

The Department uses information gathered from research, facility site visits, and stakeholder feedback to establish the unit value (such as the length of time being paid for) and the price. The Department solicits public comment during waiver renewal through stakeholder meetings. These meetings involve provider groups, client advocacy groups, and clients in order to provide feedback on rate determination methods. Additional information pertaining to public input for the CLLI 2020 waiver renewal is located in Main 6-I.

The Department regularly assesses rate efficiency, economy, quality of care, and sufficiency of provider populations by monitoring and analyzing paid claims utilization multiple times throughout the state fiscal year. The Department also analyzes geographic provider density to ensure clients are able to access waiver services. In addition to these processes, the Department regularly solicits external stakeholder feedback in order to assess whether rates are efficient, economic, allow for a high quality of care to be provided, and are sufficient to maintain the provider population.

The state's process for soliciting public comment on rate determination methods involves a standardized and documented process consisting of Presentation of Rate Setting Methodology to stakeholders prior to 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.

Once the rate has been determined, comparisons of other state Medicaid rates and private pay rates for similar or identical services are analyzed to ensure the appropriateness of the determined rate. Once a rate is implemented, all rates are subject to legislative appropriations.

Rate information is made available to waiver participants via publishing of the fee schedule on the Department's external website. Notification of changes to the fee schedule is also sent out in the provider bulletin which is also published on the Department's website

The State will, upon identification of need, prospectively implement a differential in the rate structure to account for variance in minimum wage requirements and acknowledgment of unique geographical considerations impacting access to care. Distinct rates by locality, county, metropolitan area or other types of regional boundaries will be implemented as the Department determines potential access to care considerations. Upon the subsequent waiver amendment or renewal, the Department will update the corresponding rate and any changes in methodology.

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:*

Fee-for-service billing claims flow directly from providers to the MMIS which is administered by the Department's Fiscal Agent, Affiliated Computer Services (ACS).

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.

(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 service 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.

Case managers monitor service provision to ensure that services are being provided according to the service 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 service plan, the case manager reports the information to the Department for investigation.

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:

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:

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

- ( ) ***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:

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:

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:*

The Department does not include costs for food or for the living area when calculating the rate for Facility-Based Respite Care; although 42 CFR §441.310(a)(2) does allow for the cost of room and board to be claimed when it is provided as part of respite services delivered in a facility that is not a private residence.

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

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	5303.29	90415.21	95718.50	194131.21	65549.84	259681.05	163962.55
2	4377.64	96406.67	100784.31	200925.80	68473.36	269399.16	168614.85
3	5369.49	102294.24	107663.73	207958.20	71527.27	279485.47	171821.74
4	5526.80	105456.18	110982.98	215236.74	74717.39	289954.13	178971.15
5	5675.86	108050.40	113726.26	222770.03	78049.79	300819.82	187093.56

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
Year 1	218	218
Year 2	195	195
Year 3	197	197
Year 4	200	200
Year 5	203	203

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.*

Update for WYs 3-5 for Amendment with requested effective date of 7/01/2022:
The Department estimated the average length of stay (ALOS) on the waiver by reviewing historical data included in the annual 372 data report. The Children with Life Limiting Illnesses (CLLI) Waiver ALOS varies quite a bit year-to-year FY 2019-20 came back historically high at 290 days. The Department does not expect ALOS to increase anymore and therefore held ALOS constant at the FY 2019-20 amount for future years.

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 utilizes 372 reports as the source of data to estimate the number of users, units per user, and cost per unit. The most recent 372 was from FY 2017-18. The Department reviews 372 data from FY 2007-08 through FY 2017-18 but may only include certain FYs in the development of trends.

The Department examined historical growth rates and the fraction of the total population that utilized each service. Once the historical data was analyzed, the Department selected trend factors to forecast, the number of clients utilizing each service, the number of units per user, and the average cost per unit. 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 FY 2012-13 through FY 2019-20 but might only include certain FYs in the development of trends. For example, the Department may look at data from FY 2007-08 and beyond but apply a trend that only incorporates growth rates from FY 2016-17 and FY 2017-18.

Fraction of growth rates: The source of data is 372 waiver reports which include the number of utilizers of each service and total waiver clients. The Department divides services utilizers into total waiver enrollments to calculate the fraction of the total population that uses services. Dates of data are all available historical data which for this waiver dates back to FY 2012-13 however the Department focuses on more recent data for trend development.

The default utilizer trend used for the majority of services is to take a look at the percent of the waiver that used the service in the previous 2 fiscal years and take an average of those shares. The default trend selection for units per utilizer is to take the average annual growth of the previous two years. Certain years of data are not included because they are considered to be outliers based on sudden changes in utilization, new limits placed on services, or a change in policy.

Rates included in the Department's Cost Neutrality Demonstration may not match the Department's published rate schedule. In order to accurately project total expenditures for a service, the avg. cost/unit may be adjusted to account for a particular rate being implemented for less than a 12 month period.
The following services received the (A) 1% reduction on 7/01/2020:

- *Respite Care Unskilled per Day*
- *Respite Care Skilled CNA up to 4 Hour Visit*
- *Respite Care Skilled RN/LPN per Day*
- *Respite Care Skilled CNA per Day*
- *Respite Care Facility-Based*
- *Respite Care Unskilled up to 4 Hour Visit*
- *Respite Care Skilled RN/LPN up to 4 Hour Visit*
- *Bereavement Counseling*
- *Palliative/Supportive Care services-Pain and Symptom Management*
- *Palliative/Supportive Care services-Care Coordination*
- *Expressive Therapy-Music Therapy Group*
- *Expressive Therapy-Music Therapy Individual*
- *Expressive Therapy-Art and Play Therapy Individual*
- *Expressive Therapy-Art and Play Group*
- *Massage Therapy*
- *Therapeutic Life-Limiting Illness Support-Individual Therapeutic End of Life Support per 15-minute Visit*
- *Therapeutic Life-Limiting Illness Support-Family Therapeutic End of Life Support per 15- minute Visit*
- *Therapeutic Life-Limiting Illness Support-Group Therapeutic End of Life Support per 15- minute Visit*

Update for WYs 2-5 for Amendment with requested effective date of 07/01/2021:
All services were updated to include the most recent 372 data (SFY 2018-19), which did not include telehealth utilization since telehealth was not established as an option during SFY2018-19.

Update for WYs 2-5 for Amendment with requested effective date of 01/01/2022:

Factor D was updated to include a 2.5% ATB increase approved by the Colorado State Legislature in 2021 for all services.

Update for WYs 3-5 for Amendment with requested effective date of 07/01/2022:
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 examined historical growth rates, the fraction of the total population that utilized each service, and graphical trends. Once the historical data was analyzed, the Department selected trend factors to forecast the number of clients utilizing each service, the number of units per user, and the average cost per unit. 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. FY 2019-20 utilization (units and number of utilizers per service) and expenditure were lower than expected due to COVID-19. Specifically, CNA - 4 hours or more, Massage Therapy, and Skilled In-Home Respite require hands-on care to the member and would not maintain integrity if provided via telehealth. Therefore, the Department predicts low utilization for these services through the public health emergency but does not expect a permanent decline; the Department selected trends based on the assumption that lower utilization and expenditure would not persist. Similarly, Art and Play Therapy and Therapeutic Grief Counseling should show an increase in utilization because of telehealth allowances.

Historical growth rates: The source of data is 372 waiver reports. The Department reviews data from FY 2012-13 through FY 2018-19 but might only include certain FYs in the development of trends. For example, the Department may look at data from FY 2007-08 and beyond but apply a trend that only incorporates growth rates from FY 2018-19 and FY 2019-20.

Fraction of growth rates: The source of data is 372 waiver reports which include the number of utilizers of each service and total waiver clients. The Department divides services utilizers into total waiver enrollments to calculate the fraction of the total population that uses services. Dates of data are all available historical data which for this waiver dates back to FY 2012-13 however the Department focuses on more recent data for trend development.

Graphical trends: In some cases, the Department will plot the data in a graph to try and discern a reliable trend. This could be done for the following forecast elements: number of utilizers or units per utilizer. Graphical trends would not be used for rates.

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:*

Update for WYs 3-5 for Amendment with requested effective date of 7/01/2022:
To calculate State Plan services costs associated with CLLI Waiver clients, the Department analyzed historical D' values. The Department chose the average growth in cost per utilizer that matches the average growth rate of FY 2017-18 through FY 2019-20: 2.46%. The Department believes this to be the most appropriate trend given the current utilization patterns and recent growth. The claims information used in the derivation of 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'.

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 hospital costs, the Department examined utilization and average per user hospital costs. Recent actual data does not show a strong, apparent trend so the Department chose to apply a small growth trend of 3.50% which is the average growth trend from 2016-17 to FY 2017-18.

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 clients, the Department reviewed CLLI historical Factor G' data. Recent actual data does not show a strong, apparent trend so the Department chose to use the average growth trend of FY 2016-17 and FY 2017-18 which is 4.46%. The claims information used in the derivation of Factor G' 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 G'.

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	
Respite Care	
Bereavement Counseling	
Palliative/Supportive Care services	
Expressive Therapy	
Massage Therapy	
Therapeutic Life Limiting Illness Support: Individual Counseling, Family Counseling, Group Counseling	

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
Respite Care Total:						121967.09
Respite Care Unskilled per Day	Day	24	37.48	98.95	89007.50	
Respite Care Skilled CNA up to 4 Hour Visit	15 minutes	1	16.00	7.21	115.36	
Respite Care Skilled RN/LPN per Day	Day	2	16.31	282.06	9200.80	
Respite Care Skilled CNA per Day	Day	2	8.00	128.11	2049.76	
Respite Care Facility Based	Day	7	11.00	199.58	15367.66	
Respite Care					1894.26	
GRAND TOTAL:						1156117.24
Total Estimated Unduplicated Participants:						218
Factor D (Divide total by number of participants):						5303.29
Average Length of Stay on the Waiver:						269

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Unskilled up to 4 Hour Visit	15 minutes	1	344.41	5.50		
Respite Care Skilled RN/LPN up to 4 Hour Visit	15 minutes	2	138.13	15.68	4331.76	
Bereavement Counseling Total:						66459.96
Bereavement Counseling	Lump Sum	59	1.00	1126.44	66459.96	
Palliative/Supportive Care services Total:						21939.15
Pain and Symptom Management	Hour	23	7.27	77.51	12960.45	
Care Coordination	15 minutes	22	19.86	20.55	8978.71	
Expressive Therapy Total:						315509.84
Music Therapy Group	15 minutes	3	20.05	9.05	544.36	
Music Therapy Individual	15 minutes	176	95.07	16.18	270728.94	
Art and Play Therapy Individual	15 minutes	15	180.53	16.18	43814.63	
Art and Play Therapy Group	15 minutes	3	15.54	9.05	421.91	
Massage Therapy Total:						170236.45
Massage Therapy	15 minutes	136	69.31	18.06	170236.45	
Therapeutic Life Limiting Illness Support: Individual Counseling, Family Counseling, Group Counseling Total:						460004.75
Individual Therapeutic End of Life Support per 15 minute Visit	15 minutes	72	51.14	25.12	92493.85	
Family Therapeutic End of Life Support per 15 minute Visit	15 minutes	142	92.75	25.12	330842.96	
Group Therapeutic End of Life Support per 15 minute Visit	15 minutes	42	58.91	14.82	36667.94	
				GRAND TOTAL:		1156117.24
				Total Estimated Unduplicated Participants:		218
				Factor D (Divide total by number of participants):		5303.29
				Average Length of Stay on the Waiver:		269

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
Respite Care Total:						99149.71
Respite Care Unskilled per Day	Day	29	20.20	101.42	59411.84	
Respite Care Skilled CNA up to 4 Hour Visit	15 minutes	1	16.00	7.39	118.24	
Respite Care Skilled RN/LPN per Day	Day	3	17.59	289.11	15256.33	
Respite Care Skilled CNA per Day	Day	3	8.00	131.31	3151.44	
Respite Care Facility Based	Day	7	11.00	204.57	15751.89	
Respite Care Unskilled up to 4 Hour Visit	15 minutes	1	361.18	5.64	2037.06	
Respite Care Skilled RN/LPN up to 4 Hour Visit	15 minutes	2	106.50	16.07	3422.91	
Bereavement Counseling Total:						41565.60
Bereavement Counseling	Lump Sum	36	1.00	1154.60	41565.60	
Palliative/Supportive Care services Total:						35445.04
Pain and Symptom Management	Hour	27	8.79	79.45	18855.87	
Care Coordination	15 minutes	31	25.41	21.06	16589.17	
Expressive Therapy Total:						245910.44
Music Therapy Group	15 minutes	2	28.00	9.28	519.68	
Music Therapy Individual	15 minutes	159	90.09	16.58	237497.06	
Art and Play Therapy Individual	15 minutes	15	31.16	16.58	7749.49	
				GRAND TOTAL:		853639.40
				Total Estimated Unduplicated Participants:		195
				Factor D (Divide total by number of participants):		4377.64
				Average Length of Stay on the Waiver:		269

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Art and Play Therapy Group	15 minutes	1	15.54	9.28	144.21	
Massage Therapy Total:						140002.24
Massage Therapy	15 minutes	120	63.03	18.51	140002.24	
Therapeutic Life Limiting Illness Support: Individual Counseling, Family Counseling, Group Counseling Total:						291566.37
Individual Therapeutic End of Life Support per 15 minute Visit	15 minutes	38	64.75	25.75	63357.88	
Family Therapeutic End of Life Support per 15 minute Visit	15 minutes	105	77.92	25.75	210676.20	
Group Therapeutic End of Life Support per 15 minute Visit	15 minutes	20	57.71	15.19	17532.30	
				GRAND TOTAL:		853639.40
				Total Estimated Unduplicated Participants:		195
				Factor D (Divide total by number of participants):		4377.64
				Average Length of Stay on the Waiver:		269

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
Respite Care Total:						102947.66
Respite Care Unskilled per Day	Day	26	21.19	103.52	57033.31	
Respite Care Skilled CNA up to 4 Hour Visit	15 minutes	4	64.50	7.55	1947.90	
Respite Care					22401.71	
				GRAND TOTAL:		1057789.39
				Total Estimated Unduplicated Participants:		197
				Factor D (Divide total by number of participants):		5369.49
				Average Length of Stay on the Waiver:		290

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Skilled RN/LPN per Day	Day	4	18.98	295.07		
Respite Care Skilled CNA per Day	Day	4	8.00	134.02	4288.64	
Respite Care Facility Based	Day	1	11.00	208.78	2296.58	
Respite Care Unskilled up to 4 Hour Visit	15 minutes	3	361.18	5.76	6241.19	
Respite Care Skilled RN/LPN up to 4 Hour Visit	15 minutes	5	106.50	16.41	8738.32	
Bereavement Counseling Total:						80822.00
Bereavement Counseling	Lump Sum	70	1.00	1154.60	80822.00	
Palliative/Supportive Care services Total:						49163.72
Pain and Symptom Management	Hour	41	8.79	79.44	28629.38	
Care Coordination	15 minutes	32	30.47	21.06	20534.34	
Expressive Therapy Total:						258068.31
Music Therapy Group	15 minutes	3	14.67	9.28	408.41	
Music Therapy Individual	15 minutes	163	91.93	16.58	248444.50	
Art and Play Therapy Individual	15 minutes	17	31.16	16.58	8782.76	
Art and Play Therapy Group	15 minutes	3	15.54	9.28	432.63	
Massage Therapy Total:						159720.94
Massage Therapy	15 minutes	147	58.70	18.51	159720.94	
Therapeutic Life Limiting Illness Support: Individual Counseling, Family Counseling, Group Counseling Total:						407066.76
Individual Therapeutic End of Life Support per 15 minute Visit	15 minutes	59	74.65	25.75	113412.01	
Family Therapeutic End of Life Support per 15 minute	15 minutes	135	76.49	25.75	265898.36	
				GRAND TOTAL:		1057789.39
				Total Estimated Unduplicated Participants:		197
				Factor D (Divide total by number of participants):		5369.49
				Average Length of Stay on the Waiver:		290

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Visit						
Group Therapeutic End of Life Support per 15 minute Visit	15 minutes	28	65.26	15.19	27756.38	
			GRAND TOTAL:			1057789.39
			Total Estimated Unduplicated Participants:			197
			Factor D (Divide total by number of participants):			5369.49
			Average Length of Stay on the Waiver:			290

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
Respite Care Total:						115946.80
Respite Care Unskilled per Day	Day	27	23.15	103.52	64705.18	
Respite Care Skilled CNA up to 4 Hour Visit	15 minutes	4	64.50	7.55	1947.90	
Respite Care Skilled RN/LPN per Day	Day	4	20.47	295.07	24160.33	
Respite Care Skilled CNA per Day	Day	5	8.00	134.02	5360.80	
Respite Care Facility Based	Day	1	11.00	208.78	2296.58	
Respite Care Unskilled up to 4 Hour Visit	15 minutes	4	379.24	5.76	8737.69	
Respite Care Skilled RN/LPN up to 4 Hour Visit	15 minutes	5	106.50	16.41	8738.32	
Bereavement Counseling Total:						81976.60
Bereavement Counseling	Lump Sum	71	1.00	1154.60	81976.60	
Palliative/Supportive Care services Total:						53543.06
			GRAND TOTAL:			1105359.43
			Total Estimated Unduplicated Participants:			200
			Factor D (Divide total by number of participants):			5526.80
			Average Length of Stay on the Waiver:			290

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Pain and Symptom Management	Hour	42	9.56	79.44	31896.75	
Care Coordination	15 minutes	32	32.12	21.06	21646.31	
Expressive Therapy Total:						267056.27
Music Therapy Group	15 minutes	4	14.67	9.28	544.55	
Music Therapy Individual	15 minutes	166	93.38	16.58	257007.91	
Art and Play Therapy Individual	15 minutes	17	31.16	16.58	8782.76	
Art and Play Therapy Group	15 minutes	5	15.54	9.28	721.06	
Massage Therapy Total:						165865.52
Massage Therapy	15 minutes	149	60.14	18.51	165865.52	
Therapeutic Life Limiting Illness Support: Individual Counseling, Family Counseling, Group Counseling Total:						420971.18
Individual Therapeutic End of Life Support per 15 minute Visit	15 minutes	60	78.28	25.75	120942.60	
Family Therapeutic End of Life Support per 15 minute Visit	15 minutes	137	76.64	25.75	270366.76	
Group Therapeutic End of Life Support per 15 minute Visit	15 minutes	28	69.74	15.19	29661.82	
				GRAND TOTAL:		1105359.43
				Total Estimated Unduplicated Participants:		200
				Factor D (Divide total by number of participants):		5526.80
				Average Length of Stay on the Waiver:		290

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
Respite Care Total:						127603.12
Respite Care Unskilled per Day	Day	27	25.28	103.52	70658.61	
Respite Care Skilled CNA up to 4 Hour Visit	15 minutes	4	64.50	7.55	1947.90	
Respite Care Skilled RN/LPN per Day	Day	4	22.08	295.07	26060.58	
Respite Care Skilled CNA per Day	Day	6	8.00	134.02	6432.96	
Respite Care Facility Based	Day	1	11.00	208.78	2296.58	
Respite Care Unskilled up to 4 Hour Visit	15 minutes	5	398.20	5.76	11468.16	
Respite Care Skilled RN/LPN up to 4 Hour Visit	15 minutes	5	106.50	16.41	8738.32	
Bereavement Counseling Total:						83131.20
Bereavement Counseling	Lump Sum	72	1.00	1154.60	83131.20	
Palliative/Supportive Care services Total:						58205.00
Pain and Symptom Management	Hour	42	10.39	79.44	34666.03	
Care Coordination	15 minutes	33	33.87	21.06	23538.97	
Expressive Therapy Total:						275360.61
Music Therapy Group	15 minutes	5	14.67	9.28	680.69	
Music Therapy Individual	15 minutes	168	94.86	16.58	264226.84	
Art and Play Therapy Individual	15 minutes	18	31.16	16.58	9299.39	
Art and Play Therapy Group	15 minutes	8	15.54	9.28	1153.69	
Massage Therapy Total:						173369.10
Massage Therapy	15 minutes	152	61.62	18.51	173369.10	
Therapeutic Life Limiting Illness Support: Individual Counseling, Family Counseling, Group Counseling Total:						434531.21

GRAND TOTAL:	1152200.24
Total Estimated Unduplicated Participants:	203
Factor D (Divide total by number of participants):	5675.86
Average Length of Stay on the Waiver:	290

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Individual Therapeutic End of Life Support per 15 minute Visit	15 minutes	60	82.08	25.75	126813.60	
Family Therapeutic End of Life Support per 15 minute Visit	15 minutes	139	76.80	25.75	274886.40	
Group Therapeutic End of Life Support per 15 minute Visit	15 minutes	29	74.53	15.19	32831.21	
				GRAND TOTAL:		1152200.24
				Total Estimated Unduplicated Participants:		203
				Factor D (Divide total by number of participants):		5675.86
				Average Length of Stay on the Waiver:		290