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:
Children's Extensive Support (CES) Waiver

C. Waiver Number:CO.4180
Original Base Waiver Number: CO.4180.

D. Amendment Number:CO.4180.R05.27

E. Proposed Effective Date: (mm/dd/yy)

01/01/24

Approved Effective Date: 01/01/24
Approved Effective Date of Waiver being Amended: 07/01/19

2. Purpose(s) of Amendment

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

The purpose of this amendment is to:
-To allow legally responsible individuals to provide the Homemaker and Community Connector service. This flexibility was allowed during the COVID Public Health Emergency (PHE) and the state is amending the waiver application for permanent adoption.

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	

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

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*):

Children's Extensive Support (CES) Waiver

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.4180
Waiver Number:CO.4180.R05.27
Draft ID: CO.013.05.11

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/19
Approved Effective Date of Waiver being Amended: 07/01/19

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 Children's Extensive Support (CES) waiver provides specific targeted services and supports to assist a child with an intellectual and developmental disability to remain in the family home, support the long term stability of the family setting and prevent out-of-home placement of the child.

Although the CES waiver provides a variety of services and supports which can be tailored to individual family situations, it is not designed to provide services 24 hours per day to an enrolled child. All needs of the child are identified through the service planning process; however, not all needs of the child will be supported through this waiver.
Through the promotion of individual family choice and the individualized planning process CES services and supports are selected in a cost effective way allowing existing or newly developed natural supports and generic community resources to also support the needs of the child.

CES is statewide waiver that incorporates the use of the Community Centered Boards, Program Approved Service Agencies and other generic community providers to obtain the necessary services to keep the family together and avoid institutional placement.

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 10/11/2023 through 11/09/2023:

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 10/11/2023 and 10/25/2023. 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 10/11/2023. 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 10/11/2023. 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.

At the end of the 30-day public comment period the Department received 2 comments:

Comment (1 total): Supports allowing legally responsible persons to provide Homemaker and Community Connector but suggested having a cap.

Department response: At this time the cap will be annual with a suggested weekly amount. The Department would like to ensure families have the flexibility to use the service and hours when needed - such as the summer months when a child is not in school.

Comment (1 total): Supports allowing legally responsible persons to provide Homemaker and Community Connector and looks forward to working with the Department in the permanent implementation of this change including the exception process for service caps.

Department response: Thank you for submitting these comments of support for the proposed waiver amendments. The Department is committed to ensuring members are able to continue to access these vital services by the provider of their choice.

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: Julie Masters

State Medicaid Director or Designee

Submission Date: Nov 28, 2023

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

Last Name: Flores-Brennan

First Name: Adela

Title: Medicaid Director

Agency: The Department of Health Care Policy & Financing

Address: 303 E 17th Ave

Address 2:

City: Denver

State: **Colorado**

Zip:

80203

Phone:

(303) 866-3060 **Ext:** ☐ **TTY**

Fax:

(303) 866-2786

E-mail:

Adela.Flores-Brennan@state.co.us

Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

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

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

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

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

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

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

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

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

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

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

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

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

I-2-a Rate Determination Methods:
Update for the Amendment with the requested effective date of 1/1/2024:
The service titled "Parent Education" was changed to "Primary Caregiver Education." There were no changes to the service definition or rate methodology.
The Department is also updating Appendix I-2a for the addition of Respite provider specialties. Respite will be delegated into three specialties provided by a skilled, therapeutic, or unskilled provider type. This was approved by the passage of the Long Bill for SFY 23-24. The Respite service will now include the additional service components: Respite CNA - 4 hours or less, Respite CNA - 4 hours or more, Therapeutic Respite - 4 hours or less, Therapeutic Respite - 4 hours or more, Skilled In-Home Respite - 4 hours or less, Skilled In-Home Respite - 4 hours or more. The state added "unskilled" to the following Respite components for clarification with the addition of the new skilled specialties: Respite Individual and Respite Day. The state did not make any changes to Respite Group or Respite group Overnight Camp. The State will use 9817 ARPA funds for the newly added respite components specialties.

J-2c-i Factor D Derivation:
The State is updating Appendix J to reflect the 2% ATB rate increase approved in the budget request for Long Bill HB22-1329 for the following services:
Homemaker-Basic
Homemaker-Enhanced
Respite Individual
Respite Day
Community Connector
Community Connector-telehealth
Hippo-Therapy
Hippo-Therapy Group
Massage Therapy
Movement Therapy - Bachelor
Movement Therapy - Masters
Youth Day Service - Individual
Youth Day Service - Group

-The State also received approval through the Long Bill to implement a $15 Base Wage Minimum. The following services received the following increases for this implementation:
Homemaker-Basic Outside Denver 11.754%
Homemaker-Enhanced Outside Denver 8.609%
Respite Individual 11.575%
Respite Day 8.844%
Community Connector 6.835%
Community Connector - Telehealth 6.835%
Notes:
The State received approval for the rate increases through Appendix K CO.4180.R05.19 effective 7/01/2022. The State updated Appendix J to reflect the Appendix K approval and for permanent ongoing approval in the waiver.
For Homemaker services, the State estimates rates based on a weighting of the location in which services are rendered and the rates in each location. The state received a base wage adjustment for services outside of Denver County and updated the weighted rates for this service based on new utilization trends and the updated rates. Due to this weighting, rate increases may not align with the rate increases that were approved in the long bill for counties outside of Denver.
Respite -Individual and Respite Day received a targeted rate increase of 5.47% and 6.68%, respectively in addition to the across-the-board increase.

To calculate the weighted rates, the Department used recent claims data from SFY 2021-22 to more accurately determine the percent of services administered in Denver.

For utilization and units per utilizer projections, the Department utilized data from 372 reports, primarily from the previous two years.

Update for Factor D for Amendment with the requested effective date of 7/1/2023:
For each individual 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.

Historical growth rates: The source of data is 372 waiver reports. The Department reviews data from SFY 2007-08 through SFY 2020-21 but might only include certain SFYs in the development of trends. For example, the Department may look at data from SFY 2007-08 and beyond but apply a trend that only incorporates growth rates from SFY 2019-20 and SFY 2020-21. For this amendment cycle, the Department uses the average growth rate from SFY 2018-19 to SFY 2019-20 and SFY 2019-20 to SFY 2020-21 for unit-per-user trends.

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 SFY 2007-08 however the Department focuses on more recent data for trend development. For utilizer trends, the Department used the fraction of total waiver members who used each service in SFY 2019-20 and SFY 2020-21 in this amendment.

Users: As a base trend to estimate utilizers of each service in SYF 2021-22, the Department multiplied the total expected waiver members times the percent of members who used each service in the previous two state fiscal years (SFY 2019-20 and SFY 2020-21). SFY 2022-23 user estimates are based off of SFY 2020-21 data and SFY 2021-22 estimates. SFY 2023-24 user estimates are based off of SFY 2021-22 and SFY 2022-23 estimates. For example, SFY 2021-22 Respite - Individual estimates equal SFY 2021-22 total members times SFY 2019-20 and SFY 2020-21 percent of total members who used that service.

Average units per user: As a base trend to estimate units per user for each service, the Department multiplied SFY 2019-20 actuals times the average growth rate from SFY 2018-19 to SFY 2019-20 and SFY 2019-20 to SFY 2020-21.

There are a number of exceptions to the application of the base utilization trends described above. Due to a decrease in utilization of some services during the public health emergency (PHE), the Department did forecast utilization for many services using actuals from the PHE (SFY 2019-20 and SFY 2020-21). For example, hippotherapy saw fewer utilizers during the peak of the PHE; however, utilization is expected to increase back to pre-pandemic levels in the future. Furthermore, Most in-person services saw a decrease in utilization beginning in early 2020 of FY 2019-20 through FY 2020-21. This includes Adapted

Therapeutic Recreational Equipment, Assistive Technology, Hippotherapy, Home Accessibility Adaptations, Massage Therapy, Movement Therapy, Parent Education, Respite Individual Day/Group, Youth Day, Specialized Medical Equipment and Supplies, and Vehicle Modification services.

Cost per unit: For negotiated rates and per-purchase services, the Department updated the cost per unit based on SFY 2020-21 actuals.

Update for Factor D for Amendment with the requested effective date of 11/11/2023:

The Department is updating Appendix J Average Cost/Unit to reflect rate increases approved during the recent legislative session through Long Bill SB23-214. The rate increases a 3% Increase, a base wage increase for services outside Denver County to $15.75/hour, and a minimum wage increase to $17.29/hour for services inside Denver County. The increases will be effective on 07/01/2023 through an Appendix K Amendment. The State is updating Appendix J to reflect the Appendix K approval and for permanent ongoing approval in the waiver. The Department's rate sheet that reflects these increases is located at https://hcpf.colorado.gov/provider-rates-fee-schedule. The rate increases by services are as follows.

The 3% ATB increase is being implemented for the following services: Homemaker, Respite (Individual and Day), Community Connector, Hippo-Therapy, Massage Therapy, Movement Therapy, Youth Day Service.c

The base wage increase for services outside Denver County is being implemented for the following services: Homemaker, Respite (Individual and Day), Community Connector.

The Denver County minimum wage increase is being implemented for the following services: Homemaker, Respite (Individual and Day), Community Connector.

The rate for Vehicle Modification and Specialized Medical Equipment and Supplies rate was updated based on the most recently 372 reports.

Update for the Amendment with the requested effective date of 1/1/2024:
The service titled "Parent Education" was changed to "Primary Caregiver Education." There were no changes to the service definition, # Users, Average Units Per User or Average Cost/Unit.
The Department is also updating Appendix J for the addition of Respite provider specialties. Respite will be delegated into three specialties provided by a skilled, therapeutic, or unskilled provider type. This was approved by the passage of the Long Bill for SFY 23-24. The Respite service will now include the additional service components: Respite CNA - 4 hours or less, Respite CNA - 4 hours or more, Therapeutic Respite - 4 hours or less, Therapeutic Respite - 4 hours or more, Skilled In-Home Respite - 4 hours or less, Skilled In-Home Respite - 4 hours or more. The state added "unskilled" to the following Respite components for clarification with the addition of the new skilled specialties: Respite Individual and Respite Day. The state did not make any changes to Respite Group or Respite group Overnight Camp.

The Department analyzed the number of children on the waivers that are currently utilizing 90% or greater of their respite unit limit using MMIS data. The Department assumes that these high-needs children would be likely to access a higher-level of respite care if it were available to them. The Department assumed that there are currently children enrolled in the HCBS-CES waiver who are not utilizing respite services because the current level of care does not meet their significant needs. Therefore, the Department has assumed that an additional 5.0% of the total HCBS-CES waiver population would choose to access Skilled and Therapeutic Respite if it were to become available. The Department has assumed the rates for Skilled and Therapeutic Respite would be identical to the rate for CNA Respite offered under the HCBS-CLLI waiver. The Department used State Fiscal Year 2021-22 MMIS data on the number of people utilizing respite services on the CES waiver, assumed that clients would use up to the current unit limit for services, and estimated the rates based on the current respite rates on other waivers.

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 of Health Care and Policy Financing (the Department) maintains an Interagency Agreement with the Colorado Department of Public Health and Environment (CDPHE) to perform quality assurance and quality improvement activities. This agreement allows CDPHE to conduct surveys of and investigate complaints against Children's Extensive Supports service providers who provide Personal Care, Homemaker, Respite, Community Connector, Hippotherapy, Massage Therapy, Movement Therapy, and Youth Day Services. This includes the responsibilities of enrolling qualified providers by processing applications from interested providers to including assuring that all provider and pre-site visit requirements are met prior to DPHE recommendation to HCPF for program approval.

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

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

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

The Department contracts with a Fiscal Agent which maintains the Medicaid Management Information System (MMIS). The Fiscal Agent is responsible to process claims, assist in the provider enrollment and application process, 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) to review a portion of the waiver targeting criteria. The QIO reviews family and collateral reports and determines if the child meets specific targeting criteria as set forth in 10 CCR 2505-10 8.503.30. A. 8. Be determined by the Utilization Review Contractor (URC) to meet the additional targeting criteria eligibility for the HCBS-CES waiver.

The QIO will be responsible for the management of the Critical Incident Reports (CIR) for the HCBS-CES 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 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.

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

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

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

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

Appendix A: Waiver Administration and Operation

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

Department of Health Care Policy and Financing, The Office of Community Living

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 of Health Care and Policy Financing (The Department) provides on-going oversight of the Interagency Agreement with the Colorado Department of Public Health and Environment (CDPHE) through monthly meetings and reports. Issues that impact the agreement, problems discovered at specific agencies, or widespread issues and solutions are discussed. In addition, the Department is provided with monthly and annual reports detailing the number of agencies that have been surveyed, the number of agencies that have deficiencies, the number of complaints received complaints investigated and complaints that have been substantiated. The Interagency Agreement between the Department and CDPHE requires that all complaints be investigated and reported to the Department. 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 this waiver application.

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

The Department oversees the Case Management Agencies (CMAs). As a part of the overall administrative and programmatic evaluation, the Department conducts annual monitoring for each CMA. The Department reviews agency compliance with regulations at 10 C.C.R. 2505-10 Section 8.500, 8.500.90, and 8.503 et seq.

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 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 using a standardized tool in conjunction with the Benefits Utilization System (BUS) to audit client files and assure that all components of the CCB contract have been performed according to necessary waiver requirements. The BUS is an electronic record used by each CCB to maintain client-specific data. Data include 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 a notice of action requirements to assure that processes are completed according to Department prescribed schedules. The Department reviews a sample of client files to measure the accuracy of documentation and track appropriateness of services based upon the LOC determination. Additionally, the sample is used to evaluate compliance with the aforementioned case management functions. These methods are outlined in more detail in Appendix H of this waiver application. 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 oversees the fiscal agent operating the Medicaid Management Information System (MMIS). The fiscal agent is required to submit weekly reports to the Department on meeting performance standards as established in the

contract. The reports include summary data on timely and accurate coding, claims submission, and claims reimbursement, time frames for completion of data entry, processing of claims, and Prior Authorizations. The Department 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 Department is able to request ad hoc reports as needed to monitor any additional issues or concerns.

The Department has oversight of the QIO contractor 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	☒	☐	☐
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**

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

Performance Measure:
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 Administrative functions
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

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

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

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

Data Aggregation and Analysis:

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

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

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

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

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

Data Aggregation and Analysis:

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

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

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

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

		Confidence Interval =
☒ **Other** Specify: DOLA-DOH	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:

A.16 Number and percent of quality inspections performed by DOLA-DOH during the

performance review period N: Number of quality inspections completed for Home Modifications during the performance period D: Total number of inspections for Home Modification required to be completed during the performance period

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
A.19 Number and percent of deficiencies identified during the state monitoring activities that were appropriately and timely remediated by the contracted entity N:Number of deficiencies identified during the state monitoring activities that were appropriately and timely remediated by the contracted entity D:Total number of deficiencies identified during the states monitoring activities

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:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify:

		Random sample of 2 contracted entities (excluding CMAs)
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

Responsible Party for data 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**

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

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

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

A.2
The 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, number of complaints received, investigated, and substantiated. Oversight is through monthly meetings and reports. Issues that impact the agreement, problems discovered at specific agencies or widespread issues and solutions are discussed.

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

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

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

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

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

A.20
The Dept. delegates responsibility to CMAs to perform waiver operative functions including waiver operational and administrative services, general case management, functional and level of care assessment, service planning, referral care coordination, utilization review, the prior authorization of waiver services within limits, and service monitoring, reporting, and follow up.

The Dept. audits CMAs for administrative functions including: qualifications of individuals performing assessments and service planning; process regarding evaluation of need, service planning, participant monitoring (contacts), case reviews, complaint procedures, provision of participant choice, etc.

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

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.15, A.16, A.19, 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.14
If a deficiency is identified, the Dept. will issue a corrective action plan request to the vendor, in which the vendor must create a plan that addresses the deficiency and return to contractual compliance.

A.20
If problems are identified during a CMA audit, the Dept. communicates findings directly with the CMA administrator, and documents findings in the CMA's annual report of audit findings, and if needed, requires corrective action.
The Dept. conducts follow-up monitoring to assure corrective action implementation and ongoing compliance. In addition, the contract with CMAs allows 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.

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 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**			☐
	☐	**Technology Dependent**			☐
☒ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☒	**Developmental Disability**	0	17	☐
	☐	**Intellectual Disability**			☐
☐ **Mental Illness**					
	☐	**Mental Illness**			☐
	☐	**Serious Emotional Disturbance**			

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

The Department has codified additional eligibility criteria at 10 CCR 2505 – 10 8.503.30. This CES client eligibility section defines additional criteria for the CES waiver as:

1. Unmarried and less than eighteen years of age,
2. Be determined to have a Developmental Disability which includes Developmental Delay if under (five) 5 years of age, (Developmental Disability and Developmental Delay are defined at 8.600.4)
3. Reside in an eligible HCBS-CES waiver setting is defined as the following:,
   a. With biological, adoptive parent(s), or legal Guardian,
   b. In an out-of-home placement and can return home with the provision of HCBS-CES waiver services with the following requirement:
      i. The case manager will work in conjunction with the residential caregiver to develop a transition plan that includes timelines and identified services or supports requested during the time the Client is not residing in the Family home. The case manager will submit the transition plan to the Department for approval prior to the start of services.
4. Be determined by the Department or its agent to meet the following behavioral and/or medical need:,
   a. The individual demonstrates a behavior or has a medical condition that requires direct human intervention, more intense than a verbal reminder, redirection or brief observation of status, at least once every two hours during the day and on a weekly average of once every three hours during the night. The behavior or medical condition must be considered beyond what is typically Age Appropriate and due to one or more of the following conditions:
      i. A significant pattern of self-endangering behavior or medical condition which, without intervention will result in a life-threatening condition or situation. Significant pattern is defined as the behavior or medical condition that is harmful to self or others as evidenced by actual events occurring within the past six (6) months,
      ii. A significant pattern of serious aggressive behavior toward self, others or property. Significant pattern is defined as the behavior is harmful to self or others, is evidenced by actual events occurring within the past six (6) months, or
      iii. Constant vocalizations such as screaming, crying, laughing or verbal threats which cause emotional distress to caregivers. The term constant is defined as on the average of fifteen (15) minutes each waking hour.
   b. In the instance of an annual reassessment, the reassessment must demonstrate in the absence of the existing interventions or preventions provided through Medicaid that the intensity and frequency of the behavior or medical condition would resume to a level that would meet the criterion listed above.
5. Receives at least one (1) HCBS-CES waiver service each calendar month,
6. Is not simultaneously enrolled in any other HCBS waiver, and
7. Is not residing in a hospital, nursing facility, ICF-IID, other institution or correctional facility.

Developmental Disability means a disability that:

A. Is manifested before the person reaches twenty-two (22) years of age;

B. Constitutes a substantial disability to the affected individual, as demonstrated by the criteria below at C, 1 and/or C, 2; and,

C. Is attributable to an intellectual and developmental disability or related conditions which include Prader-Willi Syndrome, cerebral palsy, epilepsy, autism, or other neurological conditions when such conditions result in impairment of general intellectual functioning or adaptive behavior similar to that of a person with an intellectual or developmental disability. Unless otherwise specifically stated, the federal definition of “developmental disability” found at 42 U.S.C. Section 15002, et seq., shall not apply.

1. “Impairment of general intellectual functioning” means that the person has been determined to have a full scale intellectual equivalent which is two or more standard deviations below the mean (70 or less assuming a scale with a mean of 100 and standard deviation of 15).
   a. A secondary score comparable to the General Abilities Index for a Wechsler Intelligence Scale that is two or more standard deviations below the mean may be used only if a full scale score cannot be appropriately derived.
   b. Score shall be determined using a norm-referenced, standardized test of general intellectual functioning comparable to a comprehensively administered Wechsler Intelligence Scale or Stanford-Binet Intelligence Scales, as revised or current to the date of administration. The test shall be administered by a licensed psychologist or a school psychologist.
   c. When determining the intellectual quotient equivalent score, a maximum confidence level of ninety percent (90%) shall be applied to the full scale score to determine if the interval includes a score of 70 or less and shall be interpreted to the benefit of the applicant being determined to have a developmental disability.
2. “Adaptive behavior similar to that of a person with intellectual disability” means that the person has an overall adaptive behavior composite or equivalent score that is two or more standard deviations below the mean.
   a. Measurements shall be determined using a norm-referenced, standardized assessment of adaptive behaviors that

is appropriate to the person's living environment and comparable to a comprehensively administered Vineland Scale of Adaptive Behavior, as revised or current to the date of administration. The assessment shall be administered and determined by a professional qualified to administer the assessment used.

b. When determining the overall adaptive behavior score, a maximum confidence level of ninety percent (90%) shall be applied to the overall adaptive behavior score to determine if the interval includes a score of 70 or less and shall be interpreted to the benefit of the applicant being determined to have a developmental disability.

Developmental Delay means that a child meets one or more of the following:

A. A child who is less than five (5) years of age at risk of having a developmental disability because of the presence of one or more of the following:

1. Chromosomal conditions associated with delays in development,
2. Congenital syndromes and conditions associated with delays in development,
3. Sensory impairments associated with delays in development,
4. Metabolic disorders associated with delays in development,
5. Prenatal and perinatal infections and significant medical problems associated with delays in development,
6. Low birth weight infants weighing less than 1200 grams, or
7. Postnatal acquired problems resulting in delays in development.

B. A child less than five (5) years of age who is significantly delayed in development in one or more of the following areas:

1. Communication,
2. Adaptive behavior,
3. Social-emotional,
4. Motor,
5. Sensory, or
6. Cognition.

C. A child less than three (3) years of age who lives with one or both parents who have a developmental disability.

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:

The Department monitors each of the individuals enrolled in the CES waiver and ensures that when the child is going to age out of the CES program that an enrollment is available to transition to the Supported Living Services (SLS) waiver or the waiver for Individuals with Developmental Disabilities (DD), which provides very similar types of services for the adult population.

The case manager is responsible to complete the transition. At least 90 days prior to the individual’s 18th birthday the case manager meets with the family to begin the SLS enrollment process. On the day prior to the 18th birthday the recipient terminates CES and on the 18th birthday is enrolled in the appropriate HCBS waiver.

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.

This waiver has a spending limitation of $40,552.29. The State analyzes the other sources of payment/services including those provided by the parents, the school systems, third party payers, and EPSDT to ensure that the child's needs can be met within the spending limitation. The average expenditure per unduplicated recipient for the past five years has been approximately $15,500. The combination of all the resources has been successful in keeping children at home. If the child's need for waiver services exceeds the $40,552.29 level the State would need to determine whether this child's health and safety can adequately met under this waiver or the child should be referred to other services that are more appropriate such as the Children's Habilitation Residential Program.

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

◉ **The following dollar amount:**

Specify dollar amount: 40552

The dollar amount *(select one)*

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

Specify the formula:

◉ **May be adjusted during the period the waiver is in effect. The state will submit a waiver**

amendment to CMS to adjust the dollar amount.

○ **The following percentage that is less than 100% of the institutional average:**

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Children live in the family home and receive the majority of their care from their family, who assures the health and safety of the child. During the application process and the development of the Person-Centered Support Plan (PCSP), the service needs and the potential sources of the services are identified. The contribution of each source is assessed. If the cost of waiver services for the child would exceed the individual cost limit, the family and case manager would review the PCSP and prioritize approval only for those identified waiver supports and services waiver that assure health and safety. If the waiver service cost would still exceed the limit then the child would be referred to another waiver and would receive notice of the Fair Hearing process.

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:

Children live in the family home and receive the majority of their care from their family, who assures the health and safety of the child. Should the cost of care for a child exceed the individual cost limit, the family and case manager shall meet to review the Service Plan and prioritize those identified supports and services to assure health and safety. Should the service needs increase so that they can no longer be met through the Children's Extensive Support waiver , the child would be eligible for the Children's Residential Habilitation Residential Program, which has the ability to provide a higher level of support.

At the time the Service Plan is developed and during any subsequent amendments to the Service Plan, the Case Manager provides information and referral to family members of minor recipients. Case managers provide ongoing monitoring of services and supports identified on the Service Plan to assure the recipient is receiving the service, and the services are having the intended effect. At any time a need for additional information or referral is evident, the Case Manager provides it.

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	2243
Year 2	2402
Year 3	2630
Year 4	2823
Year 5	3220

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	

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 5	

Appendix B: Participant Access and Eligibility

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

- ◉ **Waiver capacity is allocated/managed on a statewide basis.**
- ○ **Waiver capacity is allocated to local/regional non-state entities.**

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

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

8.503.60 WAITLIST PROTOCOL
8.503.60.A When the HCBS-CES waiver reaches capacity for enrollment, a client determined eligible for HCBS-CES waiver benefits shall be placed on a statewide wait list in accordance with these rules.
1. The Community Centered Board shall determine if an applicant has developmental delay if under age five (5), or developmental disability if over age five (5) prior to submitting the HCBS-CES waiver application to the utilization review contractor. Only a client who is determined to have a developmental delay or developmental disability may apply for HCBS-CES waiver.
2. In the event a client who has been determined to have a developmental delay is placed on the wait list prior to age five (5), and that client turns five (5) while on the HCBS-CES waiver wait list, a determination of developmental disability must be completed in order for the client to remain on the wait list.
3. The case management agency shall complete the Functional Needs Assessment, as defined in Department rules, to determine the client's Level of Care.
4. The case management agency shall complete the HCBS-CES waiver application with the participation of the family. The completed application and a copy of the Functional Needs Assessment that determines the client meets the ICF/MR level of care shall be submitted to the Utilization Review Contractor within fourteen (14) calendar days of parent signature.
5. Supporting documentation provided with the HCBS-CES waiver application shall not be older than six (6) months at the time of submission to the utilization review contractor.
6. The utilization review contractor shall review the HCBS-CES waiver application. In the event the utilization review contractor needs additional information, the case management agency shall respond within two (2) business days of request.
7. Any client determined eligible for services under the HCBS-CES waiver when services are not immediately available within the federally approved capacity limits of the HCBS-CES waiver, shall be eligible for placement on a single statewide wait list in the order in which the utilization review contractor received the eligible HCBS-CES waiver application. Applicants denied program enrollment shall be informed of the client's appeal rights in accordance with 10 CCR 2505-10, Section 8.057.
8. The case management agency will create or update the consumer record to reflect the client is waiting for the HCBS-CES waiver with the wait list date as determined by the utilization review contractor.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

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

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

- ( ) **No**
- (●) **Yes**

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

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

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

☒ **SSI recipients**

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

☒ **Optional state supplement recipients**

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

Select one:

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

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

Specify percentage:

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

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

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

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

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

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

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

Specify:

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

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

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

Select one and complete Appendix B-5.

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

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

Check each that applies:

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

Select one:

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

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

Specify percentage:

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

Specify dollar amount:

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

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

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

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

Select one:

○ **100% of FPL**

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

Select one:

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

(*select one*):

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

Specify the percentage:

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

Specify dollar amount:

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

Specify percentage:

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

Specify:

○ **The following dollar amount**

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

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

Specify:

○ **Other**

Specify:

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

◉ **Not Applicable**

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

Specify:

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

○ **SSI standard**

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

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

Specify:

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

○ **Not Applicable (see instructions)**

◉ **AFDC need standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

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

Specify:

○ **Other**

Specify:

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

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

Select one:

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

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

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

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

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

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

  Specify formula:

  The allowance for personal needs is equal to 300% of the SSI standard
- ○ **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:

- ◉ **Other**

Specify:

Community Centered Boards (CCBs). These agencies are private nonprofit corporations.

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 LOC Screen utilizing the prescribed LOC Screen instrument to determine an individual's need for intermediate care facility for individuals with intellectual disabilities (ICS-IID) 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 level of care.

Copies of the LOC Screen form and the laws, regulations, policies concerning the level of care criteria are available to CMS upon request

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:

On initial evaluation, the case manager performs a face-to-face LOC Screen of the participant's abilities to perform activities of daily living and need for supervision due to behavioral, memory, or cognitive issues. The LOC Screen is conducted at the individual's place of residence through observation, participant, and collateral interviews (e.g. family, legal guardian, and natural supports). The participant's primary care provider and medical professionals may also provide information. Case managers are required to complete a participant re-screening within twelve months of the previous assessment. A re-screening may be completed sooner if the participant's condition changes, if required by program criteria, or if requested by the participant or the participant's guardian. CMAs may use phone or telehealth to complete the LOC screen when there is a documented safety risk to the case manager or client, including public health emergencies as determined by state and federal government.

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

- ( ) **Every three months**
- ( ) **Every six months**
- (●) **Every twelve months**
- ( ) **Other schedule**

  Specify the other schedule:

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

- (●) **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ( ) **The qualifications are different.**

  Specify the qualifications:

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

The CCB is required to track the re-evaluation due dates and complete them on a timely basis for each participant. The Department has two processes to assure timeliness.

1. The Prior Authorization Request (PAR) contains the Long Term Care Certification span. The detailed PAR information, including the certification end date, is uploaded into the Medicaid Management Information System and controls the time period for which claims pay. A new PAR cannot be submitted without the re-evaluation being completed so payment is not made when the re-evaluation is not completed.

2. The Department surveys CCBs for timely completion of annual re-evaluations during on-site reviews and through desk audits of participants' electronic records using the State's case management IT system. The annual program evaluation includes review of a representative sample of participant records to ensure LOC Screens and re-screens 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:

Case Management Agencies 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** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Performance Measures

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

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

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

Performance Measures

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

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

Performance Measure:

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

Data Source (Select one):
Record reviews, on-site
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 and +/- 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:
B.c.3 Number and percent of new waiver participants for whom a PMIP was completed N: Number of new waiver participants for whom a PMIP was completed D: Total number of new waiver participants reviewed

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

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

		95% confidence level and +/- 5% margin of error
☒ **Other** Specify: Case Management Agency	☒ **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 Department utilizes the Super Aggregate Report as the primary data source for monitoring the Level of Care (LOC) assurance and performance measures. The Super Aggregate Report is a custom report consisting of two parts: data pulled directly from the state's case management IT system, the Bridge, and data received from the annual program evaluations document, the QI Review Tool. (Some performance measures use State's case management IT system only data, some use QI Review Tool only data, and some use a combination of State's case management IT system 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.

Case managers complete a LOC Screen utilizing the prescribed LOC Screen instrument. The LOC Screen instrument 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 LOC Screens, the Professional Medical Information Page (PMIP)is also required to be completed by a treating medical professional who verifies the participant's need for ICF-IID level of care.

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

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

b. Methods for Remediation/Fixing Individual Problems

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

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

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

ii. Remediation Data Aggregation

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

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

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

The child's parents and/or legal guardian or representative are informed of any feasible alternatives under the waiver and given choice of either institutional or home and community based services during the initial LOC Screen and Person-Centered Support Planning (PCSP) process, and at time of continued stay reviews. Case managers identify the child's needs and supports through completion of a LOC Screen and through the Person-Centered Support Planning process with the participant and/or legal representative. Based on this assessment and discussion with the child's parents and/or legal guardian or representative, a PCSP is developed. All forms completed through the LOC Screen and PCSP processes are available for signature through digital or wet signatures based on the member's preference. Case managers complete a PCSP information and summary form that is reviewed with the child's parents and/or legal guardian or legal representative and provides the child's parents and/or legal guardian or representative with a choice of providers as well as choice of whether these services will be provided in the community or in an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID).

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 copies of freedom of choice documentation are maintained at the Case Management Agency and in the State's case management IT system which is accessible by 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):

The CCB agencies employ several methods to assure meaningful access to waiver services by Limited English Proficiency persons. The CCB agencies either employ or have access to Spanish and other language speaking persons to provide translation to participants. Documents include a written statement in Spanish instructing participants how to obtain assistance with translation. For languages where there are no staff who can translate on site, translation occurs by first attempting to have a family member translate, or aligning with specific language or ethnic centers such as the Asian/Pacific Center, or by using the Language Line available through the American Telephone & Telegram.

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	**Homemaker**		
Statutory Service	**Respite**		
Other Service	**Adaptive Therapeutic Recreational Equipment and Fees**		
Other Service	**Assistive Technology**		
Other Service	**Community Connector**		
Other Service	**Hippotherapy**		
Other Service	**Home Accessibility Adaptations**		
Other Service	**Massage Therapy**		
Other Service	**Movement Therapy**		
Other Service	**Primary Caregiver Education**		
Other Service	**Specialized Medical Equipment and Supplies**		
Other Service	**Vehicle Modifications**		
Other Service	**Youth Day Service**		

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:

Homemaker

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08050 homemaker
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Basic Homemaker Services
Services that consist of the performance of basic household tasks within the participant's primary residence (i.e., cleaning, laundry, or household care) including maintenance which are related to the participant's disability and provided by a qualified homemaker, when the parent or primary caretaker is unable to manage the home and care for the participant in the home. This assistance must be due to the participant's disability that results in additional household tasks and increases the parent/caregiver's ability to provide care needed by the participant. This assistance may take the form of hands-on assistance (actually performing a task for the participant) or cuing to prompt the participant to perform a task.

Enhanced Homemaker Services
Services provided by a qualified homemaker that consist of the same household tasks as described under Basic Homemaker services with the addition of either habilitation or extraordinary cleaning.

Habilitation includes direct training and instruction to the participant, which is more than basic cuing to prompt the participant to perform a task. Habilitation shall include a training program with specific objectives and anticipated outcomes. There may be some amount of incidental basic homemaker services that is provided in combination with enhanced homemaker services, however, the primary intent must be to provide habilitative services to increase independence of the participant.

Habilitation may include some hands-on assistance (actually performing a task for the participant) or cuing to prompt the participant to perform a task, only when such support is incidental to the habilitative services being provided and the primary duties must be to provide habilitative services to increase independence of the participant.

Enhanced Homemaker services also include the need for extraordinary cleaning as a result of the participant's behavioral or medical needs.

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

Parents of the individual receiving services by virtue of blood or adoption, may be employed by a Program Approved Service Agency to provide Homemaker services. Parents employed by an agency shall meet the same experience and qualification standards required of all agency employees.

There is a 2,080 annual unit cap for parents to provide this 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	Community Centered Board (CCB)/Organized Health Care Delivery System (OHCDS)
Agency	Program Approved Service Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Agency

Provider Type:

Community Centered Board (CCB)/Organized Health Care Delivery System (OHCDS)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Program Approval

Other Standard *(specify):*

Direct Care Staff: Be at least 18 years of age, have the ability to communicate effectively, complete required forms and reports, and follow verbal and written instructions. Have the ability to provide services in accordance with a Service Plan. Have completed minimum training based on State training guidelines. Have necessary ability to perform the required job tasks and have the interpersonal skills needed to effectively interact with persons with developmental disabilities.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy & Financing and Department of Public Health & Environment

Frequency of Verification:

Verification of provider qualification is completed upon initial Medicaid enrollment and every five years through provider revalidation, as well as through the DPHE survey process initially and every three years.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Agency

Provider Type:

Program Approved Service Agency

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

Program Approval

Other Standard *(specify):*

Direct Care Staff: Be at least 18 years of age, have the ability to communicate effectively, complete required forms and reports, and follow verbal and written instructions. Have the ability to provide services in accordance with a Service Plan. Have completed minimum training based on State training guidelines. Have necessary ability to perform the required job tasks and have the interpersonal skills needed to effectively interact with persons with developmental disabilities.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy & Financing and Department of Public Health & Environment

Frequency of Verification:

Verification of provider qualification is completed upon initial Medicaid enrollment and every five years through provider revalidation, as well as through the DPHE survey process initially and every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

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

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Respite service is provided on a short-term basis, because of the absence or need for relief to caregivers of the participant. Respite is to be provided in an age appropriate manner.

Respite may be provided on an individual or group basis in the residence of the participant or respite care provider or in the community. Respite may be provided on an overnight group basis only by facilities approved to provide supervised overnight group accommodations.

Federal financial participation is not to available for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence. Respite services shall be billed according to a unit rate or daily rate whichever is less.

Respite shall be provided based on individual or group rates as defined below:

Individual: the client receives respite in a one-on-one situation. There are no other clients in the setting also receiving respite services. Individual respite occurs for ten (10) hours or less in a twenty four (24)-hour period.

Individual day: the client receives respite in a one-on-one situation for cumulatively more than 10 hours in a 24-hour period. A full day is 10 hours or greater within a 24- hour period.

Overnight group: the client receives respite in a setting which is defined as a facility that offers 24-hour supervision through supervised overnight group accommodations. The total cost of overnight group within a 24-hour period shall not exceed the respite daily rate.

Group: the client receives care along with other individuals, who may or may not have a disability. The total cost of group within a 24-hour period shall not exceed the respite daily rate.

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

The total amount of respite provided in one plan year may not exceed 30 days and 1,880 additional 15 minute units in a plan year. The Department may approve a higher amount based on a documented increase in medical or behavioral needs as reflected in the behavior plan for behavioral needs or in the medical records for medical needs.

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	Program Approved Service Agency
Agency	Community Centered Board (CCB)/Organized Health Care Delivery System (OHCDS)

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Program Approved Service Agency

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

Program Approval

Respite care may be provided by a skilled, therapeutic, or unskilled provider.

A skilled respite provider would either be a licensed RN/LPN or certified CNA. Skilled respite is for clients with ongoing medical needs that can only be provided by an RN/LPN or CNA (i.e. suctioning).

A therapeutic respite provider would be a direct care professional that has completed at least 40 hours of training in crisis prevention, de-escalation, and intervention. Training must compass the following components: trauma informed care, youth mental health first aid, positive behavior supports, behavior intervention, de-escalation techniques, cultural competency, family systems and family engagement, child and adolescent development, mental health topics and services, substance abuse topics and services, psychotropic medications, intellectual and developmental disabilities, and child/youth specific training. Annual refresher training is required. Therapeutic respite is for clients with ongoing behavioral support needs provided by a specially trained and certified support staff.

Unskilled respite if for clients that will not have any medical needs that will need to be attended to (such as G-Tube feeding) or behavior support needs are met by unlicensed support staff.

Other Standard *(specify):*

Direct Care Staff: Be at least 18 years of age, have the ability to communicate effectively, complete required forms and reports, and follow verbal and written instructions. Have the ability to provide services in accordance with a Service Plan. Have completed minimum training based on State training guidelines. Have necessary ability to perform the required job tasks and have the interpersonal skills needed to effectively interact with persons with developmental disabilities

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy and Financing and Department of Public Health and Environment

Frequency of Verification:

Verification of provider qualification is completed by HCPF upon initial Medicaid enrollment and every five years through provider revalidation, as well as through the CDPHE survey process initially and every three years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Community Centered Board (CCB)/Organized Health Care Delivery System (OHCDS)

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

Program Approval

Respite care may be provided by a skilled, therapeutic, or unskilled provider.

A skilled respite provider would either be a licensed RN/LPN or certified CNA. Skilled respite is for clients with ongoing medical needs that can only be provided by an RN/LPN or CNA (i.e. suctioning).

A therapeutic respite provider would be a direct care professional that has completed at least 40 hours of training in crisis prevention, de-escalation, and intervention. Training must compass the following components: trauma informed care, youth mental health first aid, positive behavior supports, behavior intervention, de-escalation techniques, cultural competency, family systems and family engagement, child and adolescent development, mental health topics and services, substance abuse topics and services, psychotropic medications, intellectual and developmental disabilities, and child/youth specific training. Annual refresher training is required. Therapeutic respite is for clients with ongoing behavioral support needs provided by a specially trained and certified support staff.

Unskilled respite if for clients that will not have any medical needs that will need to be attended to (such as G-Tube feeding) or behavior support needs are met by unlicensed support staff.

Other Standard *(specify):*

Direct Care Staff: Be at least 18 years of age, have the ability to communicate effectively, complete required forms and reports, and follow verbal and written instructions. Have the ability to provide services in accordance with a Service Plan. Have completed minimum training based on State training guidelines. Have necessary ability to perform the required job tasks and have the interpersonal skills needed to effectively interact with persons with developmental disabilities

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy and Financing and Department of Public Health and Environment

Frequency of Verification:

Verification of provider qualification is completed by HCPF upon initial Medicaid enrollment and every five years through provider revalidation, as well as through the CDPHE survey process initially and every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Adaptive Therapeutic Recreational Equipment and Fees

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Adaptive Therapeutic Recreational Equipment and Fees are services that assist a client to recreate within their community. These services include recreational equipment that is adapted specifically to the client's disability and not those items that a typical age peer would commonly need as a recreation item.

a. The cost of the item shall be above and beyond what is typically expected for recreation and recommended by a doctor or therapist.
b. Adaptive recreational equipment may include an adaptive bicycle, adaptive stroller, adaptive toys, floatation collar for swimming, various types of balls with internal auditory devices, and other types of equipment appropriate for the recreational needs of a client with an intellectual and developmental disability.
c. A pass for admission to recreation centers only when needed to access professional services. Recreation passes shall be purchased as day passes or monthly passes, whichever is the more cost-effective.
d. Fees for water safety training are allowable.

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

The maximum annual allowance for adaptive recreational equipment and fees is $1,000.00 per plan year.

The following are excluded and not eligible for reimbursement under this service: entrance fees for zoos, museums, the Butterfly Pavilion, movies, theaters, concerts, professional or minor league sporting events, outdoor play structures, batteries for items, and passes for family admission to recreation centers.

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	Enrolled Medicaid Provider
Agency	Community Centered Board (CCB)/Organized Health Care Delivery System (OHCDS)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adaptive Therapeutic Recreational Equipment and Fees

Provider Category:

Agency

Provider Type:

Enrolled Medicaid Provider

Provider Qualifications

License *(specify):*

The provider shall have all licensures required by the State of Colorado for the performance of the service or support being provided.

Certificate *(specify):*

Program Approval

Other Standard *(specify):*

The product or service to be delivered shall meet all applicable manufacturer specifications, state and local codes, and Uniform Federal Accessibility Standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy and Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adaptive Therapeutic Recreational Equipment and Fees

Provider Category:

Agency

Provider Type:

Community Centered Board (CCB)/Organized Health Care Delivery System (OHCDS)

Provider Qualifications

License *(specify):*

The provider shall have all licensures required by the State of Colorado for the performance of the service or support being provided.

Certificate *(specify):*

Program Approval

Other Standard *(specify):*

The service to be delivered shall meet all applicable manufacturer specifications, state and local codes, and Uniform Federal Accessibility Standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy and Financing; Colorado Department of Public Health and Environment

Frequency of Verification:

Verification of provider qualification is completed upon initial Medicaid enrollment and every five years through provider revalidation, as well as through the DPHE survey process initially and every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Assistive Technology

HCBS Taxonomy:

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

Service Definition *(Scope):*

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

Assistive technology device means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of participants. Assistive technology service means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device. Assistive technology includes:
(1) The evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant;
(2) Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;
(3) Training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and
4) Skill acquisition devices which are proven to be a cost-effective and efficient means to meet the need and which make learning easier, such as adaptations to computers, or computer software related to the person's disability.

Purchase, training, or maintenance of service animals is specifically excluded.

Assistive Technology devices and services are only available when the cost is higher than typical expenses, are limited to the most cost-effective and efficient means to meet the need, and are not available through a third-party resource. All medically necessary items that are covered under the Durable Medical Equipment or EPSDT benefit within the state plan shall be accessed first.

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

The total cost of home accessibility adaptations, vehicle modifications, and assistive technology may not exceed $10,000 over the life of the waiver except that on a case-by-case basis the Department may approve a higher amount, to ensure the health, welfare, and safety of the participant or that enable the participant to function with greater independence in the home, or if it decreases the need for paid assistance in another waiver service on a long-term basis.

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	Enrolled Medicaid Provider
Agency	Community Centered Board (CCB)/Organized Health Care Delivery System (OHCDS)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Enrolled Medicaid Provider

Provider Qualifications

License *(specify):*

The provider shall have all licensures required by the State of Colorado for the performance of the service or support being provided.

Certificate *(specify):*

Program Approval

Other Standard *(specify):*

The product or service to be delivered shall meet all applicable manufacturer specifications, state and local codes, and Uniform Federal Accessibility Standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy and Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Community Centered Board (CCB)/Organized Health Care Delivery System (OHCDS)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Program Approval

Other Standard *(specify):*

The product or service to be delivered shall meet all applicable manufacturer specifications, state and local building codes, and Uniform Federal Accessibility Standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy and Financing

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Connector

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04070 community integration
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Supports the abilities and skills necessary to enable the individual to access typical activities and functions of community life such as those chosen by the general population. Community Connector provides a wide variety of opportunities to facilitate and build relationships and natural supports in the community while utilizing the community as a learning environment to provide services and supports as identified in the participant's service plan. These activities are conducted in a variety of settings in which participants interact with non-disabled individuals (other than those individuals who are providing services to the participant). These types of services may include socialization, adaptive skills, and personnel to accompany and support the individual in community settings, resources necessary for participation in activities and supplies related to skill acquisition, retention, or improvement. Community Connector is provided on a one-to-one basis as a learning environment to provide instruction when identified in the Service Plan.

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

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

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

The cost of admission to professional or minor league sporting events, movies, theater, concert tickets or any activity that is entertainment in nature or any food or drink items are specifically excluded under the HCBS-CES waiver and shall not be reimbursed.

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

Parents of the individual receiving services by virtue of blood or adoption, may be employed by a Program Approved Service Agency to provide the Community Connector Service. Parents employed by an agency shall meet the same experience and qualification standards required of all agency employees.

There is a 2,080 annual unit cap for parents to provide this 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	Program Approved Service Agency
Agency	Community Centered Board (CCB)/ Organized Health Care Delivery System (OHCDS)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Connector

Provider Category:

Agency

Provider Type:

Program Approved Service Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Program Approval

Other Standard *(specify):*

Direct Care Staff: Be at least 18 years of age, have the ability to communicate effectively, complete required forms and reports, and follow verbal and written instructions. Have the ability to provide services in accordance with a Service Plan. Have completed minimum training based on State training guidelines. Have necessary ability to perform the required job tasks and have the interpersonal skills needed to effectively interact with persons with developmental disabilities.

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;

•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:

The Department of Health Care Policy and Financing and Department of Public Health and Environment

Frequency of Verification:

Verification of provider qualification is completed upon initial Medicaid enrollment and every five years through provider revalidation, as well as through the CDPHE survey process initially and every three years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Connector

Provider Category:

Agency

Provider Type:

Community Centered Board (CCB)/ Organized Health Care Delivery System (OHCDS)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Program Approval

Other Standard *(specify):*

Direct Care Staff: Be at least 18 years of age, have the ability to communicate effectively, complete required forms and reports, and follow verbal and written instructions. Have the ability to provide services in accordance with a Service Plan. Have completed minimum training based on State training guidelines. Have necessary ability to perform the required job tasks and have the interpersonal skills needed to effectively interact with persons with developmental disabilities.

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;

•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:

The Department of Health Care Policy and Financing and Department of Public Health and Environment

Frequency of Verification:

Verification of provider qualification is completed upon initial Medicaid enrollment and every five years through provider revalidation, as well as through the DPHE survey process initially and every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Hippotherapy

HCBS Taxonomy:

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

Service Definition *(Scope):*

Hippotherapy is a therapeutic treatment strategy that uses the movement of the horse to assist in the development/enhancement of skills: gross motor, sensory integration, attention, cognitive, social, behavioral and communication. The use of this service is only available from a provider who is licensed, certified, registered and/or accredited by an appropriate national accreditation association. This service must be used as a treatment strategy for an identified medical or behavioral need. The need should be outlined in the individualized service plan. A Medicaid State Plan therapist/physician must identify the need this treatment strategy shall meet with a goal. The Medicaid State Plan therapist/physician will monitor the progress towards meeting this goal at least quarterly.

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

Hippotherapy cannot be available under the regular Medicaid State Plan, EPSDT or from a third-party source.

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	Community Centered Board (CCB)/Organized Health Care Delivery System (OHCDS)
Agency	Program Approved Service Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Hippotherapy

Provider Category:

Agency

Provider Type:

Community Centered Board (CCB)/Organized Health Care Delivery System (OHCDS)

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.

Certificate *(specify):*

The service to be delivered shall meet all applicable state certification requirements for the performance of the support or service being provided and program approval.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy & Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Hippotherapy

Provider Category:

Agency

Provider Type:

Program Approved Service Agency

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.

Certificate *(specify):*

The service to be delivered shall meet all applicable state certification requirements for the performance of the support or service being provided and program approval.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy & Financing and the Department of Public Health & Environment

Frequency of Verification:

Verification of provider qualification is completed upon initial Medicaid enrollment and every five years through provider revalidation, as well as the DPHE survey process initially and every three years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home Accessibility Adaptations

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

Those physical adaptations to the primary residence of the participant's family, required by the participant's service plan, are necessary to ensure the health, welfare, and safety of the participant or that enable the participant to function with greater independence in the home. All adaptations shall be the most cost-effective means to meet the identified need. Such adaptations include the installation of fencing, ramps, and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant. Excluded are those adaptations or improvements to the home that are of general utility (e.g., carpeting, roof repair, central air conditioning, etc.) and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair). Any request to add square footage to the home requires approval by the Department or its agent. Home accessibility adaptations are reviewed with the case manager and outlined in the person centered service plan to confirm the participant will meet the assessed need prior to approval and completion of work. All devices and adaptations shall be provided in accordance with applicable State or local building codes and/or applicable standards of manufacturing, design, and installation. All medically necessary items that are covered under the Durable Medical Equipment or EPSDT benefit within the state plan shall be accessed first.

The Home Accessibility Adaptations service under this waiver is limited to additional services not otherwise covered under the state plan, but consistent with the waiver objectives of avoiding institutionalization.

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

The total cost of home accessibility adaptations, vehicle modifications, and assistive technology shall not exceed $10,000 over the life of the waiver except that, on a case-by-case basis, the Department or its agent may approve a higher amount, to ensure the health, welfare, and safety of the participant or that enable the participant to function with greater independence in the home, or if it decreases the need for paid assistance in another waiver service on a long-term basis.

During the Public Health Emergency (PHE), some individuals on the waiver will have exceeded the waiver lifecycle capas there is a temporary $10,000 increase, $20,000 total, to the service limit to help members continue to live in their home and the community. This increase will continue through December 31, 2024 to ensure continuity of operations and assurance of client health, safety, and welfare within waiver benefits due to the COVID-19 pandemic. Beginning January 1, 2025, the waiver lifecycle cap will resume to $10,000 per individual.

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	Contractor Agency
Agency	Community Centered Board (CCB)/Organized Health Care Delivery System (OHCDS)
Individual	Licensed Building Contractor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Accessibility Adaptations

Provider Category:

Agency

Provider Type:

Contractor Agency

Provider Qualifications

License *(specify):*

The product or service to be delivered shall meet all applicable state licensing requirements for the performance of the support or service being provided.

Certificate *(specify):*

Program Approval

Other Standard *(specify):*

The product or service to be delivered shall meet all applicable manufacturer specifications, state and local building codes, and Uniform Federal Accessibility Standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy and Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Accessibility Adaptations

Provider Category:

Agency

Provider Type:

Community Centered Board (CCB)/Organized Health Care Delivery System (OHCDS)

Provider Qualifications

License *(specify):*

The provider shall have all licensures required by the State of Colorado for the performance of the service or support being provided.

Certificate *(specify):*

Program Approval

Other Standard *(specify):*

The product or service to be delivered shall meet all applicable manufacturer specifications, state and local building codes, and Uniform Federal Accessibility Standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy and Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Accessibility Adaptations

Provider Category:

Individual

Provider Type:

Licensed Building Contractor

Provider Qualifications

License *(specify):*

The product or service to be delivered shall meet all applicable state licensing requirements for the performance of the service or support being provided.

Certificate *(specify):*

Program Approval

Other Standard *(specify):*

The product or service to be delivered shall meet all applicable manufacturer specifications, state and local building codes, and Uniform Federal Accessibility Standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy and Financing

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Massage Therapy

HCBS Taxonomy:

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

Service Definition *(Scope):*

Massage is the physical manipulation of muscles to ease muscle contractures, spasms, extension, muscle relaxation and muscle tension including WATSU. Children with specific developmental disorders often experience painful muscle contractions. Massage has been shown to be an effective treatment for easing muscle contractures, releasing spasms, and improving muscle extension and thereby reducing pain. The use of this service is only available from a provider who is licensed, certified, registered and/or accredited by an appropriate national accreditation association. This service must be used as a treatment strategy for an identified medical or behavioral need. The need should be outlined in the individualized service plan. A Medicaid State Plan therapist/physician must identify the need this service shall meet with a goal. The Medicaid State Plan therapist/physician will monitor the progress towards meeting this goal at least quarterly.

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

Massage cannot be available under the regular Medicaid State Plan, EPSDT or from a third-party source.

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	Community Centered Board (CCB)/Organized Health Care Delivery System (OHCDS)
Agency	Program Approved Service Agency

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:

Community Centered Board (CCB)/Organized Health Care Delivery System (OHCDS)

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.

Certificate *(specify):*

The service to be delivered shall meet all applicable state certification requirements for the performance of the support or service being provided and program approval.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy and Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Massage Therapy

Provider Category:

Agency

Provider Type:

Program Approved Service Agency

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.

Certificate *(specify):*

The service to be delivered shall meet all applicable state certification requirements for the performance of the support or service being provided and program approval.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Verification of provider qualification is completed upon initial Medicaid enrollment and every five years through provider revalidation, as well as the DPHE survey process initially and every three years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Movement Therapy

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

Movement Therapy is the use of music therapy and/or dance therapy as a therapeutic tool for the habilitation, rehabilitation, and maintenance of behavioral, developmental, physical, social, communication, pain management, cognition and gross motor skills. The use of this service is only available from a provider who is licensed, certified, registered and/or accredited by an appropriate national accreditation association. This service must be used as a treatment strategy for an identified medical and/or behavioral need. The need should be outlined in the individualized service plan. A Medicaid State Plan therapist/physician must identify the need this service shall meet with a goal. The Medicaid State Plan therapist/physician will monitor the progress towards meeting this goal at least quarterly.

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:

Movement Therapy cannot be available under the regular Medicaid State Plan, EPSDT or from a third-party source.

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	Program Approved Service Agency
Agency	Community Centered Board (CCB)/Organized Health Care Delivery System (OHCDS)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Movement Therapy

Provider Category:

Agency

Provider Type:

Program Approved Service Agency

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.

Certificate *(specify):*

The service to be delivered shall meet all applicable state certification requirements for the performance of the support or service being provided and program approval.

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;

•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:

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

Frequency of Verification:

Verification of provider qualification is completed upon initial Medicaid enrollment and every five years through provider revalidation, as well as the DPHE survey process initially and every three years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Movement Therapy

Provider Category:

Agency

Provider Type:

Community Centered Board (CCB)/Organized Health Care Delivery System (OHCDS)

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.

Certificate *(specify):*

The service to be delivered shall meet all applicable state certification requirements for the performance of the support or service being provided and program approval.

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;

•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:

The Department of Health Care Policy and Financing

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Primary Caregiver Education

HCBS Taxonomy:

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

Service Definition *(Scope):*

Primary Caregiver Education provides unique opportunities for caregivers to learn how to support the member's strengths within the context of the member's disability and enhances the caregiver's ability to meet the special needs of the member. Primary Caregiver education includes: consultation and direct service costs for training caregivers in techniques to assist in caring for the member's needs, including sign language; special resource materials; cost of registration for caregivers to attend conferences or educational workshops that are specific to the member's disability; cost of membership to support or information organizations and publications designed for caregivers of children with disabilities.

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

The maximum annual allowance for Primary Caregiver Education is $1,000.00 per year.

The following items are specifically excluded under the HCBS-CES waiver and not eligible for reimbursement: transportation, lodging, food or membership to any political organizations or any organization involved in lobby activities.

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	Vendor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Primary Caregiver Education

Provider Category:

Individual

Provider Type:

Vendor

Provider Qualifications

License *(specify):*

The service to be delivered shall meet all applicable state licensing requirements for the performance of the service or support being provided.

Certificate *(specify):*

The service to be delivered shall meet all applicable state certification requirements for the performance of the service or support being provided.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Environment or the Community Centered Board (CCB) as Organized Health Care Delivery System (OHCDS)

Frequency of Verification:

CDPHE conducts a verification through the survey process initially and every three years.
The Department conducts verification initially and every five years through the provider revalidation process.
When provided through the OHCDS system, CDPHE is not responsible for the verification of provider qualifications. It is the responsibility of the CCB.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Specialized Medical Equipment and Supplies

HCBS Taxonomy:

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

Service Definition *(Scope):*

Specialized Medical Equipment and supplies include:

1. Devices, controls, or appliances, specified in the service plan, that enable participant to increase their ability to perform activities of daily living;
2. Kitchen equipment required for the preparation of special diets if this results in a cost saving over commercially prepared foods. Examples include: food processor, food scales, or a portion measurement devices.
3. General care items such as distilled water for saline solutions, supplies such as specialized eating utensils, etc., required by a child with a developmental disability and related to the disability.
4. Specially designed clothing (e.g. velcro) for participant if the cost is over and above the costs generally incurred for a participant's clothing.
5. Maintenance and upkeep of the equipment

Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State plan, EPSDT and exclude those items that are not of direct medical or remedial benefit to the participant. All medically necessary items that are covered under the Durable Medical Equipment or EPSDT benefit within the state plan shall be accessed first. All items shall meet applicable standards of manufacture, design and installation

Specify applicable (if any) limits on the amount, frequency, or duration of this 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	Community Centered Board (CCB)/Organized Health Care Delivery System (OHCDS)
Agency	Pharmacy
Agency	Medical Supply Company

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:

Agency

Provider Type:

Community Centered Board (CCB)/Organized Health Care Delivery System (OHCDS)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Program Approval

Other Standard *(specify):*

The product or service to be delivered must meet all applicable state licensing requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy and Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:

Agency

Provider Type:

Pharmacy

Provider Qualifications

License *(specify):*

Pharmacy License

Certificate *(specify):*

Program Approval

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy and Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:

Agency

Provider Type:

Medical Supply Company

Provider Qualifications

License *(specify):*

Business License

Certificate *(specify):*

Program Approval

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy and Financing

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Vehicle Modifications

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Adaptations or alterations to an automobile or van that is the participant's primary means of transportation in order to accommodate the special needs of the participant. Vehicle adaptations are specified by the service plan as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare, and safety of the participant. The vehicle that is adapted may be owned by the individual, a family member with whom the individual lives or has consistent and ongoing contact, or a non-relative who provides primary long-term support to the individual and is not a paid provider of such services. Payment may not be made to adapt the vehicles that are owned or leased by paid providers of waiver services. The following are specifically excluded:

(1) Adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the participant;

(2) Purchase or lease of a vehicle; and

(3) Regularly scheduled upkeep and maintenance of a vehicle except for upkeep and maintenance of the modifications.

(4) Vehicle Modifications are reviewed with the case manager and outlined in the person centered service plan to confirm they will meet the assessed need prior to approval and completion of work.

All medically necessary items that are covered under the Durable Medical Equipment or EPSDT benefit within the state plan shall be accessed first.

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

The total cost of home accessibility adaptations, vehicle modifications, and assistive technology may not exceed $10,000 over the life of the waiver except that on a case-by-case basis the Department may approve a higher amount, to ensure the health, welfare, and safety of the participant or if it decreases the need for paid assistance in another waiver service on a long-term basis.

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	Community Centered Board (CCB)/Organized Health Care Delivery System (OHCDS)
Agency	Enrolled Medicaid Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Vehicle Modifications

Provider Category:

Agency

Provider Type:

Community Centered Board (CCB)/Organized Health Care Delivery System (OHCDS)

Provider Qualifications

License *(specify):*

The provider shall have all licensures required by the State of Colorado for the performance of the service or support being provided.

Certificate *(specify):*

Program Approval

Other Standard *(specify):*

The product or service to be delivered shall meet all applicable manufacturer specifications, state and local codes, and Uniform Federal Accessibility Standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy and Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Vehicle Modifications

Provider Category:

Agency

Provider Type:

Enrolled Medicaid Provider

Provider Qualifications

License *(specify):*

The provider shall have all licensures required by the State of Colorado for the performance of the service or support being provided.

Certificate *(specify):*

Program Approval

Other Standard *(specify):*

The product or service to be delivered shall meet all applicable manufacturer specifications, state and local codes, and Uniform Federal Accessibility Standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health Care Policy and Financing

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Youth Day Service

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:

The purpose of Youth Day Service is to provide care and supervision to clients while the primary caregiver works or seeks employment when that care is needed due to the client's intellectual and developmental disability and not the client's age. Youth 12 years of age and older typically do not require care and supervision during the primary caregiver's absence; however, children with intellectual and developmental disabilities in this age range typically do require care and supervision while the primary caregiver is absent from the home. In the event that the cost of care and supervision during the time the parents work is greater for an eligible participant, 11 years of age or younger than child care is for same-age typical peers, then supervision is reimbursed at the difference between the cost for care and supervision and the standard cost for child care. This service shall not duplicate the respite service or any other service that includes supervision. This service is short-term and temporary.

Youth Day Service may be provided on an individual or group basis and may be provided in the residence of the participant or Youth day service provider or in the community.

Individual 15-minute unit: The client receives care and supervision in a one-on-one situation. There are no other clients in the setting also receiving Youth Day services.

Group 15-minute unit: the client receives care along with other individuals, who may or may not have a disability. Group Youth Day Services are provided to the HCBS-CES waiver participant along with other individuals who may or may not have a disability; however, reimbursement is limited to the waiver participant.

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

This service is limited to clients between the ages of 12 and 17. The age of 12 years has been designated as the age appropriate for a child to be left alone for short periods of time. This standard is based upon the Colorado Child Labor Law, which deems 12 years as the minimum age for employment. (See Colorado Revised Statutes. § 8-12-105(3)).

This benefit is not available to clients from birth through the age of 11 during the time the parent works because child care for children 11 years of age and younger is a typical expense for all working parents. This service may not be used to substitute for or supplant special education and related services that are included in a child's Individualized Education Plan (IEP) under the provisions of Individuals with Disabilities Education Improvement Act of 2004 (IDEA). This service may not be used to cover any portion of the cost of camp.

This service is limited to ten hours per day for a maximum of 90 days per service plan year.

The Department may approve a higher amount based on a need due to the client's disability or unique family circumstances.

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Program Approved Service Agency
Agency	Community Centered Board (CCB)/Organized Health Care Delivery System (OHCDS)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Youth Day Service

Provider Category:

Agency

Provider Type:

Program Approved Service Agency

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

Program Approval

Other Standard *(specify):*

Direct Care Staff: Be at least 18 years of age, have the ability to communicate effectively, complete required forms and reports, and follow verbal and written instructions. Have the ability to provide services in accordance with a Service Plan. Have completed minimum training based on State training guidelines. Have necessary ability to perform the required job tasks and have the interpersonal skills needed to effectively interact with persons with developmental disabilities

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy and Financing and Department of Public Health and Environment

Frequency of Verification:

Verification of provider qualification is completed upon initial Medicaid enrollment and every five years through provider revalidation, as well as through the DPHE survey process initially and every three years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Youth Day Service

Provider Category:

Agency

Provider Type:

Community Centered Board (CCB)/Organized Health Care Delivery System (OHCDS)

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

Program Approval.

Other Standard *(specify):*

Direct Care Staff: Be at least 18 years of age, have the ability to communicate effectively, complete required forms and reports, and follow verbal and written instructions. Have the ability to provide services in accordance with a Service Plan. Have completed minimum training based on State training guidelines. Have necessary ability to perform the required job tasks and have the interpersonal skills needed to effectively interact with persons with developmental disabilities

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy and Financing and Department of Public Health and Environment

Frequency of Verification:

Verification of provider qualification is completed upon initial Medicaid enrollment and every five years through provider revalidation, as well as through the DPHE survey process initially and every three 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:

The Department contracts through competitive procurement with Case Management Agencies serving 20 defined service areas throughout Colorado to perform Home and Community Base Services waiver operational and administrative services, case management, utilization review, and prior authorization of waiver services.

TCM includes the following case management functions: service planning meetings, dissemination of service plan, LTHH PAR review, person-centered support planning, internal case consultation, case administration, PAR development, monitoring of long-term service delivery, coordination of care, intake screening, and referral.

Administrative contractual activities include Level of Care Screens, Need Assessments, Human Rights Committee, Critical Incidents, appeals, developmental disability and delay determinations, Support Intensity Scale Assessments, and specific contract deliverables.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

○ **No. Criminal history and/or background investigations are not required.**

◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Administration and compliance with this requirement is reviewed at the time of survey of on-site surveys of service provider and case management agencies.

All Program Approved Service Agencies (PASAs) and Community Centered Boards are required to complete employment reference checks prior to hire. Pre-employment criminal history and background investigations are required for all applicants for positions in which the staff person or contractor can be expected to be alone with the participant or is expected to provide direct waiver services, which includes all direct care staff, respite providers, case managers, nurses and program supervisors, managers and directors. The scope of the criminal investigations includes statewide and federal databases. CDPHE Program Quality staff review compliance with requirements for such criminal history and background investigations at the time of on-site program quality surveys of all PASAs and CCBs. Requirements for such investigations are included in Standards for Program.

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)

Note: Required information from this page (Appendix C-2-c) is contained in response to C-5.

Appendix C: Participant Services

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

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- ○ **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ◉ **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

A parent may be paid to furnish extraordinary care through the Homemaker or Community Connector service. Extraordinary care is determined by assessing whether an individual who is the same age without a disability needs the requested level of care, the activity is one that a parent would not normally provide as part of a normal household routine and the activity is one that a parent is not legally responsible to provide and is necessary to assure the health and welfare of the participant and to avoid institutionalization. During the service planning process the case manager uses the Ages and Stages questionnaire to help determine what tasks are typical for the members' age and what is not typical for their age. The Ages & Stages document developed by Iowa State University provides guidance for the typical child's developmental milestones. Care and tasks that are not typical of their age would be considered extraordinary care.

There is a 2,080 annual unit cap for parents to provide the Homemaker service.

There is a 2,080 annual unit cap for parents to provide the Community Connector service.

An individual must be offered a choice of providers. If the client chooses a parent as a care provider, it must be documented on the Person Centered Support Plan. All case management, monitoring, and reporting activities are required for all waiver services including when a parent is paid as a care provider.

Services provided by a legal responsible individual are authorized and reviewed quarterly by the case manager based on the client's needs to ensure the provision of the service by a legally responsible individual is in the best interests of the participant.

The Department requires Electronic Visit Verification (EVV) for Homemaker services. For all services, the Department contracts with a vendor to conduct a post-payment review of claims to ensure that all services delivered receive payment.

☐ **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.*

Payment may be made to relatives or legal guardians when the relative or legal guardian is qualified to provide the following services: Homemaker; Basic and Enhanced, and Respite. A qualified relative may receive payment for providing Youth Day and Community Connector, when that relative is a qualified to be a provider. Payment may be made to parents when they are qualified to provide the following services: Homemaker and Community Connector. For the purpose of this section, a relative is defined as all persons related to the participant by virtue of blood, marriage, adoption or common law and legal guardians as appointed, but does not have a legal obligation to care for the participant.

The family member providing services shall meet requirements set forth by the qualified program approved service agency (PASA) through which the family member provides services. The family member must be at least 18 years of age, trained to perform appropriate tasks to meet the participant's needs, and demonstrate the ability to provide support to the participant as defined in the participant's Service Plan and Hiring Agreement. Participants and/or legal guardians, who choose to hire a family member must document their choice on the Service Plan. The Service Plan is developed under the coordination and direction of the community centered board Interdisciplinary Team (IDT) who provide oversight regarding the appropriateness of the family member providing services. The Service Plan identifies the needs of the person and reflects discussion on how to best meet those needs. The waiver services identified in the Service Plan are submitted for approval using a Prior Authorization Request (PAR.) When the PAR is approved those services are uploaded into the Medicaid Management Information System. Only those approved services may be reimbursed.

The Department requires Electronic Visit Verification (EVV) for Homemaker services. For all services, the Department contracts with a vendor to conduct a post-payment review of claims to ensure that all services delivered receive payment.

○ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

○ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

All parties interested in becoming Home and Community Based Services (HCBS)-Children's Extensive Support (CES) providers have access to required forms and instructions for completing the forms on the Department of Health Care Policy and Financing (the Department) website. Applications to become a provider are submitted to the Department.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services

are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

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

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

Performance Measure:
C.a.1 # & % of licensed/certified waiver providers, by type, that met licensing stds or cert reqrmts at time of scheduled or periodic recert. survey Numerator: # of licensed/certified waiver providers, by type, that met licensing stds or cert reqrmts at time of scheduled or periodic recert. survey Denominator: Total licensed/certified waiver providers, by type, surveyed during perfce period

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **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 perfce period, by type, that have the reqd prof'l licensure or cert prior to serving waiver participants N: # of waiver providers enrolled within the perfce period, by type, that have the reqd prof'l licensure or certification prior to serving waiver participants D: Total # of waiver providers enrolled within the performance period, by type.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS Data

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:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
CDPHE survey reports

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

		Sample Confidence Interval =
☒ **Other** Specify: CDPHE	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data 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.3 Number and percent of OHCDS providers during the performance period that have the required license/certification N: Number of OHCDS providers during the performance period that have the required license/certification D: Total number of OHCDS providers during performance period

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS Data

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

Data Aggregation and Analysis:

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

Performance Measure:
C.a.6 Number and percent of non-surveyed licensed/certified waiver providers, by type, that continually meet waiver licensure/certification standards Numerator: Number of non-surveyed licensed/certified waiver providers, by type, that continually meet waiver licensure/certification standards Denominator: Total number of non-surveyed licensed/certified waiver providers, by type

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS Data

Responsible Party for 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.

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 CES waiver providers who meet Department waiver training requirements in accordance with state requirements and the approved waiver Numerator: Number of surveyed CES waiver providers who meet Department waiver training requirements in accordance with state requirements and the approved waiver Denominator: Total number of surveyed waiver providers

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: Colorado Department of Public Health & Environment	☐ **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.c.2 Number and percent of CES waiver non-surveyed providers who meet department training requirements in accordance with state requirements and the approved waiver N: Number of CES waiver non-surveyed providers who meet Department training requirements in accordance with state requirements and the approved waiver D: Total CES waiver non-surveyed providers

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS

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 Dept maintains an Interagency Agreement with the Colorado Dept of Public Health and Environment (CDPHE) for licensure and survey activities. CDPHE and DHS submit monthly reports to the Dept on the number and type of providers surveyed, the findings, and remediation.

C.a.1
Providers who are interested in providing HCBS services that are required by Medical Assistance Program regulations to be surveyed prior to certification to ensure compliance with licensing and qualification standards and requirements. Certified providers are re-surveyed according to the CDPHE schedule to ensure ongoing compliance.

The Department is provided with monthly and annual reports detailing the number and types of agencies that have been surveyed, the number of agencies that have deficiencies and types of deficiencies cited, the date deficiencies were corrected, the number of complaints received, complaints investigated, substantiated, and resolved.

The Department uses CDPHE survey reports as the primary data source for this performance measure.

C.a.2
Licensed/certified providers must be in good standing with their specific specialty practice act and with current state licensure regulations. Following Medicaid provider certification, all providers are referred to the Department's fiscal agent to obtain a provider number and a Medicaid provider agreement. The fiscal agent enrolls providers in accordance with Medical Assistance Program regulations and the Department's directives and maintains provider enrollment information in the MMIS. All provider qualifications and required professional licenses are verified by the fiscal agent upon initial enrollment and in a revalidation cycle; at least every five years. Data reports verifying required professional licensure and certification are maintained by the Department's waiver provider enrollment staff.

C.a.3
CCBs are certified as Organized Health Care Delivery Systems (OHCDS) by the Department. A Program Approved Service Agency (PASA) is an agency that has been approved by the OHCDS to provide direct community-based services to individuals with intellectual or developmental disabilities. PASAs provide services to waiver participants with Intellectual/Developmentally Disabilities(IDD) enrolled in Colorado's HCBS waivers through contracts with direct support professionals.

The Department uses provider enrollment records reports as the primary data sources for this performance measure.

C.a.6
All provider qualifications are verified by the fiscal agent upon initial enrollment and in a revalidation cycle; at least every five years. Data reports verifying non-surveyed providers continually meet waiver requirements are maintained by the Department's waiver provider enrollment staff.

Department records are the primary data source for this performance measure.

C.c.1
The CDPHE reviews personnel records as part of their provider surveying activities and includes training deficiencies identified during the surveys in the written statement of deficiencies.

C.c.2
Dept. 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. The Department reviews personnel records as part of their provider certification/revalidation activities.

b. Methods for Remediation/Fixing Individual Problems

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

C.a.1
Providers who are not in compliance with CDPHE and other state standards receive deficient practice citations. Depending on the risk to the health and welfare of clients, the deficiency will require, at minimum, a plan of correction to CDPHE. Providers that are unable to correct deficient practices within prescribed timelines are recommended for termination by CDPHE and are terminated by the Department. When required or deemed appropriate, CDPHE refers findings made during survey activities to other agencies and licensing boards and notifies the Department immediately when a denial, revocation or conditions on a license occur. Complaints received by CDPHE are assessed for immediate jeopardy or life-threatening situations and are investigated in accordance with applicable federal requirements and time frames.

The Department reviews all CDPHE surveys to ensure deficiencies have been remediated and to identify patterns and/or problems on a statewide basis by service area, and by the program. The results of these reviews assist the Department in determining the need for technical assistance; training resources and other needed interventions.

C.a.1, C.a.2, C.a.6
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.2
If areas of non-compliance with standards exist, the Department issues a list of deficiencies to the provider. The Provider is required to submit an acceptable Plan of Correction to the Department within a specified timeframe. Applications for providers that do not remediate deficiencies are denied enrollment in the program.

C.a.3, C.a.6
If areas of non-compliance with standards exist, the Department issues a list of deficiencies to the provider. The provider is required to submit an acceptable Plan of Correction (POC) to the Department within a specified timeframe. If areas of non-compliance exist where the health and welfare of participants receiving services are in jeopardy, then the provider is required to correct the problem immediately and provide documentation of corrections to Department.

The Department initiates termination of the provider agreement for any provider who is in violation of any applicable certification standard, licensure requirements, or provision of the provider agreement, and does not adequately respond to a POC within the prescribed period of time.

C.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.

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.c.2
If areas of non-compliance with standards exist, the Department issues a list of deficiencies to the provider. The Provider is required to submit an acceptable Plan of Correction to the Department within a specified timeframe.

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**

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

(a) The State applies a maximum expenditure of $10,000 over the life of the waiver (5 years) for the combination of home accessibility adaptations, vehicle modifications, and assistive technology. (b) Analysis of the utilization over the past five years indicates that, in general, the limit is appropriate to meet the needs of participants. (c) Should there be sufficient justification based on utilization, the State will submit a waiver amendment to increase the limit (d) The limit can be exceeded on a case by case basis based on demonstrated need to ensure the health, welfare and safety of the participant, to enable the participant to function with greater independence in the home, or if it decreases the need for paid assistance in another waiver service on a long-term basis. (f) The parent(s)/guardian are informed at enrollment and during the Service Plan development of any limitations associated with the program.

☒ **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.

(a) This waiver has a total spending limitation of $53,748.67 for all waiver services per service plan year. This waiver has a total Denver County total spending plan limitation of $54,622.01 per service plan year.

(b)The State analyzes the other sources of payment/services including those provided by the parents, the school systems, third party payers, and EPSDT to ensure that the child's needs can be met within the spending limitation. The average expenditure per unduplicated recipient for the past five years has been approximately $15,500. The combination of all the resources has been successful in keeping children at home. The Department takes the following steps in calculating the individual budget amount:

1. The Department determines total reimbursement for all services on the waiver,
2. The Department determines the total reimbursement of each individual service to find the proportion of total current Spending Limit dollars associated with each service,
3. Using the current Spending Limit amount, the Department determined the proportion of the Spending Limit impacted by each service
4. The proportion of the Spending Limit for each of the services impacted by the rate increase is then multiplied by the percentage of the services reimbursement to the total reimbursement
5. The increased Spending Limit by services are then added together to produce the final Spending Limit calculation.

The Department will issue informational memos with this methodology when spending limits are adjusted in the future.

(c) Should there be sufficient justification based on utilization, the State will submit a waiver amendment to increase the limit

(d) If the child's need for waiver services exceeds the $50,012.67 level the State would need to determine if this child's health and safety can adequately be met under this waiver or should the child be referred to other services that are more appropriate such as the Children's Habilitation Residential Program.

(e) The safeguard in place to protect the health and welfare of the recipient is that the State Prior Authorizes the waiver services to ensure the child can be referred to more appropriate and cost effective services.

(f) The parent(s)/guardian are informed at enrollment and during the service plan development of any limitations associated with the program.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

Please see information on the proposed State Wide Transition Plan in the Main section, attachment #1.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Person-Centered Support Plan (PCSP)

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

☐ **Registered nurse, licensed to practice in the state**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**

☐ **Licensed physician (M.D. or D.O)**

☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☒ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

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

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

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

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

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

Agency supervisor educational experience:

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

☐ **Social Worker**

Specify qualifications:

☐ **Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

○ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

◉ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

The Department is currently working to implement major changes to the business process and structure of case management services available to individuals receiving Home and Community-Based Services. The Department submitted a transition plan for Conflict-Free Case Management (CFCM) on June 2, 2017. The Department has received concerns from stakeholders regarding the plan put forth in 2017, that this plan will have a potential negative impact on members. The plan identified in HB 17-1343 creates a convoluted system that adds layers into the current model and, if implemented, will complicate the system for members. The Department began stakeholder engagement in January of 2020 to discuss a change in the current plan. Once the Department established a new path forward that would better serve individuals and families, the Department requested from CMS an extension on the CFCM implementation date. CMS granted the Department an extension until 2024 to come into compliance with CFCM.

While the Department implements changes to the business processes and structure of case management services, the State Medicaid Agency allows for entities to provide both case management and direct care waiver services only when no other willing and qualified providers are available. The state currently allows an individual's HCBS provider to develop the Person-Centered Service Plan in Sedgwick, Phillips, Logan, Morgan, Washington, Yuma, Kit Carson, Cheyenne, Lincoln, Elbert, Kiowa, Prowers, Bent, Baca, Otero, Crowley, Las Animas, Huerfano, Costilla, Conejos, Alamosa, Rio Grande, Mineral, Saguache, Archuleta, La Plata, Montezuma, Dolores, San Juan, Hinsdale, Ouray, San Miguel, Montrose, Delta, Gunnison, Garfield, Pitkin, Lake, Eagle, Rio Blanco, Moffat, Routt, Jackson, Grand, Chaffee, Fremont, and Custer Counties.

Per the contract, Community Centered Boards are required to do the following in regards to mitigating conflict:

- Separation of Case Management from Service Provision - 10 CCR 2505-10, 8.607.1.D requires case management to be the responsibility of the executive level of the CCB and to be separate from the delivery of service. This rule also requires each CCB to adopt policies and procedures to address safeguards necessary to avoid conflicts of interest between case management and service provision.

- Standardize PCSP Documents- Community Centered Boards are required to complete each participant's service plan on the state's case management IT system and in the Bridge. The PCSP also includes a mandatory data field to include documentation that the client has been informed of potential conflicts of interest, the option to choose another provider, or whether the participant needs/requests information on a potential new service provider.

- Implementation of the Global QIS will include desk reviews by the Department of a representative sample of participants' LOC Screen and PCSP. The programmatic tool used in the assessment as well as the waiver participants selected in the sample will be specified by the Department. Aggregated data from the desk reviews will be reviewed and analyzed by the Department's oversight committee to evaluate performance and identify the need for quality improvement projects.

- All Community Centered Boards and case managers have received specific instructions from the Department regarding processes to be implemented to assist participants with selecting a service provider. This process requires completion of the Service Provider Selection at the time of initial enrollment in the waiver when a change in provider is requested when the participant or guardian expresses dissatisfaction with the participant's current waiver provider or when a provider terminates services. All participants are provided choice from among qualified providers at the time of service plan development.

The Department sent a letter in June of 2017 to all current CMAs notifying them of their four options to comply with federal and state statutes and regulations. Additionally, HB 17-1343 requires CMAs to submit a Business Continuity Plan to the Department by July 1, 2018 indicating which of the four options the CMA is choosing and identifying how the CMA will operate in the new system. Conflicted CMAs have submitted their Business Continuity Plan to the Department indicating their plan. However, with the Department's new case management redesign plan which includes CFCM, it is the Department's intent to remove the requirement of Business Continuity Plans and establish a new process for agencies to apply for an exception for only willing and qualified providers.

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.

Each Case Management Agency (CMA) is contractually obligated to provide information to participants about the potential services, supports, and resources that are available. The Department has taken steps to improve access to information using the Department's website. Information continues to be added in order to assist the client or family members in making informed decisions about waiver services, informal supports, and State Plan benefits. The waiver participant has the authority to determine who is included in the PCSP planning process pursuant to C.R.S. 25-5-10 (28).

Case Managers can assist the individual in directing the PCSP development process if the individual chooses. In addition, there are several advocacy organizations in Colorado that the case manager can contact if the individual wishes.

The case manager shall perform quarterly monitoring contacts with the member, as defined by the member's certification period start and end dates. An in-person monitoring contact is required at least one (1) time during the Person-Centered Support Plan certification period. The case manager shall ensure the one (1) required in-person monitoring contact occurs, with the Member physically present, in the Member's place of residence or location of services.

Upon Department approval in advance, contact may be completed by the case manager at an alternate location, via the telephone, or using a virtual technology method. Such approval may be granted for situations in which in-person face-to-face meetings would pose a documented safety risk to the case manager or client (e.g., natural disaster, pandemic, etc.).

The case manager shall perform three additional monitoring contacts each certification period either in-person, on the phone, or through other technological modalities based on the member's preference of engagement.
To facilitate person-centered practices, CMAs may use phone or other technological contact to engage in the development and monitoring of the PCSP.

All forms completed through the assessment and care plan 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 PCSP [10 C.C.R. 2505-10, Section 8.607]. The case manager meets with the client and/or legal guardian to complete a Level of Care Eligibility Determination Screen (LOC Screen), making reasonable attempts to schedule the meeting at a time and location convenient for all participants. The Colorado Code of Regulations (10 CCR 2505-10 8.607.4 B.) specifies that: Every effort shall be made to convene the meeting at a time and place convenient to the person receiving services, their legal guardian, authorized representative, and parent(s) of a minor. For each certification period, the level of care determination or redetermination will be in person (unless a documented safety risk is met as provided below).

The case manager shall perform quarterly monitoring contacts with the member, as defined by the member's certification period start and end dates. An in-person monitoring contact is required at least one (1) time during the Person-Centered Support Plan certification period. The case manager shall ensure the one (1) required in-person monitoring contact occurs, with the Member physically present, in the Member's place of residence or location of services.

Upon Department approval in advance, contact may be completed by the case manager at an alternate location, via the telephone, or using a virtual technology method. Such approval may be granted for situations in which in-person face-to-face meetings would pose a documented safety risk to the case manager or client (e.g., natural disaster, pandemic, etc.).

The case manager shall perform three additional monitoring contacts each certification period either in-person, on the phone, or through other technological modalities based on the member's preference of engagement.

The client and/or legal guardian have the authority to select and invite individuals of their choice to actively participate in the assessment process. The client and the client's chosen group provide the case manager with information about the client's needs, preferences, and goals. In addition, the case manager obtains diagnostic and health status information from the client's medical provider and determines the client's level of care using the state-prescribed LOC Screen instrument.

The case manager also identifies if any natural supports provided by a caregiver living in the home are above and beyond the workload of a typical family/household routine. The case manager works with the client and the group of representatives to identify any risk factors and addresses risk factors with the appropriate parties.

Beginning in December 2021 or sooner, the case manager will complete a needs assessment (Assessment), basic or comprehensive, as determined by the client. The Assessment collects information about the client's strengths and support needs in these areas: health; functioning; sensory & communication; safety & self-preservation; housing, employment, volunteering, and training; memory & cognition; and psychosocial. The Assessment also identifies the client's goals and needed referrals and will determine if specific waiver targeting criteria is met. Prior to the Assessment is completed, the case manager will explain the assessment process to the client and/or guardian and explain options for waivers and waiver services, as well as the option to choose between the basic or comprehensive assessment. The comprehensive option covers all of the areas of the basic option but collects more detailed information about the client. The Assessment identifies which HCBS waiver(s) the client is eligible for and be utilized to develop the PCSP.

As the PCSP is being developed, options for services and providers are explained to the client and/or legal guardian by the case manager. Before accessing waiver benefits, clients must access services through other available sources such as State Plan and EPSDT benefits. The case manager arranges and coordinates services documented in the PCSP.

Referrals are made to the appropriate providers of the client's and/or legal representative's choice when services requiring a skilled assessment, such as skilled nursing or home health aide (Certified Nursing Aide) are determined appropriate.

The PCSP defines the type of services, frequency, and duration of services needed. The PCSP also documents that the client and/or legal guardian have been informed of the choice of providers and the choice to have services provided in the community or in an institution. Health and safety risks are identified within the contingency planning section. This includes who should be contacted in the event of an emergency, and plans to address needs in these circumstances. The client may contact the case manager for ongoing case management such as assistance in coordinating services, conflict resolution, or crisis intervention. The client may contact the case manager for ongoing case management such as assistance in coordinating services, conflict resolution, or crisis intervention. The service plan must be finalized in accordance with CFR 441.301 c (2)(ix), "Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation."

The case manager reviews the LOC Screen and PCSP with the client during the required monitoring contact. This review includes the evaluation and assessment strategies for meeting the needs, preferences, and goals of the client. It also includes evaluating and obtaining information concerning the client's satisfaction with the services, the effectiveness of services being provided, an informal assessment of changes in the client's function, service appropriateness, and service cost-effectiveness.

If complaints are raised by the client about the Person-Centered Support Planning process, case manager, or other CMA functions, case managers are required to document the complaint on the CMA complaint log and assist the client to resolve the complaint. Complaints that are raised by the client about the Person-Centered Support Planning process, case manager, or other CMA functions, are required to be documented on the CMA complaint log. The case manager and/or case manager's supervisor are also required to assist in the resolution of the complaint.

This complaint log is reviewed by the Department on a quarterly basis. Department staff is able to identify trends or discern if a particular case manager or CMA is receiving an unusual number or increase in complaints and remediate accordingly.

The client may also contact the case manager's supervisor or the Department if they do not feel comfortable contacting the case manager directly. The contact information for the case manager, the case manager's supervisor, the CMA administrator, and the Department is included in the copy of the PCSP that is provided to the client. The client also has the option of lodging an anonymous complaint to the case manager, CMA, or the Department.

Clients, family members, and/or advocates who have concerns or complaints may contact the case manager, case manager's supervisor, CMA administrator, or Department directly. If the Department receives a complaint, the HCBS waiver and benefits administrator investigates the complaint and remediates the issue.

The case manager is required to complete a reevaluation, at a time and location chosen by the client, within twelve months of the initial client or previous evaluation. A reevaluation shall be completed sooner if the client's condition changes or as needed by program requirements. Upon Department approval, the annual LOC Screen and/or development of the PCSP may be completed by the case manager at an alternate location or via the telephone. Such approval may be granted for situations in which there is a documented safety risk to the case manager or client (e.g. natural disaster, pandemic, etc.). State laws, regulations, and policies that affect the PCSP development process are available through the Medicaid agency.

In cases of emergency or evacuation, the case manager may authorize needed services using a temporary interim service plan, not to exceed 60 days. This plan will be developed when additional services, essential to the member's health and safety, related to the emergency situation are identified. The case manager will authorize the services using the most effective means of written communication. Service providers may provide services authorized in this manner until the case manager is able to complete a service plan revision which will backdate to the date of the temporary interim service plan. This type of interim temporary plan will only be used for already enrolled waiver participants who have been determined eligible for the waiver pursuant to the eligibility process in the waiver.

The PCSP also includes specific information on the participant's appeal rights and when the PCSP reduces, denies, or terminates a waiver service the participant is provided with a Notice of Adverse Action, which also includes information on the participant's right to a Medicaid fair hearing.

The Department is developing a new PCSP to be implemented by December 2021 to comply with the Person-Centered Support Planning requirements in the HCBS Setting Final Rule. This plan will include documenting individual strengths, preferences, abilities, and individually identifying goals and how progress towards identified goals, and how progress will be measured. The future timeline and milestones for implementing this person-centered support plan are as follows:

- March 2019-April 2020: The Department pilots the new LOC Screen and PCSP process in the field with case managers and LTSS participants
- August 2019: PCSP is automated and integrated into the Department's IT infrastructure
- September 2019-October 2019: Training materials are developed for case managers participating in the pilot
- November 2019: Case Managers are trained on the PCSP
- November 2019-December Pilot: Case Managers complete LOC Screen, Assessment, and PCSP process in the field, and feedback meetings conducted
- December 2019-January 2020: The Department will analyze the data gathered from the PCSP pilot and hold

additional stakeholder meetings, as necessary.
- January 2020: Department will update the automation of the PCSP based on feedback
- January-March 2020: The Department will collect data regarding additional time needed due to the new Assessment and PCSP

The new LOC Screen, Assessment, and Support Plan will begin to be used statewide by December 2021. The time between the end of the pilot and the start of implementation will be used to develop a Resource Allocation methodology using the new Assessment, as well as developing training for all case management-related functions in the Department's case management system.

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.

Risk assessment and mitigation are completed by the Case Manager, who is any qualified willing provider.

Risk Assessment and Mitigation- The initial step of risk assessment includes completion of the CES Application and the LOC assessment, completion of other required assessments/exams completed by service providers (e.g., physical exam, psychiatric assessments, behavioral assessments, etc.) to identify conditions or circumstances that present a risk of adverse outcome for the participant. Concerns identified by the case manager in completing the LOC Screen (e.g., abuse, neglect, exploitation, mistreatment, behavior supports, eating, medical supports, etc.) are identified in the PCSP. Additionally, collection and documentation of other risk issues (e.g., medical diagnoses, psychiatric assessments, therapy assessments) are identified for each participant in the Developmental Disabilities Section of the PCSP. This Developmental Disabilities Section also includes a Risk Management Plan section that documents risks (e.g., Respiratory Care, Skin Care, Destructiveness, Sexual, other Medical/Behavioral, etc.) identified in the participant's CES Application. For each of these risk categories, a data field is included to document comments and to identify/describe the Service and/or Risk Management Plan. All case managers have been provided with training and written instructions on completing these parts of the PCSP and the Developmental Disabilities Section.

Back-up Plans- The PCSP document includes a specific section entitled Contingency Plan. The plan identifies the provision of necessary care for medical purposes, which may include backup residential services, in the event that the participant's family, caregiver, or provider is unavailable due to an emergency or unseen circumstances. All case managers have received training and written instruction on completing this section of the PCSP.

The service provider is informed of any identified risks prior to initiating services by obtaining a copy 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.

At the time of PCSP development, individuals are afforded the informed choice of all qualified service providers. This conversation occurs no less than annually at PCSP development time and throughout the year when case managers discuss satisfaction with services and providers.

CMAs are required to provide clients with a choice of qualified providers. CMAs are located throughout the State. The Department has opted not to mandate that CMAs use a specific form or method to inform clients about all of the supports available to clients.

The Department has also developed an informational tool in coordination with the Colorado Department of Public Health and Environment (CDPHE) to assist clients in selecting a service agency. The Department has provided all CMAs with this informational tool. In addition, the guide is available on the CDPHE website.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The State's case management IT system contains the LOC Screen, the PCSP, and the monthly case management log notes. The case manager is required to enter the PCSP into the state's case management IT system in order to receive prior authorization of services. CCB agencies are required to prepare PCSP according to the contract with the Department and CMS waiver requirements. The Department monitors the CCB agency annually for compliance. A sample of documentation including individual PCSP is reviewed for accuracy, appropriateness, and compliance with regulations.

The PCSP shall include the participant's assessed needs, goals, specific services, amount, duration, and frequency of services, documentation of choice between waiver services and institutional care, and documentation of choice of providers. CCB agency monitoring by the Department includes a statistical sample of PCSP reviews. During the review, PCSP and prior authorization request forms are compared with the documented level of care for appropriateness and adequacy. Targeted review of PCSP documentation and authorization review is part of the overall administrative and programmatic evaluation by the HCPF. Please see the Global QIS for additional information about timelines for implementing additional procedures.

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:

Maintained electronically in the State's case management IT system, which is available to the client's case manager and the Department.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

Case managers are responsible for PCSP development, implementation, and monitoring. Case managers are required to meet with clients annually for support plan development. When scheduling to meet with the client and or the client's legal guardian or representative, the case manager makes reasonable attempts to schedule the meeting at a time and location convenient for all participants. Once the PCSP is implemented case managers are required to conduct monitoring with the client to ensure the PCSP continues to meet the client's goals, preferences, and needs. Case managers must also contact the client when significant changes occur in the client's physical or mental condition. To facilitate person-centered practices, CMAs may use phone or other technological contact to engage in the development and monitoring of the PCSP. Each certification period one in-person monitoring will be required with up to three additional monitoring contacts either in person, on the phone, or through other technological contact.

The case manager shall perform quarterly monitoring contacts with the member, as defined by the member's certification period start and end dates. An in-person monitoring contact is required at least one (1) time during the Person-Centered Support Plan certification period. The case manager shall ensure the one (1) required in-person monitoring contact occurs, with the Member physically present, in the Member's place of residence or location of services.

Upon Department approval in advance, contact may be completed by the case manager at an alternate location, via the telephone, or using a virtual technology method. Such approval may be granted for situations in which in-person face-to-face meetings would pose a documented safety risk to the case manager or client (e.g. natural disaster, pandemic, etc.).

The case manager shall perform three additional monitoring contacts each certification period either in-person, on the phone, or through other technological modality based on the member's preference of engagement.

Case Managers are required to conduct monitoring with all individuals. Part of monitoring includes follow-up when situations arise when an individual is not able to receive the services authorized and to ensure the contingency plan documented on the PCSP was adequate and met the needs of the individual. Additionally, case management monitoring includes follow-up to the incident and critical incident reports, as well as using observation to document and discuss/address any concerns regarding health and welfare. The Department provided training in the first quarter of FY18-19 to case managers specific to monitoring and the requirements for monitoring. The training included contingency plan effectiveness and individual health and welfare.

Participant's exercise of free choice of providers:

Each Case Management Agency (CMA) is required to provide clients with a free choice of willing and qualified providers. CMAs have developed individual methods for providing choice to their clients. In order to ensure that clients continue to exercise a free choice of providers, the Department has added a signature section to the PCSP that allows clients to indicate whether they have been provided with a free choice of providers. All forms completed through the assessment and care plan 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:
In 2007, the Department implemented a new PCSP which includes a section for health services and other non-waiver services. At the same time, the Department added acute care benefits and Behavioral Health Organizations breakout sessions to the annual case managers training conference to ensure case managers have a greater understanding of the additional health services available to long-term care clients.

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

* Assists with the coordination of needed services.
* Communicate with the service providers regarding service delivery and concerns
* Review and revise services, as necessary
* Notifying clients regarding a change in services

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.

In cases of emergency or evacuation, the case manager may authorize needed services using a temporary interim service plan, not to exceed 60 days. This plan will be developed when additional services, essential to the member's health and safety, related to the emergency situation are identified. The case manager will authorize the services using the most effective means of written communication. Service providers may provide services authorized in this manner until the case manager is able to complete a service plan revision which will backdate to the date of the temporary interim service plan. This type of interim temporary plan will only be used for already enrolled waiver participants who have been determined eligible for the waiver pursuant to the eligibility process in the waiver.

Methods for systematic collection of information about monitoring results that are compiled, including how problems identified during monitoring are reported to the state:

The Department will conduct annual internal programmatic reviews using the Department prescribed Programmatic Tool. The tool is a standardized form with waiver-specific components to assist the Department to measure whether or not CMAs remain in compliance with Department rules, regulations, contractual agreements, and waiver-specific policies.

In addition, the Department audits each CMA for administrative functions including qualifications of the individuals performing the assessment and support planning, the process regarding the evaluation of needs, client monitoring (contact), case reviews, complaint procedures, provision of client choice, waiver expenditures, etc. This information is compared with the programmatic review for each agency. This information is also reviewed and analyzed in aggregate to track and illustrate state trends and will be the basis for future remediation.

The Department also has a Program Integrity section responsible for an ongoing review of sample cases to reconcile services rendered compared to costs. Cases under review are those referred to Program Integrity through various sources such as Department staff, CDPHE, and client complaints. The policies and procedures Program Integrity employs in this review are available from the Department.
Costs are also monitored by Department staff reviewing the 372 reports and budget expenditures.

b. Monitoring Safeguards. *Select one:*

- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

The Department is currently working to implement major changes to the business processes and structure of case management services available to individuals receiving HCB services. These changes will have a direct impact on person-centered support planning and service delivery in Colorado. First, the Department submitted its transition plan for CFCM on June 2nd, 2017. The Department has received concerns from stakeholders regarding the plan put forth in 2017. The Department began stakeholder engagement in January of 2020 to discuss a change in the current plan. Once the Department established a new path forward that would better serve Individuals and families, the Department requested from CMS an extension on the Conflict-Free Case Management implementation date. CMS granted the Department an extension until 2024 to come into compliance with Conflict-Free Case Management. The Department contracted with a vendor to provide recommendations for a case management model in Colorado for all HCBS waivers. Based on the recommendations, the Department is developing a new CM reimbursement structure.

Until the changes to business processes and structure of case management services are implemented, the State Medicaid Agency allows for entities to provide both case management and direct care waiver services only when no other willing and qualified providers are available. The Department sent a letter in June of 2017 to all current CMAs notifying them of their four options to comply with federal and state statutes and regulations. Additionally, all current CMAs must submit a Business Continuity Plan to the Department by July 1, 2018 indicating which of the four options the CMA is choosing and identifying how the CMA will operate in the new system. All current CMAs were also required to request an exception to the federal rule separating case management from direct service provision. Those requests were received by the Department on July 1, 2017. The Department has reviewed the requests and current system structure and determined that there is no other willing and qualified provider to provide CM in rural and frontier counties of Colorado.

The state currently allows the individual’s HCBS provider to develop the PCSP (because there is no other available willing and qualified entity besides their case management agency) in Sedgwick, Phillips, Logan, Morgan, Washington, Yuma, Kit Carson, Cheyenne, Lincoln, Elbert, Kiowa, Prowers, Bent, Baca, Otero, Crowley, Las Animas, Huerfano, Costilla, Conejos, Alamosa, Rio Grande, Mineral, Saguache, Archuleta, La Plata, Montezuma, Dolores, San Juan, Hinsdale, Ouray, San Miguel, Montrose, Delta, Gunnison, Garfield, Pitkin, Lake, Eagle, Rio Blanco, Moffat, Routt, Jackson, Grand, Chaffee, Fremont, and Custer Counties. Per the contract, the CCB is required to do the following in regards to mitigating conflict.

CCBs are required to complete the HCBS-CES application, which includes significant assessment data on each waiver participant. The assessment ensures that the CCB has standard information on the service and support needs of each waiver participant prior to PCSP development.

Separation of Case Management from Service Provision- 10 CCR 2505-10, 8.607.1.D requires case management to be the responsibility of the executive level of the CCB and to be separate from the delivery of services. Additionally, this rule also requires each CCB to adopt policies and procedures to address safeguards necessary to avoid conflicts of interest between case management and service provision. The assessment ensures that the CCB has standard information on the service and support needs of each waiver participant prior to PCSP development.

Standardized PCSP Documents- CCBs are required to complete each participant’s PCSP on the state’s case management IT system and in the Bridge. The PCSP also includes a mandatory data field to include documentation that the client has been informed of potential conflicts of interest, the option to choose another provider, or whether the participant needs/requests information on a potential new service provider.

Implementation of the Global QIS will include desk review by the Department of a representative sample of the level of participant’s care assessments and PCSP. The Department will specify the programmatic tool used in the assessment and the waiver participants selected in the sample. Aggregated data from the desk reviews will be reviewed and analyzed by the Department Oversight Committee to evaluate performance and identify the need for quality improvement projects.

All CCBs and case managers have received specific instructions from the Department regarding implementing processes to assist participants with selecting a service provider. This process requires completion of the Service Provider Selection form at the time of initial enrollment in the waiver when a change in provider is requested when the participant or guardian expresses dissatisfaction with the participant’s current waiver provider or when a provider terminates services. All participants are provided a choice among qualified providers at the time of PCSP development. Documentation of the confirmation is maintained on the state’s case management IT system. Lastly,

all case managers have been directed by the Department to monitor participants' satisfaction with choices in service providers at the time of PCSP development and every quarter as required in quarterly monitoring. Such monitoring must be documented in the PCSP and in case manager contact notes maintained on the state's case management IT system. The Department's On-site Program Quality Surveys: Every three years, the Department staff complete surveys of CCBs and review, specifically, separation of case management from service delivery, the PCSP development process, provider selection processes, and monitoring of participant satisfaction with services and provider choice.

The on-site survey process also includes interviews with participants and guardians regarding PCSP development and choice among qualified providers. More information on this process is included Appendix H.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

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

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

Performance Measure:
D.a.1 Number and percent of waiver participants whose Person-Centered Support Plan (PCSP) address the needs identified in the Level of Care Screen (LOC Screen) and determination Numerator: Number of participants whose PCSPs address the needs identified in the LOC screen & determination Denominator: Total number of waiver participants reviewed

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

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

Agency		
☐ **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**

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:
D.a.2 Number and percent of waiver participants whose PCSPs address the waiver participant's personal goals N: Number of waiver participants whose PCSPs address the waiver participant's personal goals D: Total number of waiver participants reviewed

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with +/- 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.a.3 Number and percent of waiver participants whose PCSPs address identified health and safety risks through a contingency plan Numerator: Number of waiver participants whose PCSPs address identified health and safety risks through a contingency plan Denominator: Total number of waiver participants reviewed

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with +/- 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**

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 whose PCSPs were revised, as needed, to address changing needs Numerator: Number of waiver participants whose PCSPs were revised, as needed, to address changing needs Denominator: Total number of participants who required a revision to their PCSP to address changing needs that were reviewed

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

Responsible Party for data	**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 = 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**

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:
D.c.2. Number and percent of waiver participants with a prior PCSP that was updated within one year Numerator: Number of waiver participants with a prior PCSP that was updated within one year Denominator: Total number of waiver participants with a prior PCSP in the sample

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
D.c.3 # and % of CES waiver participants and/or family members who indicate on the NCI survey they know who to contact to make changes to their PCSP N: # of CES waiver participants and/or family members who indicate on the NCI survey they know who to contact to make changes to their PCSP D: Total number of CES waiver participants and/or family members responding to the NCI survey

Data Source (Select one):
Other
If 'Other' is selected, specify:
NCI Survey Tool

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: NCI Survey Team	☒ **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:

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.1 # and % of CES waiver participants and/or family members responding to the NCI survey who indicate they received services and supports outlined in their PCSP N: # of CES waiver participants and/or family members responding to the NCI survey who indicate they received services and supports outlined in their PCSP D: Total # of CES waiver participants responding to NCI Survey

Data Source (Select one):
Other
If 'Other' is selected, specify:
NCI Survey 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 =
☒ **Other** Specify: NCI Survey Team	☒ **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.2 Number and percent of waiver participants whose scope and type of services are delivered as specified in the PCSP N: # of waiver participants whose scope and type of services are delivered as specified in the PCSP D: Total # of waiver participants in the sample

Data Source (Select one):
Other
If 'Other' is selected, specify:
Participant's record in the State's case management IT system/Bridge records and Medicaid Management Information System (MMIS) Data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with +/- 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 whose amount of services are delivered as specified in the PCSP Numerator: Number of waiver participants whose amount of services is delivered as specified in the PCSP Denominator: Total number of waiver participants in the sample

Data Source (Select one):
Other
If 'Other' is selected, specify:
Participant's record in the State's case management IT system/Bridge records and Medicaid Management Information System (MMIS) Data

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

		95% confidence level with +/- 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.5 Number and percent of waiver participants whose frequency and duration of services are delivered as specified in the PCSP Numerator: # of waiver participants whose frequency and duration of services are delivered as specified in the PCSP Denominator: Total # of waiver participants in the sample

Data Source (Select one):
Other
If 'Other' is selected, specify:
Participant's record in the State's case management IT system/Bridge records and Medicaid Management Information System (MMIS) Data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with +/- 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 whose PCSPs document a choice between/among HCBS waiver services and qualified waiver service providers
Numerator: Number of waiver participants whose PCSPs document a choice between/among HCBS waiver services and qualified waiver service providers.
Denominator: Total number of waiver participants in the sample

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with +/- 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**

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:
D.e.2 Number and percent of CES waiver participants and/or family members responding to the NCI survey who indicate they had a choice of service providers N: Number of CES waiver participants and/or family members responding to the NCI survey who indicate they had a choice of service providers D: Total number of CES waiver participants and/or family members responding to the NCI survey

Data Source (Select one):
Other
If 'Other' is selected, specify:
National Core Indicator Survey

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

D.a.1
All of the services listed in the PCSP must correspond with the needs listed in the ADLs, Supervision, and medical sections of the LOC Screen. If a participant scores two or more on the LOC Screen, the participant's need must be addressed through a waiver/state plan service or by a third party (natural supports, other state programs, private health insurance, or private pay). The reviewers use the State's case management IT system and/or Bridge to discover deficiencies for this performance measure and report in the QI Review Tool.

D.a.2
PCSP must appropriately address personal goals as identified in the Personal Goals section of the PCSP. Goals should be individualized and documented in the HCBS Goals sections of the participant's record. The reviewers use the State's case management IT system and/or Bridge to discover deficiencies for this performance measure and report in the QI Review Tool.

D.a.3
Health and safety risks must be addressed in the participant's record through a contingency plan. The narrative in the contingency plan must be individualized and include a plan to address situations in which a participant's health and welfare may be at risk in the event that services are not available. The reviewers use the State's case management IT system to discover deficiencies for this performance measure and report in the QI Review Tool.

D.c.1
If 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 person-centered support planning process are available for signature through digital or wet signatures based on the member's preference. The reviewers use the BUS 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.c.3, D.d.1, D.e.2
Colorado participates in the National Core Indicators (NCI) study that assesses performance and outcome indicators for state developmental disabilities service systems. This study allows the Department to compare its performance to service systems in other states and within our state from year to year.
Performance and outcome indicators to be assessed covering the following domains:
- Consumer Outcomes
- System Performance
- Health, Welfare, & Rights
- Service Delivery System Strength & Stability

In addition, Colorado has added some waiver-specific questions to assist with assuring that participants know who to contact if SPs need updating; PCSP meets the participant's expectations; and, that participants had a choice of providers.

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 CMAs annually to assist with improving compliance with PCSP performance measures and in developing future individual PCSP. The remediation process includes a standardized template for individual CMA Corrective Action Plans (CAPs) to ensure all of the essential elements, including root-cause analysis, are addressed in the CAP. Time-limited CAPs are required for each performance measure when the threshold of compliance is at or below 85%. The CAPS must also include a detailed account of actions to be taken, staff responsible for implementing the actions, timeframes, and a date for completion. The Department reviews the CAPs, and either accepts or requires additional remedial action. The Department follows up with each individual CMA quarterly to monitor the progress of the action items outlined in their CAP.

The Department compiles and analyzes CMA CAPs to determine a statewide root cause for deficiencies. Based on the analysis, the Department identifies the need to provide policy clarifications, and/or technical assistance, design specific training annually, and determine the need for modifications to current processes to address statewide systemic issues.

The Department monitors PCSP 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 pieces of training delivered. Additional training, technical assistance, or systems changes will be implemented based on those results.

D.c.3, D.d.1, D.e.2
The Department compares data on response rates to NCI questions and responses from waiver year to waiver year. The Department analyzes the outcome of the survey and uses this information to assist with the development of the waiver training curriculum as well as to develop needed policy changes.

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**

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

Notification Upon Enrollment for Waiver Services- The CCB will inform individuals of the fair hearing process as it relates to the Level of Care (LOC) evaluation and reevaluation and waiver eligibility due to LOC. This occurs by providing the LTC 803 form only for LOC and waiver eligibility due to LOC.

The Case Management Agency (CMA) will inform individuals of their opportunity to request a fair hearing as it relates to the receipt of services and waiver eligibility due to the lack of receipt of services. This occurs by providing the LTC 803 form when there is a denial of services, a decrease in services, discontinuation of services, or discontinuation from the waiver due to lack of receipt of services or not residing in the community. The 803 forms completed are available for the case manager and case manager supervisor signature through digital or wet signatures.

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 Community-Centered Board (CCB) is required to generate the LTC 803 Form utilizing the Benefits Utilization System (BUS) and mail it to the participant at least ten days before the date of the intended action. The Department of Health Care Policy & Financing (the Department) rules and regulations regarding notification are located at 10 CCR 2505-10 8.057.2.

When Notice is Provided- A waiver participant is notified of his/her right to a fair hearing upon enrollment in the waiver and when the CCB anticipates an adverse action will be taken (i.e. when the CCB is not providing the individual choice home and community-based services an alternative to institutional services, is denying the individual choice in waiver services or choice in qualified providers, denying enrollment, or taking action to suspend, reduce or terminate services).

Location of Notice Records- Notices of the adverse action and opportunity for a fair hearing are maintained in the BUS and referenced by the participant's State Medicaid identification number. Copies of participant requests for a fair hearing are maintained by the Colorado Office of Administrative Courts and in the participant's master record maintained by the CCB.

CCB and CMA agencies are not required to provide assistance in pursuing a Fair Hearing. However, Colorado does have free or low cost and pro bono entities who will assist individuals and the CCB or CMA can provide this assistance to individuals if needed. Individuals are provided a list of these entities as a part of the notification of their rights to a fair hearing.

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.

Operational Responsibility- The Department is responsible for operating the additional dispute resolution process. Administrative rules describing the requirements for this process are located at 10 CCR 2 2505-10 § 8.605.2 and apply to all persons receiving services for Individuals with Intellectual Disabilities, including waiver participants.

Process Description- A waiver participant may utilize the additional process to dispute specific actions taken by the CCB or qualified provider. This additional dispute resolution process is not a pre-requisite or substitute for the Medicaid Fair Hearing process specified in Appendix F 1. The participant is informed of his/her rights associated with each process. The additional process is available when the CCB intends to take action based on a decision that: a) the applicant is not eligible or the participant is no longer eligible for services and supports in the developmental disabilities system, b) the participant's services and supports are to be terminated or, c) services set forth in the participant's service plan are to be provided, or d) are to be changed, reduced, or denied. Additionally, the process is available when a qualified provider decides to change, reduce or terminate services or supports. Notification of the intended action shall be provided to the participant in writing at least 15 days prior to the effective date of the intended action. If the participant decides to contest the intended action, he/she may file a complaint with the agency intending to take the action. When a participant files a complaint the agency shall afford the participant access to the following procedures:

Local Informal Negotiations- Within 15 days receipt of the complaint, the agency shall afford the participant and any of his/her representatives the opportunity to informally negotiate a resolution to the complaint. If both parties waive the opportunity for informal negotiations, or if such negotiations fail to resolve the complaint, the agency shall afford the participant an opportunity to present information and evidence to support his/her position to an impartial decision maker. The impartial decision maker may be the director of the agency taking the action or their designee. The impartial decision maker shall not have been directly involved in the specific decision at issue.

Meeting With an Impartial Decision Maker- The agency and participant shall be provided at least a 10-day notice of a meeting with the impartial decision maker. The impartial decision maker may be the director of the agency taking the action or their designee. Per 10 CCR 2 2505-10 § 8.605.2the impartial decision maker cannot have been directly involved in the specific decision at issue. The participant may bring a representative to the meeting and shall be provided with the opportunity to respond to or question the opposing position. A decision by the impartial decision maker shall be provided to both parties within 15 days of the meeting and shall include the reasons/rationale for the decision. If the complaint is not resolved, either party may object to the decision and request a review of the decision by the Department within 15 days of the postmark of the written decision.

Department Review of the Dispute Decision- The Department is responsible to review the dispute decision. When a complainant submits a request for review to the Department the party (agency or participant) responding to the complaint has 15 days to respond and submit additional documentation supporting their decision to the Department. The Department may request additional information from either party. The dispute resolution review by the Department is a de novo review of the dispute and a decision shall be rendered to the parties within 10 working days of submission of all relevant information. The decision rendered by the Department is considered to be the final agency action on the dispute in relation to this specific process. This process and final agency action taken in the dispute is not a substitute or pre-requisite to the Medicaid Fair Hearing Process or any decision rendered in the process.

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:

The Department of Health Care Policy & Financing (the Department) is responsible for operating the state grievance/complaint system. Administrative rules describing the requirements for this process are located at 10 CCR 2505-10 § 8.605.5 et seq. and apply to all persons receiving services for Individuals with Intellectual Disabilities through the Department, including waiver participants.

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).

The Department is responsible for operating the grievance complaint system. A waiver participant may file a grievance/complaint regarding any dissatisfaction with services and supports provided. All CCB and qualified provider agencies are required to have specific written procedures to address how grievances will be handled. The agencies' procedures shall identify who at the agency is to receive the grievance and who will support the participant in pursing his/her grievance, how the parties shall come together to resolve the grievance (including the use of mediation), the timelines for resolving the grievance and that the agency director considers the matter if the grievance cannot be resolved at a lower level. An agency is required to maintain documentation of grievances/complaints received and the resolution thereof. An agency shall provide information on its grievance/complaint procedure at the time a participant is enrolled into the waiver and anytime the participant indicates dissatisfaction with some aspect of the services and supports provided. 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.Such information also states that the use of the grievance/complaint procedures is not a pre-requisite or substitute for the Medicaid Fair Hearing process specified in Appendix F 1. Participants have access to both processes.

Participants or his/her representatives may file a grievance with the Department via telephone, US mail or e-mail. The Department has written procedures for addressing grievances/complaints regarding services and supports provided in the developmental disabilities services system (Quality Management Manual June 2007). These procedures specify that the Department staff are to determine the level of involvement of state staff in resolving complaints including, where indicated, direct complaint investigation by the Department staff and requirements for documentation of results in the Department complaint log. All complaints received via voicemail or e-mail are to be responded to within one business day. Primary involvement by the Department staff in resolving the complaint is generally only implemented when local efforts to resolve the complaint have failed, or if the complainant has a valid reason for not contacting the local agency (e.g., previous efforts to resolve similar complaints have failed, complaint involves a manager at the agency, fear of retaliation, etc.) Timelines for resolving the complaint are to be commensurate with the seriousness of the complaint (e.g., a complaint regarding a health and welfare issue shall be resolved immediately, complaints regarding agency meal menu selection procedures should be resolved promptly, etc.). The Department staffs are responsible for follow-up with the complainant regarding resolution of the complaint and for documenting the complaint and its resolution in the Complaint Log. The Department staff are also responsible for maintaining a written record of all complaints investigated by the Department Staff.

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).

Reporting to Law Enforcement and Child Protection- All service providers, Community Centered Boards (CCB), and Case Management Agencies (CMA) are required to report any incident in which a crime may have been committed to local law enforcement pursuant to Title 18 8 115, C.R.S. (Colorado Criminal Code - Duty To Report A Crime). The agencies, CCB, and CMA must also report any suspected incidents of abuse, neglect, or self-neglect to law enforcement and to county departments of social services child protection units. Requirements for reporting are located at 10 CCR 2505-10 8.608.8.

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 Incidents 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.

Critical Incident Types:

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.

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.

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 caretaker that results in damage to the consumer's property or theft the incident shall be listed as mistreatment

Death Unexpected or expected

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

Medication Management 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.

Missing Person is not immediately found, their safety is at serious risk, or there is a risk to public safety.

Unsafe Housing/Displacement Individual is residing in unsafe living conditions due to a natural event (such as a fire or flood) or environmental hazard (such as infestation) and is at risk of eviction or homelessness.

Other Serious issues that do not yet have their own category of critical incident type.

Provider Reporting: The Department of Health Care & Policy Financing (the Department) requires all PASAs to report specific types of incidents to the CMA immediately upon detection via telephone, e-mail, or facsimile but no more than 24 hours after the incident occurrence. These incidents include allegations of mistreatment, abuse, neglect and exploitation, medical crises requiring emergency treatment, death, victimization as a result of a serious crime, alleged perpetration of a serious crime, and missing persons. Requirements for such reporting are located at 10 CCR 2505-10 Section 8.608.8(2)(7) Subsequent to initial reporting, the agency must submit a written incident report to the CMA within 24 hours of the discovery of the incident.

CMA Reporting- CMAs are required to report all Critical Incidents to the Department within 24 hours (1 business day). Critical Incidents are reported to the Department via the web-based Critical Incident Reporting System (CIRS) operated by the Department through a secure portal.

The Department’s oversight for monitoring safeguards and standards is with the use of critical incident reports (CIRs) or complaint logs. 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.

In the event an individual must evacuate their current setting, the Department has developed processes that will ensure the health, safety, and welfare of the client while allowing for additional flexibility in the location and timeliness of the critical incident reporting due to the emergent need. The member’s case manager will enter the member’s critical incident and any identified follow-up to the critical incident utilizing existing timelines identified by the Department and may request an extension in timelines for entry from the Department to the urgent nature of the evacuation.

In cases of emergency or evacuation, the case manager may authorize needed services using a temporary interim service plan, not to exceed 60 days. This plan will be developed when additional services, essential to the member's health and safety, related to the emergency situation are identified. The case manager will authorize the services using the most effective means of written communication. Service providers may provide services authorized in this manner until the case manager is able to complete a service plan revision which will backdate to the date of the temporary interim service plan. This type of interim temporary plan will only be used for already enrolled waiver participants who have been determined eligible for the waiver pursuant to the eligibility process in the waiver.

Case managers are responsible for following up with appropriate individuals and/or agencies in the event any issues or complaints have been presented. Each client and/or legal guardian is informed at the time of initial evaluation and reevaluation to notify the case manager if there are changes in the care needs and/or problems with services.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The Community Centered Board (CCB) and Case Management Agency (CMA) provide information about mistreatment, abuse, neglect, and exploitation to the participants, guardians, involved family members, and authorized representatives at initial enrollment and annually thereafter. This will include 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.

Additionally, the information will include the requirements of service provider agencies and CMAs for detecting and follow-up to suspicions and allegations of mistreatment, abuse, neglect, and exploitation.
The Department has developed Policies and Procedures for the Critical Incident Reporting System (CIRS). Similar resources are also available to clients and case managers about emergency backup and safety and prevention strategies.

Case managers must document if abuse, neglect, or exploitation is suspected during the initial and annual assessment process. The client and/or the client's representative participate in the development of the PCSP and are provided a copy of the completed document. The Department uses its case management system, the State's case management IT system, to track the provision of this information and training. The case manager must confirm within the PCSP that the client and/or client's representative have been informed of and trained on the process for reporting critical incidents including abuse, neglect, and exploitation.

Resource materials are available through the case manager and the Department's website. This information packet developed by the Department will be distributed by case managers to clients and/or client representatives at the initial intake and annual Continued Stay Review (CSR). This information includes a list of client roles and responsibilities, case management roles, and how to file a complaint or appeal outside of the CMA system.

Clients are encouraged to report critical incidents to their provider(s), case manager, Adult Protective Services (APS), local ombudsman, and/or any other client advocate. The information packet includes what types of critical incidents to report and to whom the critical incident should be reported.

The PCSP identifies concerns about abuse, neglect, mistreatment, and exploitation that were identified in the participant's level of care assessment. The intellectual and developmental disabilities section of the PCSP has data fields to document the participant's response to whether he/she feels safe in the home and whether he/she would like to learn self-advocacy skills. When requested by the participant and/or guardian, individual services and support plans can be developed to teach the participant how to protect him/herself to prevent and report abuse, neglect, mistreatment and exploitation.

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.

Response to Critical Incidents Reportable To Law Enforcement and Child Protection- Investigations by law enforcement agencies and county departments of Child Protective Services (CPS) take precedence over investigations conducted by the Department or Community Centered Boards (CCBs). Critical incidents reportable to Law Enforcement or CPS are when a crime may have been committed against or by a waiver participant, and allegations of abuse, neglect, or self-neglect of a waiver participant. Following the Law Enforcement or CPS investigation, the CMA is responsible for follow-up action. In these circumstances, the case manager will contact the waiver participant and/or representatives to determine the impact on the participant's ongoing health and welfare. This may include contacting provider agencies, representatives from CPS, or other involved parties to gather information. When appropriate, the CMA must conduct a review of any questions not resolved by law enforcement or county CPS investigation (e.g., provider training, program management supervision, etc.).

Response to Critical Incidents by CMAs-CMAs must ensure the health, safety, and welfare of waiver participants, provide access to victim's supports when needed, and take follow-up actions to address the Critical Incident and prevent a recurrence.

Response to Critical Incidents by CCBs-CCBs are required to investigate all allegations of mistreatment, abuse, neglect, and exploitation pursuant to the Department Rule 10 CCR 2505-10 8.608. All investigations completed by CCBs are to comply with the recommended standards of practice specified in the Conducting Serious Incident Investigations manual developed by Labor Relations Alternatives, Inc. The local Human Rights Committee (HRC) reviews all written investigation reports and, where appropriate, issues recommendations for follow-up actions by the provider agency and or the CCB and or the CMA.

Response to Critical Incidents by service providers and PASAs-Service providers must ensure the immediate and on-going health, safety, and welfare of waiver participants, provide access to victim's supports when needed, and take follow-up action to address the Critical Incident and prevent a recurrence.

Response to Critical Incidents by The Department-The Department contracts 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 Department takes remedial action to address with service providers and/or CMAs when needed for deficient practice in reporting and management of Critical Incidents to ensure the health, safety, and/or welfare of waiver participants. This includes a formal request for response, technical assistance, Department investigation, the imposition of corrective action, termination of CMA contract, and termination of a service provider's Colorado Provider Participation Agreement/Program Approval for the HCBS-CES waiver.

The Department provides each CMA with a quarterly and annual report outlining identified CIR trends for that CMA coverage area. The CMA utilizes this information to target case management action to mitigate trends.

When the Department determines that an investigation by state staff is required the investigation is initiated within 24 hours. The Department determines the need for state-level investigation based on 1) the severity of the critical incident (e.g., hospitalization due to pneumonia versus physical abuse resulting in an injury, etc.); 2) the critical incident history of the waiver participant; and 3) the history of the CMA and provider agencies regarding reporting and response to critical incidents.

Additionally, The Department conducts or closely monitors those investigations in which there may be a direct conflict of interest when the investigating party is or is part of the investigated party. The Department reviews all complete, written critical incident and follow-up investigation reports, in the event of abuse, neglect, or exploitation. This is to ensure the investigation is thorough, conclusions are based upon evidence, and that all investigative questions are addressed. Timelines for completion of follow-up and/or investigation of critical incidents depend upon the severity and complexity of the incident but are generally resolved within 30 days of the critical incident unless a good cause for a delay exists (e.g., awaiting investigation by law enforcement, lack of access to witnesses or the victim for interviews, etc.). Investigations completed by the Department are conducted in accordance with the recommended standards of practice specified in the Conducting Serious Incident Investigations manual developed by Labor Relations Alternatives, Inc.

Notification of Outcomes of Investigations- All investigations completed by the Department are documented in a written investigation report. If the target of the investigation is a staff person/host home provider or a provider agency to which the allegations are against, the written investigation report is not shared with the target(s) of the investigation. When the CMA is not the target of the investigation, a summary is provided to inform them whether the allegation was substantiated, and any recommendations or directives including deficiencies requiring plans of correction. The Department will notify the participant, legal representative, and/or his/her guardian of the findings of the investigation and any follow-up action required, within 5 working days of completing the written investigation report. Investigators are encouraged to keep participants, authorized representatives, and guardians advised of the progress of the investigation, and to assist providers with putting victim supports into place. Summary information regarding the findings and recommendations of all investigations are made available to provider agencies, waiver participants, authorized representatives, and/or guardians within five (5) days of local HRC review of the investigation. The information may be shared with the service provider agency prior to HRC review to prevent future incidents, address quality of care issues, or provide victim supports.

Practices regarding notification of the outcomes of investigations completed by local law enforcement and child protective services agencies are under the purview of those agencies. Typically, those agencies provide standard information on the outcomes of the investigation to victims of abuse, neglect, or exploitation.

Upon completion of the investigation, the CMAs will provide verbal and written information to the participant, and where appropriate, guardian or authorized representatives, on the outcomes of the investigation. Service provider agencies are also notified of the outcome of the investigation and, where appropriate, recommendations or directives to prevent future incidents and to provide support to the participant. Service provider agencies are also expected to provide documentation of follow-up action to the investigation to the CMA for review and approval by the local HRC.

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.

On-going oversight of Critical Incidents is the responsibility of the Department. The Department conducts oversight through the following methods:

The Department contracts with a Quality Improvement Organization, QIO, to review all Critical Incidents. The QIO monitors Critical Incidents for the completion of necessary follow-up to ensure the health, safety, and welfare of waiver participants. The QIO provides monthly reports to the Department on the number and types of Critical Incidents, a summary of Critical Incidents, and follow-up action completed. There is an immediate notification process for the QIO to notify the Department of high-risk or priority Critical Incidents.

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

CIR TRIAGE is as follows: assignment of levels of priority to Critical Incidents Types to determine the most effective order in which to process each report.

o HIGH PRIORITY: those which need immediate attention and must be addressed when received as no indication of ensuring health and safety is demonstrated. CIRs that would be considered High Priority would be those categorized as:

• Mistreatment (abuse, neglect, exploitation) in which immediate action must be taken to ensure an individual's health and safety, or if law enforcement has not been notified per Mandatory Reporting Requirements.

• Missing Person in which an individual with a line of sight supports/high care needs has not been found when CIR is submitted.

• Unsafe housing or displacement from a natural disaster, fire, or stemming from caretaker neglect, which leaves the individual without housing and needs immediate attention and housing to ensure health and safety.

• Death under suspicious circumstances that needs investigation, involves mistreatment, law enforcement, or where the cause of death is unknown and autopsy must be performed by a coroner.

• Injury/Illness in which no treatment has been sought, trends imply mistreatment, or those which have no immediate intervention noted to ensure the health and safety of an individual receiving services. DIDD Waivers also include Safety and Emergency Control Procedures resulting in serious injury caused by staff with no least restrictive measures utilized prior to holds/restraints or if mistreatment by staff is suspected.

• Medication Mismanagement in which error leads to an adverse medical crisis (or death) and needs immediate attention to ensure health and safety or mistreatment or theft/mistreatment by staff is a concern.

• Criminal Activity in which individual receiving services is incarcerated for a major serious offense such as homicide and needs immediate follow-up due to seriousness of charge and notification to the Department for possible media coverage of the event.

• Damage/Theft of Property to an individual receiving services self or property which results in a need for immediate action to ensure health and safety or must be reported to Law Enforcement

• Any other CIR in which immediate assurance of health and safety is crucial and has not been addressed by CMA/Agency/staff.

• Any CIR in which there is media involvement or coverage

• It should also be noted that Critical Incidents vary greatly, and the priority level may be subjective. This is also not an all-inclusive list due to variance in events.

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

o LOW PRIORITY: those Critical Incidents that have been remediated by CMA/agencies, have addressed immediate and long-term needs, have implemented services or supports to ensure health and safety and those that have protocols in place to prevent a recurrence of a similar CIR. Critical Incidents that would be Low Priority would be:

• Death, expected. Resulting from long-term illness or natural causes, hospice or palliative care was utilized and documented.

• Missing Person in which the person was immediately found, had no injury and a plan was implemented to prevent a recurrence.

The Department takes remedial action to address with service providers and/or CMAs when needed for deficient practice in reporting and management of Critical Incidents to ensure the health, safety, and/or welfare of waiver participants. This includes a formal request for response, technical assistance, Department investigation, the imposition of corrective action, termination of CMA contract, and termination of a service provider's Colorado Provider Participation Agreement/Program Approval for the HCBS-CES waiver.

The Department provides each CMA with a quarterly and annual report outlining identified CIR trends for that CMA coverage area. The CMA utilizes this information to target case management action to mitigate trends.

The Department maintains an Interagency Agreement (IA) with the Colorado Department of Public Health and Environment (CDPHE) to conduct on-site licensure and re-certification and complaint surveys for HCBS-CES providers. CDPHE submits a report monthly to HCPF on the number and type of providers surveyed and the findings. If a deficient practice is detected with critical incident reporting, the agency must correct the practice in order to obtain licensure or recertification.

In addition, case managers are required to maintain records for all critical incidents that are reported or are known to case managers. The Department performs CMA monitoring through a review of critical incident and complaint reporting. All case managers must complete training on Critical Incident Reporting requirements within 120 days of the hire date per contract requirements.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Restraints- The use of physical, mechanical, and chemical restraints is not prohibited in state statutes or policies. However, § 25.5-10-221 C.R.S. prohibits the use of certain mechanical devices (e.g., poesy vests, straitjackets, wrist and ankle restraints) and places specific restrictions on the use of physical and mechanical restraints. § 26-20-103 C.R.S. provides additional prohibitions and restrictions on the use of restraints.

Restraints may be used only in an emergency after alternative procedures have been attempted and failed, and to protect the client and others from injury. An "emergency is defined as a serious, probable, imminent threat of bodily harm to self or others where there is the present ability to affect such bodily harm. Only trained provider staff may use mechanical or physical restraints. Providers are to use alternative methods of positive behavior support (e.g., de-escalation techniques, positive reinforcement, verbal counseling, etc.) and/or the least restrictive alternative to bring the client's behavior into control prior to the use of mechanical or physical restraints.

Direct care service providers must be trained in general positive behavioral supports and in service and supports specific to individuals for whom services are provided (e.g., Individual Service and Support Plan to address behavior and individual's Safety Control Procedure.) In addition, the PASA and CMA must have policies and procedures specific to the use of emergency control procedures (i.e., unanticipated use of restraint) and should include positive behavioral interventions in such procedures.

Only trained provider staff may use mechanical or physical restraints. Restraints may be used only in an emergency after alternative procedures have been attempted and failed, and to protect the client and others from injury. An "emergency is defined as a serious, probable, imminent threat of bodily harm to self or others where there is the present ability to effect such bodily harm.
Requirements and safeguards for the use of mechanical and physical restraints are specified in CCR 2505-10 § 8.608.3 et seq. and 8.608.4 et seq., which also require the following:

1. The individual shall be released from physical or mechanical restraint as soon as the emergency condition no longer exists.
2. Physical or mechanical restraint cannot be a part of an Individual Service and Support Plan and only can be used in accordance with rules and regulations.
3. No physical or mechanical restraint of a person receiving services shall place excess pressure on the chest or back of that person or inhibit or impede the person's ability to breathe.
4. During physical restraint, the person’s breathing and circulation must be monitored to ensure that these are not compromised.
5. Each CMA and provider agency must have written policies and procedures on the use of physical restraint exceeding 15 minutes. Such policies and procedures must allow for physical restraint exceeding 15 minutes only when absolutely necessary for safety reasons and provide for backup by appropriate professional and/or agency staff.
6. Relief periods of, at a minimum, 10 minutes every hour must be provided to a person in mechanical restraint, except when the person is sleeping. A written record of relief periods must be maintained.
7. A person placed in a mechanical restraint must be monitored at least every 15 minutes by agency staff trained in the use of mechanical restraint to ensure that the person’s physical needs are met and the person’s circulation is not restricted or airway obstructed. A written record of such monitoring must be maintained.

The use of restraints in a prone position is prohibited.

Mechanical restraints used for medical purposes following a medical procedure or injury must be authorized by a physician's order that must be renewed every 24 hours. Other requirements applicable to mechanical restraint also apply.

Mechanical or physical restraints used for diagnostic or other medical procedures conducted under the control of the agency (e.g., drawing blood by an agency nurse) must be dually authorized by a licensed medical professional and agency administrator, and its use documented in the client’s record.

Monitoring- CMA and provider agency staff are responsible for monitoring incident reports to identify when restraints are not used in accordance with statutory and regulatory requirements. Use of restraints not conforming to those requirements meets the definition of abuse (unreasonable restraint), is required to be

reported as an allegation of abuse, and is subject to the investigation of abuse requirements specified in 10 CCR 2505-10 8.608.8. The use of physical, mechanical, and chemical restraints are reviewed by a local Human Rights Committee, pursuant to the Department Rule 10 CCR 2505-10 8.6008.5, either prior to the planned use of restraints or after each incident in which restraint was used.

Emergency Control Procedures- Emergency Control Procedures are defined as the unanticipated use of a restrictive procedure or restraint in order to keep the client and others safe. Each provider agency is required to have written policies on the use of Emergency Control Procedures, the types of procedures that may be used, and requirements for staff training. Behaviors requiring Emergency Control Procedures are those that are infrequent and unpredictable. Emergency Control Procedures may not be employed as punishment, for the convenience of staff, or as a substitute for services, supports, or instruction.
Within 24 hours after the use of an Emergency Control Procedure, the responsible staff person must file a written incident report. The incident report must include the following information:

1. A description of the Emergency Control Procedure employed, including beginning and ending times;
2. An explanation of why the procedure was judged necessary; and,
3. An assessment of the likelihood that the behavior that prompted the use of the Emergency Control Procedure will recur.

Within three days after the use of an Emergency Control Procedure, the CMA/case manager, guardian, and authorized representative if within the scope of his or her duties, must be notified of the use of the mechanical or physical restraint.

Safety Control Procedure- Safety Control Procedure is defined as a written plan describing what procedures will be used to address emergencies that are anticipated, and stating that physical or mechanical restraints are to be used to ensure the safety of the client or others when previously exhibited behavior is likely to occur again. The use of Safety Control Procedures must comply with the following:

Each Case Management Agency and program-approved service agency must have written policies on the use of Safety Control Procedures, the types of procedures that may be used, and requirements for staff training. When a Safety Control Procedure is used, the provider agency must file an incident report within three days with the CMA/case manager for each use of a Safety Control Procedure. If the Safety Control Procedure is used more than three times within the previous 30 days, the client's interdisciplinary team must meet to review the situation and to endorse the current plans or to prepare other strategies.

In conformance with the requirements of § 26-20-104, C.R.S. chemical restraints may be used only in an emergency and cannot be ordered or used on a PRN basis. Only a licensed physician that has directly observed the emergency can prescribe chemical restraints or he/she may order the use of the medication for an emergency via telephone if a licensed registered nurse has directly observed the client and determined that an emergency exists. The licensed registered nurse must transcribe and sign the order at the time the order is received.
Subsequent to the administration of the chemical restraint, the physician or licensed registered nurse must observe the effects of the chemical restraint and record the effects in the record of the participant.

Within 24 hours, the responsible provider agency staff must file a written incident report documenting the use of the chemical restraint with the CMA/case manager.
Training Requirements- All direct service staff must receive training on the use of restraints and Emergency Control Procedures and Safety Control Procedures prior to having unsupervised contact with waiver clients. Additionally, provider staff responsible for the use of restraints must receive specific training on the emergency procedures to be used with clients under their care.

The Department ensures that requirements and safeguards for the use of mechanical and physical restraints specified in Rules located at 10 CCR 2505-10 § 8.608.3 et seq. and 8.608.4 et seq. are met through on-site certification and recertification surveys. Surveys are conducted by the Colorado Department of Public Health and Environment (CDPHE) on behalf of the Department through interagency agreement.

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:

State oversight of the use of restraints is the responsibility of the Department of Health Care Policy & Financing (the Department). Such oversight is accomplished through the operation of the Critical Incident Reporting System (CIRS), review of Case Management Agency (CMA) incident data and Program Quality surveys of CMA and Program Approved Service Agencies (PASA).

Critical Incident Reporting System (CIRS) Monitoring- The web-based CIRS system operated by the Department includes a specific data field for recording if any critical incident involved the use of restraints. Therefore, any use of restraint in an allegation of serious abuse, medical crisis (i.e. needing emergency medical treatment), a crime against a person, or death is reported immediately to the Department. Such incidents receive additional scrutiny by the Department staff that includes a review of the original written incident report to ensure restraint was used in compliance with statutory and regulatory requirements. The CIRS monitoring operates on a daily/continuous basis.

The Critical Incident Reporting Team monitors data on a monthly and quarterly basis. Provider trends are relayed to the Department's Benefits Division to address and determine appropriate actions as needed.

The Department provides each CMA with a quarterly and annual report outlining identified CIR trends for that CMA coverage area. The CMA utilizes this information to target case management action to mitigate trends.

Program Quality Surveys- The Department conducts regulatory surveys of CMAs that include a review of the agency's incident management practices, compliance with standards for incident reporting and review, and data analysis practices. Such surveys include a specific review of written incident reports documenting the use of restraints to ensure such reports contain the information required by 10 CCR 2505-10 § 8.608.4(A)(4) and 8.608.4(B) and that restraints are used only within the requirements specified in 10 CCR 2505-10 § 8.608.3 et seq. and 8.608.4 et seq. The Department delegates authority to CDPHE to conduct an on-site regulatory survey of PASAs. Additionally, surveys of CMAs include a specific review of the local HRC review activities, the composition of the participant's interdisciplinary team, and an investigation of allegations of abuse related to unreasonable restraint. When non-compliant use of restrictive procedures, restraints, or any use of seclusion is detected, deficiencies are cited and the responsible agency is required to submit a plan of correction.

Seclusion- The use of seclusion is specifically prohibited by § 25.5-10-221 C.S.R. The oversight mechanisms described above in G.1.c. are employed when an incident involving seclusion is detected.

The Department has waiver-specific performance measures included in the Quality Improvement Strategy (QIS) regarding the use of restraints. Please see the Performance Measure section of this application for additional information. Please note that the review of these waiver specific performance measures will be subject to the same remediation, data aggregation, review, and quality improvement processes specified in the Global QIS.

The Department maintains an Interagency Agreement with the Colorado Department of Public Health and Environment (CDPHE) to monitor the use of restraints by HCBS-CES waiver service providers. CDPHE conducts on-site recertification surveys of service agencies that include a review of the agency’s incident management practices, compliance with standards for incident reporting, and review and data analysis practices. Such surveys include a specific review of written incident reports documenting the use of restraints to ensure such reports contain the information required by the Department. When non-compliant use of restraints or any use of seclusion is detected, deficiencies are cited, and the responsible agency is required to submit a plan of correction. Program Quality on-site surveys are completed at least every three years. CDPHE submits a report monthly to HCPF on the number and type of providers surveyed and the findings.

3)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

The Department's Critical Incident Reporting system detects the use of unauthorized restrictive interventions through the receipt and follow-up on Critical Incident Reports submitted by Case Management Agencies. The Department monitors these reports to ensure they follow the below policies and procedures related to restrictive interventions.

The use of aversive or noxious stimuli is specifically prohibited by s§ 25.5-10-221 C.R.S. Restrictive procedures may be used only when alternative non-restrictive behavior programs have been proven to be ineffective in changing the behavior. The service provider shall work in conjunction with the client's interdisciplinary team to develop an Individual Service and Support Plan that explains the use of any restrictive procedures. Restraints may not be used as part of a behavior plan and can only be used as part of an Emergency or Safety Control Procedure, as described in G.2.a.i.

10 CCR 2505-10 § 8.600.4 defines a Restrictive Procedure as any of the following when the intent or plan is to bring the person's behavior into compliance: A. Limitations of an individual's movement or activity against his or her wishes; or, B. Interference with an individual's ability to acquire and/or retain rewarding items or engage in valued experiences. Additionally, this rule defines Challenging Behavior as Behavior that puts the person at risk of exclusion from typical community settings, community services, and supports, or presents a risk to the health and safety of the person or others or significant risk to the property.

10 CCR 2505-10 § 8.608.2 provides specific requirements anytime a Restrictive Procedure is to be used as part of an Individual Service and Support Plan (ISSP).

The rights of participants may be removed or suspended only in accordance with state law § 25.5-10-118 C.R.S and 10 CCR 2505-10 § 8.604.3. A suspension of rights is authorized under the two following processes:

-Imposition of Legal Disability: Pursuant to § 25.5-10-116 C.R.S. any individual, including a case manager for a waiver participant, may petition the district court to issue an imposition of legal disability to remove a participant's legal right. The statute provides specific requirements for when such an imposition may be granted and within six months after a legal disability has been imposed a review must occur. All actions to remove a legal right require a court order.

-Suspension of rights: Under the Statewide Transition Plan (STP), providers and case management agencies are moving toward compliance with the requirements of the HCBS Settings Final Rule, including that any rights suspension or restrictive procedure must comply with the HCBS Settings Final Rule requirements, pursuant to 79 Fed. Reg. 2948 and 42 C.F.R. § 441.301, § 25.5-10-118 C.R.S., and 10 CCR 2505-10 § 8.604.3. As of January 1, 2021, case managers were required to enter information about new and up-for-renewal rights modifications in the State's case management IT system. The Department is working with stakeholders to codify the federal settings criteria within state regulations, with the expectation that this codification will be effective by roughly Summer 2021. Under this codification, all rights suspensions and restrictive procedures will be treated as a rights modification under the Federal Rule, and thus requires informed consent. In order to implement a rights modification, the following criteria must be met:

A. Rights modifications are based on the specific assessed needs of the individual, not the convenience of the provider.

B. May only be imposed if the individual poses a danger to themselves or the community.

C. The case manager is responsible to obtain informed and other documentation related to rights modifications/limitations and maintain these materials in their file as a part of the person-centered planning process.

D. Any rights modification must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:

1. Identify a specific and individualized need.

2. Document the positive interventions and supports used prior to any modifications to the person-centered service plan.

3. Document less intrusive methods of meeting the need that has been tried but did not work.

4. Include a clear description of the condition that is directly proportionate to the specific assessed need.

5. Include regular collection and review of data to measure the ongoing effectiveness of the modification.

6. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

7. Include the informed consent of the individual.

8. Interventions and supports will cause no harm to the individual.

State regulations and safeguards in place to protect participant's rights are included in 10 CCR 2505-10 § 8.604.1 et seq,8.604.2 et seq. and 8.604.3 et seq. and includes the following:

All participants, guardians, and authorized representatives must be provided a written and verbal explanation of the client's rights at the time the person is determined eligible to receive developmental disability services, at the time of enrollment, and when substantive changes to services and supports are considered through the service plan development process. The information must be provided in an easy-to-understand format and in the client's native language, or through other modes of communication as may be necessary to enhance understanding. CCB and provider agencies are required to provide assistance and ongoing instruction to clients in exercising their rights. No client, his/her family members, guardian, or authorized representatives, may be retaliated against in their receipt of services or supports or otherwise as a result of attempts to advocate on their own behalf. Agency staff is required to successfully complete training on and be knowledgeable of client's rights and the procedural safeguards for protecting those rights.

When a suspension of a client's rights is under consideration, the rights must be specifically explained to the individual, with written notice of the proposed suspension given to the client, when appropriate, and/or his/her guardian.

At the time a right is suspended, such action shall be referred to the local HRC for review and recommendation. This review must include an opportunity for the client, guardian, or authorized representative to present relevant information to the local HRC. If suspended, the suspension is documented in the client's service plan. The client's service plan must specify the services and supports required in order to assist the person to the point that suspension of rights is no longer needed.

When a right has been suspended, the continuing need for such suspension must be reviewed by the participant's IDT at a frequency decided by the team, but not less than every six months. The review must include the original reason for suspension, the participant's current circumstances, the success or failure of programmatic intervention, and the need for continued suspension or modification. Affected rights must be restored as soon as circumstances justify. Case managers are responsible for monitoring that restrictive procedures and a suspension of rights are used only in compliance with these requirements. Additionally, local HRCs are responsible to ensure restrictive procedures and procedures to suspend rights are used only in compliance with the requirements of state law and Department regulations.

Documentation Requirements- The use of restrictive procedures must be included in the client's service plan or service plan addendum. Copies of the comprehensive life review, functional analysis assessment, written ISSP, and data documenting the use of the restrictive procedures must be maintained in the client's records. Additionally, the CCB is responsible for providing the local HRC with copies of all pertinent documents and data for the HRC to complete its review and must maintain documentation of the HRC's review and recommendations.

Staff Requirements- Staff is required to be trained specifically on the implementation of the ISSP with a restrictive procedure prior to its use. Documentation of training and a signed assurance that the staff person had demonstrated competence in the implementation of the ISSP with a restrictive procedure must be included on the written ISSP. (Staff responsible for supervising an ISSP with restrictive procedures and for implementing a suspension of rights must meet the qualifications of a Developmental Disabilities Professional, defined at 10 CCR 2505-10 § 8.600.4 as a person who has, at least, a Bachelors Degree and a minimum of two years experience in the field of developmental disabilities or a person with at least five years of experience in the field of developmental disabilities with competency in the following areas: a) Understanding of civil, legal and human rights; b) Understanding of the theory and practice of positive and non-aversive behavioral intervention strategies;

c) Understanding of the theory and practice of non-violent crisis and behavioral intervention strategies. Monitoring- Community Centered Boards and provider agency staff are responsible for monitoring services (e.g., incident reports, anecdotal data, interviews, etc.) to identify when restrictive interventions are not used in accordance with statutory and regulatory requirements. The use of restrictive procedures and rights suspensions are reviewed by a local Human Rights Committee, pursuant to The Department Rule 10 CCR 2505-10 8.6008.5, either prior to the planned use of a restrictive procedure or rights suspension or immediately after a right is suspended on an emergency basis. Failure to adhere to these rules requires corrective action against the 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:

The Department of Health Care Policy and Financing (the Department) is responsible for oversight as the single state Medicaid agency. State oversight of the use of restrictive interventions is the responsibility of the Department. The Department conducts oversight through the following methods to detect unauthorized use or inappropriate/ineffective restrictive interventions.

The Department maintains an Interagency Agreement with the Colorado Department of Public Health and Environment (CDPHE) to monitor the use of restrictive interventions for HCBS-CES service providers not licensed by CDHS. CDPHE conducts on-site recertification surveys of service agencies that include a review of the agency’s incident management practices, compliance with standards for incident reporting, and review and data analysis practices. Such surveys include a specific review of written incident reports documenting the use of interventions to ensure such reports contain the information required by the Department. When non-compliant use of interventions is detected, deficiencies are cited, and the responsible agency is required to submit a plan of correction. Program Quality on-site surveys are completed at least every three years. CDPHE submits a report monthly to HCPF on the number and type of providers surveyed and the findings.

Critical Incident Reporting System (CIRS) Monitoring- The web-based CIRS system operated by the Department includes a specific data field for recording if any critical incident involved the use of restrictive interventions. Therefore, any use of a restrictive intervention in an allegation of serious abuse, medical crisis (i.e. needing emergency medical treatment), a crime against a person, or death is reported immediately to the Department. Such incidents receive additional scrutiny by the Department staff that includes a review of the original written incident report to ensure restrictive interventions were used in compliance with statutory and regulatory requirements. The CIRS monitoring operates on a daily/continuous basis.

The Department provides each CMA with a quarterly and annual report outlining identified CIR trends for that CMA coverage area. The CMA utilizes this information to target case management action to mitigate trends.

Program Quality Surveys- The Department conducts regulatory surveys of CMAs that include a review of the agency's incident management practices, compliance with standards for incident reporting and review, and data analysis practices. Such surveys include a specific review of written incident reports documenting the use of restrictive interventions to ensure such reports contain the information required by 10 CCR 2505-10 § 8.608.4(A)(4) and 8.608.4(B) and that restrictive interventions are used only within the requirements specified in 10 CCR 2505-10 § 8.608.3 et seq. and 8.608.4 et seq. Additionally, surveys of CMAs include a specific review of the local HRC review activities, the composition of the participant's interdisciplinary team, and an investigation of allegations of abuse related to unreasonable restrictive interventions. When non-compliant use of restrictive procedures, restraints, or any use of seclusion is detected, deficiencies are cited and the responsible agency is required to submit a plan of correction.

The Critical Incident Reporting Team monitors data on a monthly and quarterly basis. Provider trends are relayed to the Department's Benefits Division to address and determine appropriate actions as needed.

CIRs data are tracked, trended, and analyzed by the Critical Incident Reporting Team on a monthly and quarterly basis. Specific provider trends are relayed to the Benefits division to address and determine what improvement strategies need to be implemented.

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:

Seclusion: § 25.5-10-221 C.R.S. prohibits the use of seclusion. Monitoring by case managers, investigation of complaints made to Case Management Agencies (CMA) and the Department of Health Care and Policy Financing (the Department), and program quality surveys conducted by the Department are used to detect the illegal use of seclusion and to prevent any future use of seclusion by a provider agency.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

○ **No. This Appendix is not applicable** *(do not complete the remaining items)*

◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

In order to detect potentially harmful practices, and follow up to address such practices, the following entities are responsible for monitoring medication administration:

HCBS-CES waiver service providers must complete on-site monitoring of the administration of medications to waiver participants including inspecting medications for labeling, safe storage, completing pill counts, and reviewing and reconciling the medication administration records, and interviews with staff and participants.

As part of the health inspection and survey process, CDPHE reviews medication administration procedures, storage of all medication, including controlled substances, medication audit and disposal practices, and reporting required for drug reactions and medication errors. If deficiencies are cited in any of these areas, CDPHE will follow-up with the provider to ensure compliance with the regulations.

Medication Management and Administration is a responsibility of the PASA and is monitored through CDPHE. The Department requires all PASA's to submit incidents of medication errors that result in a risk to the health or safety of an individual and meet Critical Incident reporting guidelines within 24 hours. The Department completes reviews of CIRs submitted to ensure compliance with requirements and completes follow up with PASA's for remediation/mitigation when necessary.

In addition, the Department monitors Critical Incident Reports submitted by providers for instances of a critical incident resulting from a medication management issue.

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.

The Department of Health Care Policy and Financing (the Department) is responsible for oversight as the single state Medicaid agency. The Department provides oversight through the following methods:

The Department maintains an Interagency Agreement with the Colorado Department of Public Health and Environment (CDPHE) to monitor medication administration for HCBS-CES service providers. CDPHE conducts on-site recertification surveys of service agencies. When any deficient practices detected, deficiencies are cited, and the responsible agency is required to submit a plan of correction. Program Quality on-site surveys are completed at least every three years. CDPHE submits a report monthly to HCPF on the number and type of providers surveyed and the findings.

In addition, the Department monitors Critical Incident Reports submitted by providers for instances of a critical incident resulting from a medication management issue.

Information obtained by the Department through these methods is used to identify and address potentially harmful practices. This information is additionally used to provide training and/or awareness to Case Managers and service providers.

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or

waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Medications may be administered by service providers when done in conformance with the requirements of 10 CCR 2505-10 § 8.609.6.D and 6 CCR 1011-1 Chapter 24. The following requirements must be met when service providers administer medications.

The participants service plan must indicate assistance with medication administration is needed.

Assessment- PASAs are required to assess each participant's need for support in medication management and administration. PASAs are required to provide sufficient support to the participant to ensure his/her safe use of medications.

Staff Administration- Unless the assessment indicates that the participant is independent in administering his/her medications, the administration of medication must comply with 6 CCR 1011-1 Chapter 24 and prescribed by a physician or dentist. When medications are administered to a participant, the PASA must ensure that a written record of medication administration is maintained, including time and amount of medication taken by the person receiving services.

iii. Medication Error Reporting. *Select one of the following:*

◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

Medication errors meeting the criteria of a critical incident are reported to The Department through the CIRS.

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

Medication errors must be recorded anytime an error was made in the dose, route, time, medication provided, or missed medication. Additionally, direct service staff are required to complete a written incident report of any medication errors (including those not meeting the critical incident criteria), which must be reviewed by the service provider agency and the participants case manager.

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

Medication errors reported in the CIRS are those resulting in an 1) Adverse health outcome, a medical crisis; 2) Death; 3) An allegation of neglect or abuse that results in an adverse medical/health outcome; or, 4) A pattern or trend of medication errors that indicate possible abuse or neglect.

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance

of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The Department of Health Care Policy & Financing (the Department) is responsible for ongoing monitoring of the performance of providers that administer medications. To identify problems in provider performance, to support remediation, and to support quality improvement activities, the Department employs the following monitoring methods:

Monitoring Through the Critical Incident Reporting System (CIRS)- As identified in Appendix G.3.iii, specific types of medication errors are required to be reported as a critical incident in the web-based CIRS. Such reports are reviewed by the Department staff as soon as possible upon receipt but always before the end of the next business day and as part of monthly IRT meetings. The CIRS allows the Department staff to issue specific directives to the Case Management Agencies (CMAs) to ensure remediation of identified problems. Specific provider trends identified immediately or through monthly and quarterly reports, are relayed to the Department's Benefits staff to address and determine if further improvement strategies are needed.

The Department provides each CMA with a quarterly and annual report outlining identified CIR trends for that CMA coverage area. The CMA utilizes this information to target case management action to mitigate trends.

Program Quality On-site Surveys- CDPHE, on behalf of the Department conducts on-site regulatory surveys of providers and includes a review of the agency's medication administration practices. These surveys evaluate the practices of the agency to ensure a) unlicensed direct support service providers have met state requirements for training and certification; b physician's orders for all medications; c) safe storage of medications; d) appropriate documentation of medication administration, refusals and errors; and e) that participants have a sufficient supply of medications. CDPHE submits a report monthly to HCPF on the number and type of providers surveyed and the findings.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
G.a.1 # and % of waiver participants &/or family/guardians who received info/education on how to identify & report abuse, neglect, exploitation (ANE), unexplained death & other critical incidents (CI) N: # of waiver participants &/or family/guardians who rcvd info/ed on how to id & report ANE, unexplained death & other CI D: Total # of waiver participants &/or family/guardians in the sample

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level and +/-5% 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.2 Number and percent of all critical incidents that were reported by the Case Management Agency (CMA) within required timeframe as specified in the approved waiver N: Number of all critical incidents reported by the CMA within the required timeframe as specified in the approved waiver D: Total number of all critical incidents reported by the CMA

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
G.a.3 Number and percent of all critical incidents that were remediated N: Number of all critical incidents that were remediated D: Total number of critical incidents

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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:
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 trainings

Responsible Party for data collection/generation	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

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

Data Aggregation and Analysis:

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

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

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

Performance Measure:
G.b.3 Number and percent of annual reports provided to Case Management Agencies (CMAs) on identified trends in critical incidents N: Number of annual reports provided to the CMAs on identified trends in critical incidents D: Total number of annual reports required to be provided to CMAs

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:
State's case management IT System Data and/or CDPHE Reports; Record Reviews

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

☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
G.b.4 Number and percent of preventable critical incidents reported that have been effectively resolved. N: Number of preventable critical incidents reported that have been effectively resolved. D: Total number of preventable critical incidents reported.

Data Source (Select one):
Other
If 'Other' is selected, specify:
State's case management IT System Data/Critical Incident Reports

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

Data Aggregation and Analysis:

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

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:
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**	☐ **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:

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

Performance Measure:
G.c.2 Number and percent of providers surveyed during the performance period that met requirements for use of physical or mechanical restraints. Numerator: Number of providers surveyed during the performance period that met requirements for use of physical or mechanical restraints Denominator: Total number of providers surveyed during the performance period.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
G.c.6 Number and percent of waiver participants with Restrictive Intervention Plans where proper procedures were followed in initially establishing the Restrictive Intervention Plan N:# of wvr participants w/ Restrictive Intervention Plan where proper procedures were followed in initially establishing the Restrictive Intervention Plan D:# of wvr participants w/ a Restrictive Intervention Plan

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

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

☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or

sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
G.d.3 Number and percent of waiver participants who received care from a medical professional within the past 12 months Numerator: The number of participants who received care from a medical professional within the last 12 months Denominator: The total number of participants reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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 Benefits Utilization System (BUS) and the Critical Incident Reporting System (CIRS) and/or complaint logs as the primary method for discovery for the Health and Welfare assurance and performance measures.

CMAs are required to report critical incidents into the state prescribed critical incident reporting system (CIRS) and follow up on each Critical Incident Report (CIR) through the CIRS. Following the receipt of the initial critical incident report, the QIO reviews the documentation to determine if the instance was substantiated. If the documentation does not clearly state whether instance was substantiated, the QIO requests follow up by the CMA to gather the needed information from the parties involved.

G.a.1
An information packet developed by the Dept. must be provided to participants during initial intake and annual CSR. The information includes participant rights, how to file a complaint outside the system, information describing the CIRS and time frames for starting an investigation, the completion of the investigation or informing the participant/complainant of the results of the investigation. Participants are encouraged to report critical incidents to their provider(s), case manager, protective services, local ombudsman and/or any other advocate. The information also includes what types of incidents to report and to whom the incident should be reported.

Compliance with this performance measure requires that the signature section in the service plan indicates that participants (and/or family or guardian) have been provided information regarding rights, complaint procedures, and have received information/education on how to report abuse, neglect, exploitation (ANE) and other critical incidents.

G.a.2
Critical incidents are reported to the Dept. via the web-based CIRS. CMAs and waiver service providers are required to report critical incidents within specific timeframes. The Department monitors critical incident reporting through the CIRS and/or complaint logs.

G.a.3
All follow up action steps taken must be documented in the participant’s CIRS record. Documentation must include a description of any mandatory reporting to APS, referral to law enforcement, notification to ombudsman, or additional follow-up with the participant. The CIR Administrator determines if adequate follow up was conducted and if all appropriate actions were taken and may require additional follow up or investigation if needed.

G.a.4
Critical incidents involving providers surveyed by CDPHE must be reported to the Dept. and CDPHE and are responded to by CDPHE. A hotline is set up for complaints about quality of care, fraud, abuse, and misuse of personal property. CDPHE evaluates complaints and initiates an investigation if warranted. The investigation begins within 24 hours or up to 3 days depending upon the nature of the complaint and risk to the participant’s health and welfare.

G.a.6
CMAs and providers are required to attend preventative strategies trainings. Training records of preventative strategies training are maintained by the Dept.

G.b.3
The Dept. examines data for specific trends to include individuals that have multiple CIRs; identifies participants who have more than one CIR in 30 days, more than three CIRs in six months, and more than five CIRs in 12 months. The Dept. produces critical incident trend reports to be provided to all CMAs at least annually. Records of the reports and dates provided are maintained by the Dept.

G.b.4
The Dept. examines data in the CIRS to determine when critical incidents were preventable and whether resolutions were effective.

G.b.6
Root cause identified/trends reduced as a result of systemic intervention data are tracked and analyzed by the CIR Team on a monthly and quarterly basis including through mortality review committee.

G.c.1
Oversight and discovery of restrictive interventions where proper procedures were not followed are completed through the review of complaints regarding services and supports and conducting surveys of CMAs by Dept. staff and providers by CDPHE .

The Department also monitors for the inappropriate/ineffective use of restrictive interventions through the CIRS. These incidents receive additional scrutiny by the Department staff that includes review of the original written incident report to ensure restrictive intervention was used in compliance with statutory and regulatory requirements.

G.c.2
Providers must demonstrate during the survey process that they have met requirements for the: use of physical or mechanical restraints, requirements for implementing a restrictive intervention, and the use of training and support plans with restrictive interventions.

Department staff review CDPHE reports that are submitted on the number and type of providers surveyed and the findings.

G.c.6
The Dept. takes remedial action to address with waiver service providers and/or CMAs when needed for deficient practice in following the proper procedures of restrictive interventions. This includes formal request for response, technical assistance, Dept. investigation, imposition of corrective action, termination of CMA contract, and termination of waiver service providers.

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 Case Management Agency (CMA) administrator or director and reported in the individual's annual report of findings. CMAs deficient in completing accurate and required critical incident reports 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 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 has 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 of the essential elements, including a 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 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 formal request for response, technical assistance, Dept. investigation, imposition of corrective action, termination of CMA contract, and termination of waiver service providers.

G.a.3
CMAs deficient in completing accurate and required follow ups will receive 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 where upon review of the complaint or occurrence report the Dept. identifies individual provider issues, the Dept. will address these issues directly with the provider and participant/guardian. If the Department identifies trends or patterns affecting multiple providers or participants, the Dept. will communicate a change or clarification of rules to all providers in monthly provider bulletins. If existing rules require an amendment the Dept. will develop rules or policies to resolve widespread issues.

G.a.6
The Dept. requires agencies who do not attend preventative strategies training as required to submit a corrective action plan. If remediation does not occur timely or appropriately, the Dept. issues a "Notice to Cure" the deficiency to the CMA/provider. This requires the agency to take specific action within a designated timeframe to achieve compliance.

G.b.3, G.b.4
The Dept. utilizes this information to develop statewide trainings, 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 division to address and determine what additional remediation/improvement strategies need to be implemented.

G.c.1, G.c.6
The Dept. takes remedial action to address with waiver service providers and/or CMAs when needed for deficient practice in following the proper procedures of restrictive interventions. This includes formal request for response, technical assistance, Dept. investigation, imposition of corrective action, termination of CMA contract, and termination of waiver service providers.

G.c.2
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:

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 CES 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) Pursuant to 2 CFR Part 200 - Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards Subpart F – Audit Requirements §200.502 (i), Medicaid payments to a sub-recipient for providing patient care services to Medicaid eligible individuals are not considered federal awards expended under this part unless a State requires the funds to be treated as federal awards expended because reimbursement is on a cost-reimbursement basis. Therefore, the Department does not require an independent audit of waiver service providers.

Case Management Agencies (CMAs) are subject to the audit requirements within 2 CFR Part 200 for all Medicaid administrative payments. To ensure compliance with components detailed in the OMB Uniform Guidance, CMAs contract with external Certified Public Accountant (CPA) firms to conduct an independent audit of their annual financial statements and conduct the Single Audit when applicable. The Department is responsible for overseeing the performance of the CMAs, reviewing the Single Audits of all CMAs who meet the $750,000 threshold, and issuing management decisions on any relevant audit findings.

(b) & (c) Title XIX of the Social Security Act, federal regulations, the Colorado Medicaid State Plan, state regulations, and contracts establish record maintenance and retention requirements for Medicaid services. A case record/medical record or file must be maintained for each waiver participant. Providers are required to retain records that document the services provided and support the claims submitted for a period of six years. Records may be maintained for a period longer than six years when necessary for the resolution of any pending matters such as an ongoing audit or litigation.

The Department maintains documentation of provider qualifications to furnish specific waiver services submitted during the provider enrollment process and updated according to applicable licensure and survey requirements. This documentation includes copies of the Medicaid Provider Participation Agreement, copies of the Medicaid certification, verification of applicable State licenses, and any other documentation necessary to demonstrate compliance with the established provider qualification standards. All providers are screened monthly against the exclusion lists. Providers are compared against the List of Excluded Individuals 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 Department monitors the action of licensing boards to ensure Medicaid providers are in good standing.

Claims are submitted to the Department's fiscal agent for reimbursement. Claims data are 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:

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.

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.

Additional information in Main B. Optional

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
I.a.1. Number and percent of waiver claims coded and paid according to the reimbursement methodology in the waiver N: Number of waiver claims coded and paid according to the reimbursement methodology in the waiver D: Total number of paid waiver claims in this sample

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Medicaid Management Information System (MMIS) Claims 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 +/- 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 with adequate documentation that services were rendered N: Number of claims with adequate documentation of services

rendered D: Total number of claims in the sample

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

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95% confidence level with +/- 5% margin of error*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***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 approved waiver N: Number of claims paid where the rate is consistent with the approved rate methodology in the approved waiver D: Total number of paid waiver claims reviewed

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Medicaid Management Information System (MMIS) Claims 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 +/- 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:
Medicaid Management Information Systems (MMIS) Claims 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 +/- 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 a number of mechanisms:
1. Rates are loaded with procedure code and modifier combinations, thus any use of incorrect coding results in a claim paid at $0.00 or a denied claim,
2. System edits exist to ensure that only specific (appropriate provider types) are able to bill for waiver services,
3. Finally, by performing a review of claims in conjunction with the Department published billing manual identifies any incorrect coding which resulted in a paid claim.

Duties of providers include a requirement of documentation of care, in/out times, and confirmation that care was provided per state rules and regulations. Additionally, there must be the completion of appropriate service notes regarding service provision for each visit. Documentation shall contain services provided, date and time in and out, and a confirmation that care was provided. Such confirmation shall be according to agency policy. This is then reviewed by CDPHE upon survey.

All waiver services included in the participant's 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 a Prior Authorization Request (PAR) that matches the procedure code, allowed units, a date span, and billing/attending provider prior to rendering payment. The claims data reported in the quality performance measures were pulled and analyzed from the MMIS.

I.a.1
This performance measure ensures that claims paid for waiver services have utilized the correct coding for each of the 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 is approved, authorized, and billed correctly.

I.a.3
The Department utilizes the client's Prior Authorization Request (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 occur 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.

Benefits and Services Management Division staff initiate any edits to the Medicaid Management Information System (MMIS) that are necessary for the remediation of any deficiencies identified by the annual reporting of performance measures. Any inappropriate payments or overpayments identified are referred to the PICO Section for investigation as detailed in Appendix I-1 of the application.

I.a.1
Any incorrect coding which resulted in paid claims is remediated by the Department. The Benefits and Services Management Division staff collaborates with the Department's Rates Division and Health Information Office to initiate any edits to the MMIS that are necessary for remediation of any deficiencies identified by the annual reporting of performance measures.
In the event an overpayment is discovered, an accounts receivable balance is established with the provider. Overpayments are referred to the PICO Section for investigation as detailed in Appendix I-1 of the waiver application.

I.a.3
In the event an overpayment is discovered, an accounts receivable balance is established with the provider. Overpayments are referred to the PICO Section for investigation as detailed in Appendix I-1 of the waiver application.

I.b.1
Errors identified during claims data analysis as paying in excess of the Department's allowable rate may be attributed to wrong rates in prior authorization forms or additional system safeguards not being in place by the Department. PAR entry errors are addressed with CMAs to prevent future billing errors. The providers receiving overpayments are notified of payment errors and the Department establishes an accounts receivable balance to recover overpayments. The Department reviews errors to determine what additional safeguards are needed to prevent future overpayments.

I.b.2
Benefits and Services Management Division staff coordinate with the Department's Claims Systems and Operations Division staff to initiate any edits necessary to the MMIS for the remediation of deficiencies identified during the performance measure reporting.

ii. Remediation Data Aggregation

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

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

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

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 Home and Community Based Service (HCBS) waiver Children's Extensive Supports (CES) utilizes Fee-for-Service (FFS) and negotiated market price methodologies. Each rate has a unit designation and reimbursement is equal to the rate multiplied by the number of units utilized. HCBS CES FFS rate schedules are published through the Dept's provider bulletin annually and posted to the Dept's website.

The Dept's adopted rate methodology incorporates the following factors for all services not included in the negotiated price or public pricing methodology described below:

A. Indirect and Direct Care Requirements:
Salary expectations for direct and indirect care workers 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 for service delivery. Finally, collaboration with policy staff ensures the salaried positions, wages, and hours required to conform to the program or service design and are in compliance with the Code of Colorado Regulations and statutes.

B. Denver City Minimum Wage Consideration:
As a result of House Bill 19-1210 and Denver Council Bill 1237 (CB-1237), Denver has enacted a citywide annual minimum wage increase for all workers effective January 1, 2020. The implementation of this minimum wage will result in the following changes to minimum wage in subsequent years.

- *$12.85 an hour, effective January 1, 2020,*
- *$14.77 an hour, effective January 1, 2021, and*
- *$15.87 an hour, effective January 1, 2022.*

There will also be annual adjustments to the minimum wage based on the Consumer Price Index each year thereafter. This requirement for increases to Denver's minimum wage will affect services currently utilizing a Bureau of Labor Statistics (BLS) Colorado mean wage below the minimum wage threshold. As a result, the Dept is using the Denver minimum age in place of the Colorado BLS mean wage for providers within Denver city and county limits in order to account for geographic wage variances existing within the market. The Dept will update Denver provider service rates as changes to minimum wages become effective.

C. Facility Expense Expectations:
Incorporates the facility type through the use of existing facility property records listing square footage and actual value. Facility expenses also include estimated repair and maintenance costs, utility expenses, and phone and internet expenses. Repair and maintenance price per square foot is determined by industry standards and vary for facilities that are leased and facilities that are owned. Utility pricing includes gas and electricity which are determined annually through the Public Utility Commission who provides summer and winter rates and thermostat conversions for appropriate pricing. Finally, internet and phone services are determined through the use of the Build Your Own Bundle tool available through the Comcast Enterprise website.

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

E. Capital Overhead Expense Expectations:
Identifies and incorporates additional capital expenses such as medical equipment, supplies, and IT equipment directly related to providing the service to Medicaid clients. Capital Overhead Expenses are rarely utilized for HCBS services but may include items such as massage tables for massage therapy or supplies for art and play therapy.

All Facility, Administrative, and Capital Overhead expenses are reduced to per employee cost and multiplied by the total FTE required to provide services per Medicaid client. To ensure rates do not exceed funds appropriated by the Colorado State Legislature, a budget neutrality adjustment is applied to the final determined rate.

Following the development of the rate, stakeholder feedback is solicited, and appropriate, necessary changes may be made to the rate.

HCBS CES FFS rates utilizing the methodology described above include:

1. Personal Care
2. Respite (Respite Individual - unskilled, Respite Day - unskilled, Respite CNA - 4 hours or less, Respite CNA - 4 hours or more, Therapeutic Respite - 4 hours or less, Therapeutic Respite - 4 hours or more, Skilled In-Home Respite - 4 hours or less, Skilled In-Home Respite - 4 hours or more) (new service components for the skilled and therapeutic respite were added 1/1/2024)
3. Homemaker (Basic or Enhanced)
4. Community Connector
5. Community Connector - Telehealth
6. Massage Therapy
6. Movement Therapy (Master's or bachelor's degree Provider)
7. Hippotherapy (Individual or Group)
8. Youth Day Services (Individual)

The HCBS CES waiver utilizes a negotiated market price methodology for services in which reimbursement will differ by client, by product, and frequency of use. The services utilizing the negotiated market price methodology include:
1. Respite (Group or Overnight Group)
2. Specialized Medical Equipment and Supplies (Disposable Supplies or Equipment)
3. Adapted Therapeutic Recreational Equipment and Fees
4. Parent Education - name changed to Primary Caregiver Education as of amendment with requested effective date of 1/1/2024.
5. Home Accessibility Adaptations
6. Assistive Technology
7. Vehicle Modifications
8. Youth Day Services (Group)

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

The Dept requires case managers to attempt to obtain at least two (2) competitive bids for the Home Accessibility Adaptation and Vehicle Modification services. Payment is authorized to the provider with the most cost-effective bid which meets the needs of the participant.

Respite (Group or Overnight Group), Specialized Medical Equipment and Supplies, and Youth Day Services (Group) have a maximum limit set forth on the fee schedule and in Appendix C.

After the implementation of the rate, only legislative increases or decreases are applied. These legislative rate changes are often annual and reflect inflationary increases or decreases. The rates for the HCBS CES waiver are reviewed for appropriateness every five years with the waiver renewal. CES waiver service rates were set in 2018 as part of the change to the Dept's approved rate methodology. The Dept reviewed the rate-setting methodology in 2018.

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.

The Dept posts a fee schedule on our public-facing website that publishes rates and rates-related information. This information is kept current, and a new version is posted reflecting any changes in rates, services, or other rates-related information alongside versions of the fee schedule effective for previous periods.

The Dept 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 Dept also analyzes geographic provider density to ensure clients are able to access waiver services. In addition to these processes, the Dept 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 Dept'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 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 was reviewed and feedback that could be validated was incorporated into the rates. All information from the stakeholder process is posted on the Department's external website. Additional information on public input is located in Main 6-I.

The Dept is solely responsible for rate determination for all HCBS waivers. Oversight of the rate determination process is conducted at multiple internal levels, within the Finance Office and the Office of Community Living. Additionally, the rate determination is validated through the stakeholder feedback process during which the Dept provides information to stakeholders and providers in order to solicit feedback about additional considerations for each service.

The rates for Respite Individual and Respite Day were reviewed following the 2017 Medicaid Provider Rate Review Analysis Report, which found that they varied between 36.70% and 184.58% of their relevant benchmark comparisons. The Department recommended increasing rates for waiver services as identified through the ongoing rate-setting process, with special attention to services that were identified by stakeholders through the rate review process and those that have the biggest gaps, or budget neutrality factor, between current rates and appropriate rates developed through the Department's rate-setting methodology. The Department is closing the gap or reducing the budget neutrality factor, for these services in the HCBS waivers.

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.

The starting rate for CES youth day group was $223.05 effective 7/1/2019. It then received an increase effective 1/1/2020 to $228.00. Then, a 1% decrease was applied effective 7/1/2020 which was calculated based on the rate effective 6/30/2019. Therefore, the FY 2020-21 rate is higher than the FY 2019-20 but only because there was a rate increase midyear FY 2019-20. So, although it looks like this service received an increase that is only because of the math inherent in the calculation. This is not a methodology change and there is no change to source data. This is the historical process for calculating average rates across fiscal years.

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

Additional information located in Main B. Optional

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

Providers may submit claims directly to the MMIS.

Providers may also choose to contract with an Organized Health Care Delivery System (OHCDS) agencies. These providers submit documentation of service provision to and are reimbursed by the OHCDS. The OHCDS submits claims to the MMIS.

Providers may use the OHCDS arrangement for all HCBS-CES services.

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:*

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.

(a) The first edit in the MMIS when a claim is filed ensures that the waiver client is eligible for Medicaid. The Colorado Benefits Management System (CBMS) is a unified system for data collection and eligibility. Electronic eligibility files from CBMS are downloaded daily into the MMIS in order to ensure updated verification of eligibility.

(b) The MMIS validates the prior authorization of submitted claims. Claims for services submitted without prior authorization are denied.

(c) Providers submit claims for reimbursement for services provided. Providers must attest to the veracity of the claim being submitted. Case managers monitor service provision through Targeted Case Management 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. If the provider's client records do not match the claims filed, a payment recovery occurs.

The Dept operates an Electronic Visit Verification (EVV) system to document that a variety of HCBS services are provided to members.

Electronic Visit Verification (EVV) is a technology used to verify that home or community based service visits occur. The purpose of EVV is to ensure that services are delivered to people needing those services and that providers only bill for services rendered. EVV typically verifies visit information through a mobile application on a smart phone or tablet, a toll-free telephone number, or a web-based portal.

EVV captures six points of data as required by the 21st Century Cures Act: individual receiving the service, attendant providing the service, type of service provided, location of service delivery, date of service, and time that service provision begins and ends.

The Department implemented a hybrid or open EVV model. The State contracts with an EVV vendor for a state-managed solution. This solution is available to providers at no cost. Providers may also choose to utilize an alternate EVV system procured and managed by the provider agency. The State's EVV Solution and Data Aggregator for alternate vendor data transfer are available for use.

Services which must be electronically verified: As of August 3, 2020, the Department implemented EVV for federally mandated and additional services that are similar in nature and service delivery. The Department mandates Electronic Visit Verification (EVV) per CCR 2505-10 Section 8.001. Required EVV waiver services include:
Homemaker
Personal Care
Respite

The Department also mandates EVV for the following State Plan Services:
Home Health
Hospice
Occupational Therapy
Pediatric Behavioral Therapies
Pediatric Personal Care
Physical Therapy
Private Duty Nursing
Speech Therapy

On February 1, 2022, the Department activated a pre-payment EVV claim edit. EVV-required services, excluding CDASS and hospice, require corresponding EVV records prior to payment. This has resulted in improved provider compliance and better oversight of service provision.

Provider agencies utilizing the State EVV Solution have access to a portal to view and modify visit activity, and in limited circumstances, create EVV records. All information entered via the provider portal is notated as manual entry or edit

and is subject to Department audit.

In the event the caregiver is unable to collect EVV data at the time of service delivery, provider agencies will need to enter missing data. Within the State EVV Solution, an agency administrator may complete visit maintenance in the EVV Solution provider portal. The administrator will enter the missing data and select a reason code on why a manual entry was done. Manual entry may be entered on a case-by-case basis. Manual entries are subject to increased scrutiny by the Department and providers must maintain service records for these visits.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

◉ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***

○ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are not made through an approved MMIS.***

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a***

managed care entity or entities.

☒ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☐ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***

○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

◉ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*

○ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that

the state or local government providers furnish:

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:

(a) Each Community Centered Board (CCB) is designated as an OHCDS. Agencies must be approved to provide Targeted Case Management services for this designation.

(b) Providers may enroll directly with the Department by submitting an application. Included in the application is a Claims Submission Method Form. On this form, providers elect to enroll directly with the Department or to contract with an OHCDS. Additional information on provider enrollment is available on the Department's website.

(c) Department regulations require that case managers provide participants, guardians, and/or authorized representatives a listing of all qualified providers in the area. The Department's website also contains a statewide list of qualified providers for waiver services.

(d) The Department maintains documentation of qualifications for all providers. This documentation includes copies of the Medicaid Provider Agreement, copies of the Medicaid certification, verification of applicable State licenses, and any other documentation necessary to demonstrate compliance with the established provider qualification standards.
(e) The OHCDS agencies subcontract with providers certified by the Department to provide specific waiver services or with independent contractors which have been verified by the OHCDS to have met all applicable licensing and/or established provider qualification standards. The Department assures provider qualifications are met by OHCDS subcontractors through administrative monitoring. Verifying and monitoring the service delivery of enrolled participants receiving a defined service from a qualified provider is the responsibility of the OHCDS. These standards are detailed at 10 CCR 2505-10 8.500.111.
(f) Financial accountability is assured for services delivered in the OHCDS arrangement through the same methods and processes used for services delivered in a direct service provider arrangement and as described in Appendix I-1 and Appendix I-2.d of this application.
(g) The Department does not reimburse for claims processing fees.

Participants have free choice of all qualified providers, across the state, to include those not affiliated with an OHCDS.

iii. Contracts with MCOs, PIHPs or PAHPs.

- ○ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ◉ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

As defined in 8.503.110.A the CCB as the OHCDS is required to:
- *Ensure that the contractor or employee meets minimum provider qualifications as set forth in the HCBS-CES waiver,*
- *Ensure that services are delivered according to the HCBS-CES waiver definitions and as identified in the client's service plan,*
- *Ensure the contractor maintains sufficient documentation to support the claims submitted, and*
- *Monitor the health and safety of HCBS-CES waiver clients receiving services from a subcontractor.*

- ○ ***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:*

Do not complete this item.

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: ICF/IID

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	10477.06	56158.65	66635.71	229247.30	9034.09	238281.39	171645.68
2	10894.66	56175.50	67070.16	236055.94	9552.65	245608.59	178538.43
3	12234.15	70837.32	83071.47	243066.80	10100.97	253167.77	170096.30
4	15132.55	75794.95	90927.50	250285.88	10680.77	260966.65	170039.15
5	26573.26	77918.28	104491.54	257719.37	11293.85	269013.22	164521.68

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:
		ICF/IID
Year 1	2243	2243
Year 2	2402	2402
Year 3	2630	2630
Year 4	2823	2823
Year 5	3220	3220

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

The Department estimated the average length of stay (ALOS) on the waiver by reviewing historical data included in the annual 372 data report from FY 2013-14 through FY 2017-18. As with enrollment, the Department believes this measure also might be plateauing. The highest Average Length of Stay has been 333 days. The Department has selected a trend of 0.60% which is the average ALOS growth over the previous 5 years for which we have actuals.

Update for WYs 3-5 for Amendment with a requested effective date of 7/01/2021:
The Department estimated the average length of stay (ALOS) on the waiver by reviewing historical data included in the annual 372 data report from SFY 2013-14 through SFY 2018-19. As with enrollment, the Department believes this measure also might be plateauing. The highest the ALOS has ever been is 333 days. The Department has selected a trend of 0.46% which is 25% of the average annual growth in the average length of stay for the last four years. Actuals have jumped around in the last several years so the Department selected a small positive trend to allow for expected fluctuations.

Update for WYs 4-5 for Amendment with a 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 from SFY 2013-14 through SFY 2019-20. As with enrollment, the Department believes this measure also might be plateauing. The highest ALOS has ever been 333 days. The Department has selected a trend of 0.20% which is 25% of the average annual growth in the average length of stay for the last four years. Actuals have jumped around in the last several years so the Department selected a small positive trend to allow for expected fluctuations.

Update for WY5 for Amendment with the requested effective date of 7/01/2023:
The Department estimated the average length of stay (ALOS) on the waiver by reviewing historical data included in the annual 372 data report (SFYs 2016-17 through 2020-21). As with enrollment, the Department believes this measure also might be plateauing. The highest ALOS has ever been is 333 days. The Department used the average 4-year growth rate in ALOS from SFY 2017-18 through SFY 2020-21.

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 Dept 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 Dept utilizes data from the 372 reports, the most recent available report was for FY 2017-18. The Dept examined historical growth rates, the fraction of the total population that utilized each service, and graphical trends. Once the historical data was analyzed, the Dept 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.

Certain years of data are not included because they are considered to be outliers based on out-of-date policy, sudden changes in utilization, new limits placed on services, or some other reason. By policy and procedure, these characteristics are used to determine when data is an outlier. The state will make available to CMS upon request, the specific characteristics for the data outlier of a specific service.

Historical growth rates: The source of data is 372 waiver reports. The Dept reviews data from FY 2007-08 through FY 2017-18 but might only include certain FYs in the development of trends. For example, the Dept may look at data from FY 2007-08 and beyond but apply a trend that only incorporates growth rates from FY 2015-16 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 Dept 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 2007-08 however the Dept focuses on more recent data for trend development.

Graphical trends: In some cases, the Dept 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.

Rates included in the Dept's Cost Neutrality Demonstration may not match the Dept'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 Individual*
- *Respite Day*
- *Community Connector*
- *Hippo-Therapy*
- *Hippo-Therapy Group*
- *Massage Therapy*
- *Movement Therapy-Bachelors*
- *Movement Therapy-Masters*
- *Youth Day Service-Individual*
- *Youth Day Service-Group*

The following services received the (A) 1% reduction on 7/01/2020 and then will receive a (B) Denver minimum wage increase on 1/1/2021:
(Note: The rates listed below will not match the Dept's Cost Neutrality Demonstration. In order to accurately project total expenditures for the service, the avg. cost/unit is adjusted to account for the rate being implemented for less than a 12-month period).

- *Homemaker-Basic: The Denver share of expenditure for this service is 1.31% with the Denver-only provider wage of $5.68 for FY 2020-21 and $6.93 for FY 2021-22.*
- *Homemaker-Enhanced: The Denver share of expenditure for this service is 1.46% with the Denver only provider wage of $7.93 for FY 2020-21 and $9.34 for FY 2021-22.*

The following services did not receive a legislative rate decrease/increase as they are negotiated rates and are not adjusted in the Fall 2020 amendments:

- *Respite Group*

- *Respite Group Overnight Camp*
- *Adapted Therapeutic Recreation Equipment*
- *Adapted Therapeutic Recreation Fees*
- *Assistive Technology*
- *Home Accessibility Adaptations*
- *Parent Education*
- *Specialized Medical Supplies-Disposable*
- *Specialized Medical Equipment*
- *Vehicle Modifications*

The starting rate for the CES youth day group was $223.05 effective 7/1/2019. It then received an increase effective 1/1/2020 to $228.00. Then, a 1% decrease was applied effective 7/1/2020 which was calculated based on the rate effective 6/30/2019. Therefore, the FY 2020-21 rate is higher than the FY 2019-20 but only because there was a rate increase midyear FY 2019-20. So although it looks like this service received an increase that is only because of the math inherent in the calculation. This is not a methodology change and there is no change to source data. This is the historical process for calculating average rates across fiscal years.

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 in SFY2018-19.

Historical growth rates: The source of data is 372 waiver reports. The Department reviews data from FY 2007-08 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 2017-18 and FY 2018-19.

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 2007-08 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.

Update for WY 3-5 with the requested effective date of 7/01/2021:
For each individual 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.

Movement Therapy and Community Connector were updated to include telehealth service delivery options, although there may not have been a cost-per-unit differential to the traditional delivery methods.

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 in SFY 2018-19. This information has been added to all applicable waivers

Update for WYs 3-5 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 the following services: Homemaker - Basic and Enhanced, Respite - Individual and Individual Per Diem,

Community Connector, Hippotherapy, Massage Therapy, Movement Therapy, Youth Day Service - Individual and Group. Also, Factor D was updated to reflect the Denver Minimum Wage increase effective 1/1/2022 of 7.45% (Denver's rate is now $15.87/hr. from $14.77)

Update for WY 4-5 with the requested effective date of 7/01/2022:
For each individual 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.

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

For Respite Individual, Respite Day, Respite Group Overnight Camp, Adapted Therapeutic Recreation Fees, Community Connector - Telehealth, Hippo-Therapy, Home Accessibility Adaptations, Massage Therapy, Movement Therapy - Bachelors, Parent Education, Vehicle Modification, Youth Day Service - Individual, and Youth Day Service - Group. The State's main trend for utilizers is the average of the previous two years of waiver participation of that service as a percentage of the total unduplicated count as reported on 372 reports. The number of users by service that was reported on the SFY 2019-20 372 report came in lower than expected, resulting in a decrease in utilizers for future WYs.

For Homemaker-Basic, Homemaker-Enhanced, Respite Group Overnight Camp Community Connector-Telehealth, Hippo-Therapy, Home Accessibility Adaptations, Massage Therapy, Movement Therapy-Bachelors, Movement Therapy-Masters, Youth Day Service-Individual, Youth Day Service-Group. The State's main trend for units per utilizer is the average of the previous two years of actuals as reported on 372 reports. Utilization reported on the SFY 2019-20 372 report came in lower than expected, resulting in a decrease in utilization for future WYs. Additionally, during the COVID-19 pandemic, utilization trends changed significantly compared to previous years' trends.

For Homemaker-Basic, Homemaker-Enhanced, Respite Group Overnight Camp, Community Connector-Telehealth, Hippo-Therapy, Home Accessibility Adaptations, Massage Therapy, Movement Therapy-Bachelors, Movement Therapy-Masters, Youth Day Service-Individual, Youth Day Service-Group. The State's main trend for utilizers is the average of the previous two years of waiver participation of that service as a percentage of the total unduplicated count as reported on 372 reports. The number of users by service that was reported on the SFY 2019-20 372 report came in higher than expected for these services, resulting in an increase to utilizers for these services in WYs 4-5.

Additional information in Main B. Optional

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

To calculate State Plan services costs associated with CES Waiver clients, the Department analyzed historical D' values using data obtained from recent 372 reports, the most recent being from FY 2017-18. D' has been increasing fairly steadily since FY 2014-15. The Department is expecting relatively low growth (under 1%) in all waiver years which is reflected in a trend factor of 0.03% for WY 1-5.

Update for WYs 3-5 for Amendment with a requested effective date of 7/01/2021:
To calculate State Plan services costs associated with CES Waiver clients, the Department analyzed historical D' values from recent 372 reports, the most recent being from FY 2018-19. D' has been increasing fairly steadily since FY 2014-15. The Department is expecting to see steady growth in all waiver years which is reflected in a trend factor of 1.66% for WY 1-5.

Update for WYs 4-5 for Amendment with a requested effective date of 7/01/2022:
To calculate State Plan services costs associated with CES Waiver clients, the Department analyzed historical D' values. D' has been increasing fairly steadily since SFY 2014-15. The Department is expecting to see steady growth in all waiver years which is reflected in a trend factor of 2.38% for WY 4-5. This is a proportion of the growth from the most recent SFY 2019-20 372 report.

The State has seen very high growth in D' annual growth. This can be partially attributed to changes in eligibility policy for the children's waivers, which has led to increased waiver participation. However, barring additional policy changes, the State does not anticipate that the aggressive growth will continue. As such, the State has selected a D' annual trend of 2.38%, which is equal to 50% of the SFY 2019-20 growth.

Update for WY 5 Amendment with a requested effective date of 7/01/2023:
To calculate State Plan services costs associated with CES Waiver clients, the Department analyzed historical D' values. D' has been increasing fairly steadily since SFY 2014-15, with a slight decrease in FY 2020-21. The Department is expecting to see steady growth in all waiver years which is reflected in a trend factor of 2.95% for WY 5. This is the average growth rate from the past two years of 372 data, specifically from SFY 2018-19 to SFY 2019-20 and SFY 2019-20 to SFY 2020-21.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

To calculate ICF/IID costs, the Department examined utilization and average per-user ICF/IID costs. The Department applied a trend of 3.69% for each year which is the average growth rate of the two most recent years of actuals data (FY 2018-19 and FY 2019-20). This number is in line with the statutorily-required annual rate increase of 3% for nursing facilities.

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 ICF/IID clients, the Department reviewed historical data and chose to apply a modest trend of .28% each year which is the average growth rate of years FY 2015-16 and FY 2016-17, the most recent years with actuals data. The growth rate for FY 2015-16 was -46.02% and the growth rate for FY 2016-17 was 5.74%. The Department is expecting a one-time level shift down of state plan service costs to occur in FY 2018-19 due to the implementation of the Accountable Care Collaborative (ACC) Phase 2.

Update for WY 4-5:
The Department updated this forecast to include FY 2019-20 Lag 372 Report data. Therefore, most forecasted values have changed due to incorporating one more year of actual data. FY 2019-20 expenditure came in higher than projected values, so the forecast has increased from what is in the approved waiver. Total unduplicated count and the average length of stay have been updated to adjust for actuals in the FY 2019-20 372s and to reflect the Department's assumptions for waiver enrollment moving forward.

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	
Homemaker	
Respite	
Adaptive Therapeutic Recreational Equipment and Fees	
Assistive Technology	
Community Connector	
Hippotherapy	
Home Accessibility Adaptations	
Massage Therapy	
Movement Therapy	
Primary Caregiver Education	
Specialized Medical Equipment and Supplies	
Vehicle Modifications	
Youth Day Service	

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*
Homemaker Total:						***2627034.16***
Homemaker - Basic	*15 min*	*405*	*823.12*	*4.32*	***1440130.75***	
Homemaker - Enhanced	*15 min*	*425*	*398.39*	*7.01*	***1186903.41***	
Respite Total:						***5921165.85***
Respite Individual	*15 min*	*733*	*1214.94*	*5.55*	***4942558.16***	
Respite Day	*Day*	*135*	*11.07*	*221.93*	***331663.29***	
Respite Group	*15 min*	*149*	*11.85*	*310.24*	***547775.26***	
Respite Group Overnight Camp	*Day*	*104*	*2.65*	*359.83*	***99169.15***	
				GRAND TOTAL:		***23500051.66***
				Total Estimated Unduplicated Participants:		***2243***
				Factor D (Divide total by number of participants):		***10477.06***
				Average Length of Stay on the Waiver:		*309*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite CNA - 4 hours or less	15 min	0	0.00	0.01	0.00	
Respite CNA - 4 hours or more	Day	0	0.00	0.01	0.00	
Therapeutic Respite - 4 hours or less	15 min	0	0.00	0.01	0.00	
Therapeutic Respite - 4 hours or more	Day	0	0.00	0.01	0.00	
Skilled In-Home Respite - 4 hours or less	15 min	0	0.00	0.01	0.00	
Skilled In-Home Respite - 4 hours or more	Day	0	0.00	0.01	0.00	
Respite CNA - 4 hours or less	15 min	0	0.00	0.01	0.00	
Respite CNA - 4 hours or more	Day	0	0.00	0.01	0.00	
Therapeutic Respite - 4 hours or less	15 min	0	0.00	0.01	0.00	
Therapeutic Respite - 4 hours or more	Day	0	0.00	0.01	0.00	
Skilled In-Home Respite - 4 hours or less	15 min	0	0.00	0.01	0.00	
Skilled In-Home Respite - 4 hours or more	Day	0	0.00	0.01	0.00	
Respite Individual - unskilled	15 Min	0	0.00	0.01	0.00	
Respite Day - unskilled	Day	0	0.00	0.01	0.00	
Respite Individual - unskilled	15 Min	0	0.00	0.01	0.00	
Respite Day - unskilled	Day	0	0.00	0.01	0.00	
Adaptive Therapeutic Recreational Equipment and Fees Total:						**223497.33**
Adapted Therapeutic Recreation Equipment	Item	105	1.16	503.99	61385.98	
Adapted Therapeutic Recreation Fees	Item	272	4.84	123.14	162111.35	
Assistive Technology Total:						**170053.18**
Assistive Technology	Item	302	1.00	563.09	170053.18	
Community Connector Total:						**4370503.25**

GRAND TOTAL:	**23500051.66**
Total Estimated Unduplicated Participants:	**2243**
Factor D (Divide total by number of participants):	**10477.06**
Average Length of Stay on the Waiver:	309

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Connector	15 min	702	678.93	9.17	4370503.25	
Community Connector - Telehealth	15 min	0	0.00	0.01	0.00	
Hippotherapy Total:						370667.91
Hippo-Therapy	15 min	212	81.54	21.43	370449.27	
Hippo-Therapy Group	15 min	2	12.00	9.11	218.64	
Home Accessibility Adaptations Total:						774654.55
Home Accessibility Adaptations	Per Purchase	167	1.00	4638.65	774654.55	
Massage Therapy Total:						1946377.59
Massage Therapy	15 min	563	179.22	19.29	1946377.59	
Movement Therapy Total:						2200630.89
Movement Therapy - Bachelors	15 min	892	153.31	16.09	2200348.05	
Movement Therapy - Masters	15 min	1	12.00	23.57	282.84	
Primary Caregiver Education Total:						28066.72
Parent Education	Session	74	1.00	379.28	28066.72	
Primary Caregiver Education	Session	0	0.00	0.01	0.00	
Primary Caregiver Education	Session	0	0.00	0.01	0.00	
Specialized Medical Equipment and Supplies Total:						367041.57
Specialized Medical Supplies-Disposable	Item	1011	5.58	57.51	324435.76	
Specialized Medical Equipment	Item	102	1.40	298.36	42605.81	
Vehicle Modifications Total:						204554.80
Vehicle Modifications	Per Purchase	40	1.00	5113.87	204554.80	
Youth Day Service Total:						4295803.86
Youth Day Service-Individual	15 min	593	1149.54	5.55	3783308.57	
Youth Day Service-Group	15 min				512495.29	

GRAND TOTAL:	23500051.66
Total Estimated Unduplicated Participants:	2243
Factor D (Divide total by number of participants):	10477.06
Average Length of Stay on the Waiver:	309

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		139	16.53	223.05		
				GRAND TOTAL:		23500051.66
				Total Estimated Unduplicated Participants:		2243
				Factor D (Divide total by number of participants):		10477.06
				Average Length of Stay on the Waiver:		309

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
Homemaker Total:						3112109.35
Homemaker - Basic	15 min	434	931.66	4.46	1803358.36	
Homemaker - Enhanced	15 min	455	398.39	7.22	1308750.99	
Respite Total:						6464573.81
Respite Individual	15 min	785	1222.36	5.64	5411876.66	
Respite Day	Day	145	11.07	225.72	362314.46	
Respite Group	15 min	159	11.85	310.24	584538.70	
Respite Group Overnight Camp	Day	111	2.65	359.83	105843.99	
Respite CNA - 4 hours or less	15 min	0	0.00	0.01	0.00	
Respite CNA - 4 hours or more	Day	0	0.00	0.01	0.00	
Therapeutic Respite - 4 hours or less	15 min	0	0.00	0.01	0.00	
Therapeutic Respite - 4 hours or more	Day	0	0.00	0.01	0.00	
Skilled In-Home Respite - 4 hours or less	15 min	0	0.00	0.01	0.00	
Skilled In-Home					0.00	
				GRAND TOTAL:		26168962.77
				Total Estimated Unduplicated Participants:		2402
				Factor D (Divide total by number of participants):		10894.66
				Average Length of Stay on the Waiver:		311

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite - 4 hours or more	Day	0	0.00	0.01		
Respite CNA - 4 hours or less	15 min	0	0.00	0.01	0.00	
Respite CNA - 4 hours or more	Day	0	0.00	0.01	0.00	
Therapeutic Respite - 4 hours or less	15 min	0	0.00	0.01	0.00	
Therapeutic Respite - 4 hours or more	Day	0	0.00	0.01	0.00	
Skilled In-Home Respite - 4 hours or less	15 min	0	0.00	0.01	0.00	
Skilled In-Home Respite - 4 hours or more	Day	0	0.00	0.01	0.00	
Respite Individual - unskilled	15 Min	0	0.00	0.01	0.00	
Respite Day - unskilled	Day	0	0.00	0.01	0.00	
Respite Individual - unskilled	15 Min	0	0.00	0.01	0.00	
Respite Day - unskilled	Day	0	0.00	0.01	0.00	
Adaptive Therapeutic Recreational Equipment and Fees Total:						240527.29
Adapted Therapeutic Recreation Equipment	Item	112	1.16	516.41	67091.99	
Adapted Therapeutic Recreation Fees	Item	291	4.84	123.14	173435.30	
Assistive Technology Total:						182441.16
Assistive Technology	Item	324	1.00	563.09	182441.16	
Community Connector Total:						4818222.82
Community Connector	15 min	752	705.64	9.08	4818222.82	
Community Connector - Telehealth	15 min	0	0.00	0.01	0.00	
Hippotherapy Total:						408355.81
Hippo-Therapy	15 min	227	84.73	21.22	408139.33	
Hippo-Therapy Group	15 min	2	12.00	9.02	216.48	
Home Accessibility						830318.35

GRAND TOTAL:	26168962.77
Total Estimated Unduplicated Participants:	2402
Factor D (Divide total by number of participants):	10894.66
Average Length of Stay on the Waiver:	311

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adaptations Total:						
Home Accessibility Adaptations	Per Purchase	179	1.00	4638.65	830318.35	
Massage Therapy Total:						2297240.66
Massage Therapy	15 min	603	199.46	19.10	2297240.66	
Movement Therapy Total:						2502691.00
Movement Therapy - Bachelors	15 min	955	164.49	15.93	2502411.04	
Movement Therapy - Masters	15 min	1	12.00	23.33	279.96	
Primary Caregiver Education Total:						30342.40
Parent Education	Session	80	1.00	379.28	30342.40	
Primary Caregiver Education	Session	0	0.00	0.01	0.00	
Primary Caregiver Education	Session	0	0.00	0.01	0.00	
Specialized Medical Equipment and Supplies Total:						393070.72
Specialized Medical Supplies-Disposable	Item	1083	5.58	57.51	347540.98	
Specialized Medical Equipment	Item	109	1.40	298.36	45529.74	
Vehicle Modifications Total:						219896.41
Vehicle Modifications	Per Purchase	43	1.00	5113.87	219896.41	
Youth Day Service Total:						4669172.99
Youth Day Service-Individual	15 min	635	1149.54	5.64	4116962.56	
Youth Day Service-Group	15 min	148	16.53	225.72	552210.44	
				GRAND TOTAL:		26168962.77
				Total Estimated Unduplicated Participants:		2402
				Factor D (Divide total by number of participants):		10894.66
				Average Length of Stay on the Waiver:		311

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
Homemaker Total:						**4688939.40**
Homemaker - Basic	15 min	539	780.61	4.72	**1985934.29**	
Homemaker - Enhanced	15 min	649	547.29	7.61	**2703005.11**	
Respite Total:						**7137295.01**
Respite Individual	15 min	895	1186.62	5.78	**6138503.92**	
Respite Day	Day	147	10.19	231.36	**346561.08**	
Respite Group	15 min	186	8.75	310.24	**504915.60**	
Respite Group Overnight Camp	Day	115	3.56	359.83	**147314.40**	
Respite CNA - 4 hours or less	15 min	0	0.00	0.01	**0.00**	
Respite CNA - 4 hours or more	Day	0	0.00	0.01	**0.00**	
Therapeutic Respite - 4 hours or less	15 min	0	0.00	0.01	**0.00**	
Therapeutic Respite - 4 hours or more	Day	0	0.00	0.01	**0.00**	
Skilled In-Home Respite - 4 hours or less	15 min	0	0.00	0.01	**0.00**	
Skilled In-Home Respite - 4 hours or more	Day	0	0.00	0.01	**0.00**	
Respite CNA - 4 hours or less	15 min	0	0.00	0.01	**0.00**	
Respite CNA - 4 hours or more	Day	0	0.00	0.01	**0.00**	
Therapeutic Respite - 4 hours or less	15 min	0	0.00	0.01	**0.00**	
Therapeutic Respite - 4 hours or more	Day	0	0.00	0.01	**0.00**	
Skilled In-Home Respite - 4 hours or less	15 min	0	0.00	0.01	**0.00**	
Skilled In-Home Respite - 4 hours or more	Day	0	0.00	0.01	**0.00**	
Respite Individual - unskilled	15 Min	0	0.00	0.01	**0.00**	
Respite Day - unskilled	Day	0	0.00	0.01	**0.00**	
Respite Individual -					**0.00**	

GRAND TOTAL:	**32175819.66**
Total Estimated Unduplicated Participants:	**2630**
Factor D (Divide total by number of participants):	**12234.15**
Average Length of Stay on the Waiver:	300

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
unskilled	15 Min	0	0.00	0.01		
Respite Day - unskilled	Day	0	0.00	0.01	0.00	
Adaptive Therapeutic Recreational Equipment and Fees Total:						275333.99
Adapted Therapeutic Recreation Equipment	Item	96	1.04	531.02	53017.04	
Adapted Therapeutic Recreation Fees	Item	354	5.10	123.14	222316.96	
Assistive Technology Total:						241002.52
Assistive Technology	Item	428	1.00	563.09	241002.52	
Community Connector Total:						7590533.80
Community Connector	15 min	1007	804.00	9.31	7537636.68	
Community Connector - Telehealth	15 min	101	57.49	9.11	52897.12	
Hippotherapy Total:						390692.14
Hippo-Therapy	15 min	233	77.05	21.75	390470.14	
Hippo-Therapy Group	15 min	2	12.00	9.25	222.00	
Home Accessibility Adaptations Total:						1011225.70
Home Accessibility Adaptations	Per Purchase	218	1.00	4638.65	1011225.70	
Massage Therapy Total:						2134024.20
Massage Therapy	15 min	750	145.32	19.58	2134024.20	
Movement Therapy Total:						2818827.48
Movement Therapy - Bachelors	15 min	1100	155.27	16.33	2789115.01	
Movement Therapy - Masters	15 min	8	155.27	23.92	29712.47	
Primary Caregiver Education Total:						41341.52
Parent Education	Session	109	1.00	379.28	41341.52	
Primary Caregiver Education	Session	0	0.00	0.01	0.00	
Primary Caregiver Education	Session				0.00	

GRAND TOTAL:	32175819.66
Total Estimated Unduplicated Participants:	2630
Factor D (Divide total by number of participants):	12234.15
Average Length of Stay on the Waiver:	300

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		0	0.00	0.01		
Specialized Medical Equipment and Supplies Total:						**475753.00**
Specialized Medical Supplies-Disposable	Item	1185	6.10	57.51	**415711.04**	
Specialized Medical Equipment	Item	129	1.56	298.36	**60041.97**	
Vehicle Modifications Total:						**332401.55**
Vehicle Modifications	Per Purchase	65	1.00	5113.87	**332401.55**	
Youth Day Service Total:						**5038449.35**
Youth Day Service-Individual	15 min	699	1148.96	5.78	**4642051.17**	
Youth Day Service-Group	15 min	155	11.33	225.72	**396398.18**	

GRAND TOTAL:	**32175819.66**
Total Estimated Unduplicated Participants:	**2630**
Factor D (Divide total by number of participants):	**12234.15**
Average Length of Stay on the Waiver:	300

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
Homemaker Total:						**5257716.74**
Homemaker - Basic	15 min	599	666.05	5.33	**2126477.85**	
Homemaker - Enhanced	15 min	815	466.83	8.23	**3131238.88**	
Respite Total:						**9458739.88**
Respite Individual	15 min	959	1248.69	6.44	**7711859.49**	
Respite Day	Day	146	11.37	263.74	**437813.67**	

GRAND TOTAL:	**42719201.21**
Total Estimated Unduplicated Participants:	**2823**
Factor D (Divide total by number of participants):	**15132.55**
Average Length of Stay on the Waiver:	304

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Group	15 min	229	16.11	323.90	1194928.64	
Respite Group Overnight Camp	Day	122	2.60	359.83	114138.08	
Respite CNA - 4 hours or less	15 min	0	0.00	0.01	0.00	
Respite CNA - 4 hours or more	Day	0	0.00	0.01	0.00	
Therapeutic Respite - 4 hours or less	15 min	0	0.00	0.01	0.00	
Therapeutic Respite - 4 hours or more	Day	0	0.00	0.01	0.00	
Skilled In-Home Respite - 4 hours or less	15 min	0	0.00	0.01	0.00	
Skilled In-Home Respite - 4 hours or more	Day	0	0.00	0.01	0.00	
Respite CNA - 4 hours or less	15 min	0	0.00	0.01	0.00	
Respite CNA - 4 hours or more	Day	0	0.00	0.01	0.00	
Therapeutic Respite - 4 hours or less	15 min	0	0.00	0.01	0.00	
Therapeutic Respite - 4 hours or more	Day	0	0.00	0.01	0.00	
Skilled In-Home Respite - 4 hours or less	15 min	0	0.00	0.01	0.00	
Skilled In-Home Respite - 4 hours or more	Day	0	0.00	0.01	0.00	
Respite Individual - unskilled	15 Min	0	0.00	0.01	0.00	
Respite Day - unskilled	Day	0	0.00	0.01	0.00	
Respite Individual - unskilled	15 Min	0	0.00	0.01	0.00	
Respite Day - unskilled	Day	0	0.00	0.01	0.00	
Adaptive Therapeutic Recreational Equipment and Fees Total:						260414.77
Adapted Therapeutic Recreation Equipment	Item	108	1.04	538.04	60432.65	
Adapted					199982.12	

GRAND TOTAL:	42719201.21
Total Estimated Unduplicated Participants:	2823
Factor D (Divide total by number of participants):	15132.55
Average Length of Stay on the Waiver:	304

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Therapeutic Recreation Fees	Item	346	5.10	113.33		
Assistive Technology Total:						**293437.08**
Assistive Technology	Item	486	1.00	603.78	**293437.08**	
Community Connector Total:						**13273373.10**
Community Connector	15 min	1347	965.00	10.16	**13206526.80**	
Community Connector - Telehealth	15 min	108	60.92	10.16	**66846.30**	
Hippotherapy Total:						**328341.66**
Hippo-Therapy	15 min	215	68.68	22.19	**327661.98**	
Hippo-Therapy Group	15 min	2	36.00	9.44	**679.68**	
Home Accessibility Adaptations Total:						**1040543.94**
Home Accessibility Adaptations	Per Purchase	229	1.00	4543.86	**1040543.94**	
Massage Therapy Total:						**2227977.41**
Massage Therapy	15 min	802	139.11	19.97	**2227977.41**	
Movement Therapy Total:						**4281629.97**
Movement Therapy - Bachelors	15 min	890	138.71	16.66	**2056708.65**	
Movement Therapy - Masters	15 min	710	128.43	24.40	**2224921.32**	
Primary Caregiver Education Total:						**36627.65**
Parent Education	Session	101	1.00	362.65	**36627.65**	
Primary Caregiver Education	Session	0	0.00	0.01	**0.00**	
Primary Caregiver Education	Session	0	0.00	0.01	**0.00**	
Specialized Medical Equipment and Supplies Total:						**602618.72**
Specialized Medical Supplies-Disposable	Item	1530	6.10	57.51	**536740.83**	
Specialized Medical Equipment	Item	138	1.60	298.36	**65877.89**	
Vehicle Modifications Total:						**357970.90**

GRAND TOTAL:	**42719201.21**
Total Estimated Unduplicated Participants:	**2823**
Factor D (Divide total by number of participants):	**15132.55**
Average Length of Stay on the Waiver:	304

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Vehicle Modifications	Per Purchase	70	1.00	5113.87	357970.90	
Youth Day Service Total:						5299809.39
Youth Day Service-Individual	15 min	741	1124.13	5.90	4914583.95	
Youth Day Service-Group	15 min	158	10.59	230.23	385225.44	
				GRAND TOTAL:		42719201.21
				Total Estimated Unduplicated Participants:		2823
				Factor D (Divide total by number of participants):		15132.55
				Average Length of Stay on the Waiver:		304

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
Homemaker Total:						7076163.72
Homemaker - Basic	15 min	641	697.80	5.69	2545078.96	
Homemaker - Enhanced	15 min	873	596.58	8.70	4531084.76	
Respite Total:						29510425.23
Respite Individual	15 min	0	0.00	0.01	0.00	
Respite Day	Day	0	0.00	0.01	0.00	
Respite Group	15 min	245	17.39	323.90	1379992.14	
Respite Group Overnight Camp	Day	130	2.60	364.51	123204.38	
Respite CNA - 4 hours or less	15 min	57	1540.00	7.96	698728.80	
Respite CNA - 4 hours or more	Day	1	1.00	142.40	142.40	
Therapeutic Respite - 4 hours or					698728.80	
				GRAND TOTAL:		85565890.30
				Total Estimated Unduplicated Participants:		3220
				Factor D (Divide total by number of participants):		26573.26
				Average Length of Stay on the Waiver:		304

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
less	15 min	57	1540.00	7.96		
Therapeutic Respite - 4 hours or more	Day	1	1.00	142.40	**142.40**	
Skilled In-Home Respite - 4 hours or less	15 min	52	1540.00	17.14	**1372571.20**	
Skilled In-Home Respite - 4 hours or more	Day	1	1.00	314.90	**314.90**	
Respite CNA - 4 hours or less	15 min	57	1540.00	7.96	**698728.80**	
Respite CNA - 4 hours or more	Day	1	1.00	142.40	**142.40**	
Therapeutic Respite - 4 hours or less	15 min	57	1540.00	7.96	**698728.80**	
Therapeutic Respite - 4 hours or more	Day	1	1.00	142.20	**142.20**	
Skilled In-Home Respite - 4 hours or less	15 min	52	1540.00	17.14	**1372571.20**	
Skilled In-Home Respite - 4 hours or more	Day	1	1.00	314.90	**314.90**	
Respite Individual - unskilled	15 Min	1079	1448.08	6.84	**10687351.71**	
Respite Day - unskilled	Day	156	12.14	288.11	**545634.24**	
Respite Individual - unskilled	15 Min	1079	1448.08	6.84	**10687351.71**	
Respite Day - unskilled	Day	156	12.14	288.11	**545634.24**	
Adaptive Therapeutic Recreational Equipment and Fees Total:						**344655.01**
Adapted Therapeutic Recreation Equipment	Item	156	1.31	543.62	**111094.18**	
Adapted Therapeutic Recreation Fees	Item	371	5.10	123.44	**233560.82**	
Assistive Technology Total:						**313965.60**
Assistive Technology	Item	520	1.00	603.78	**313965.60**	
Community Connector Total:						**29723961.14**
Community Connector	15 min	1594	1614.00	11.52	**29637688.32**	

GRAND TOTAL:	**85565890.30**
Total Estimated Unduplicated Participants:	**3220**
Factor D (Divide total by number of participants):	**26573.26**
Average Length of Stay on the Waiver:	304

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Connector - Telehealth	15 min	116	64.56	11.52	86272.82	
Hippotherapy Total:						621120.24
Hippo-Therapy	15 min	230	118.00	22.86	620420.40	
Hippo-Therapy Group	15 min	2	36.00	9.72	699.84	
Home Accessibility Adaptations Total:						1113245.70
Home Accessibility Adaptations	Per Purchase	245	1.00	4543.86	1113245.70	
Massage Therapy Total:						2455160.74
Massage Therapy	15 min	858	139.11	20.57	2455160.74	
Movement Therapy Total:						5454561.87
Movement Therapy - Bachelors	15 min	953	140.34	17.16	2295047.38	
Movement Therapy - Masters	15 min	760	165.43	25.13	3159514.48	
Primary Caregiver Education Total:						78332.40
Parent Education	Session	0	0.00	0.01	0.00	
Primary Caregiver Education	Session	108	1.00	362.65	39166.20	
Primary Caregiver Education	Session	108	1.00	362.65	39166.20	
Specialized Medical Equipment and Supplies Total:						704168.58
Specialized Medical Supplies-Disposable	Item	1761	6.10	57.51	617778.17	
Specialized Medical Equipment	Item	148	1.79	326.10	86390.41	
Vehicle Modifications Total:						444273.06
Vehicle Modifications	Per Purchase	74	1.00	6003.69	444273.06	
Youth Day Service Total:						7725857.02
Youth Day Service-Individual	15 min	793	1417.78	6.08	6835741.20	
Youth Day Service-Group	15 min	169	14.91	353.25	890115.82	

GRAND TOTAL:	85565890.30
Total Estimated Unduplicated Participants:	3220
Factor D (Divide total by number of participants):	26573.26
Average Length of Stay on the Waiver:	304