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:

E. Proposed Effective Date: (mm/dd/yy)
06/30/20

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:

-Update day the Youth Day Service to to demonstrate the services is exempt from the Final Settings Rule and to exclude "per diem" from the Fee for Service methodology
-Update to Quality Improvement Strategies
-Update Performance Measures A.1, A.3, and A.6
-Update Post Payment Review (PPR) sampling methodology
-Update unduplicated counts
-Update cost neutrality projections
-Add geographical minimum wage language

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	6-I, 7-A
☒ Appendix A Waiver Administration and Operation	QI
☐ Appendix B Participant Access and Eligibility	
☒ Appendix C Participant Services	1a
☐ Appendix D Participant Centered Service Planning and Delivery	
☐ Appendix E Participant Direction of Services	
☐ Appendix F Participant Rights	
☐ Appendix G Participant Safeguards	
☒ Appendix H	1-a-i, b-i, b-ii
☒ Appendix I Financial Accountability	1, 2a
☒ Appendix J Cost-Neutrality Demonstration	1, 2

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:

-Update rate methodology with geographical minimum wage language
-Update Quality Improvement Strategy and Performance Measures

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
Draft ID: CO.013.05.02

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

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:

- [x] **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 2/06/2020 through 3/06/2020:

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 widest circulation in each city with a population of 50,000 or more on 2/06/2020 and 2/20/2020. 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://www.colorado.gov/pacific/hcpf/hcbs-waiver-transition. 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 2/06/2020. The Department had the waiver amendment reviewed by the State Medical Care Advisory Committee (otherwise known as “Night MAC”) in accordance with 42 CFR 431.12 and Section 1.4 of the Department’s State Plan on 02/26/2020. 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 response are documented in a listening log that is posted to the Department’s website and submitted to CMS.

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

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

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

7. Contact Person(s)

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

Last Name:

Eggers

First Name:

Lana

Title:

Waiver Administration & Compliance Unit Supervisor

Agency: Colorado Department of Health Care Policy & Financing

Address: 1570 Grant Street

Address 2:

City: Denver

State: **Colorado**

Zip: 80203

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

Fax: (303) 866-2786

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

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Colorado**

Zip:

Phone: **Ext:** ☐ **TTY**

Fax:

E-mail:

8. Authorizing Signature

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

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name: Johnson

First Name: Tracy

Title: Medicaid Director

Agency: Colorado Department of Health Care Policy & Financing

Address: 1570 Grant Street

Address 2:

City: Denver

State: **Colorado**

Zip: 80203

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

Fax: (303) 866-4411

E-mail: Tracy.Johnson@state.co.us

Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

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

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

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

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

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

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

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):

Information pertaining to Appendix D-1-b:
Documentation of the confirmation is maintained on the BUS. Lastly, all case managers have been directed by the Dept to monitor participants' satisfaction with choices in service providers at the time of service plan development and every quarter as required in quarterly face-to-face monitoring. Such monitoring must be documented in the service plan and in case manager contact notes maintained on the BUS.

The Dept's On-site Program Quality Surveys: Every three years, the Dept staff complete surveys of CCBs and review, specifically, separation of case management from service delivery, the Service Plan 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 Service Plan development and choice from among qualified providers. More information on this process is included Appendix H.

As part of the Department's transition plan for conflict free case management, the Department will implement the following additional firewalls:

The Department will review the current processes for the use and issuance of a "Disclosure of Conflict of Interest" among Community Centered Boards (CCB) and require all Case Management Agencies (CMA) to provide such a disclosure when the CMA also provides direct services. This form will be provided to all individuals receiving HCBS waiver services when the conflict exists. The form will include information about the services provided by the CMA, implications for service planning, why there is a conflict of interest, the agency's structure and organization, and that individuals have the right to choose from any qualified and willing provider, to include the right to change agencies at any time during the Service Plan year. This disclosure will also state that the only time the conflict can exist is when the CMA is the only agency in a geographic area to provide services or there is no other CMA in the area. This requirement may require regulatory and/or contract changes in Colorado. The estimated date to implement these changes is March 2018.

The Department will require all CMAs to develop Standard Operating Procedures (SOP) for the authorization of services. The SOP will comply with regulations regarding the process for selection of service provider, identify the process for offering choice to individuals, require use of the "Disclosure of Conflict of Interest" form, clarify the roles and responsibilities of a case manager versus the service provider, and indicate a separation of functions. The advisory committee and/or board of directors must approve the SOP. CMAs will be required to document and provide to the Department upon request, confirmation that case managers have been oriented to the SOP. The requirement of this SOP and the regulations by which it must comply may require regulatory changes in Colorado. The estimated date to implement new regulations or new contract requirements is March 2018.

The Department will review the current processes for its monitoring of the maintenance and use of complaint and grievance logs. Based on this review, the Department may implement new monitoring practices to ensure that CMAs are compliant with expectations for capturing, trending and acting on complaints and grievances. For example, the Department may recommend that all CMAs develop a SOP for addressing complaints and grievances. The SOP will comply with regulations and contract requirements to have grievance and complaint policies readily available for all individuals and be required to document and address any complaints and grievances related to choice and conflict of interest. The SOP will require case managers to maintain a log of grievances and complaints, which will include tracking of resolution. While the Department has contractual requirements for this work, additional review of the processes in place for the managing of complaints and grievances may indicate that the Department needs regulatory or contractual changes to strengthen, refine and standardize the management of complaints and grievances across all CMAs. The estimated date to implement any contractual or regulatory changes is March 2018.

The Department required all CMAs to provide the Department an organizational chart documenting the separation of case management from provider agency staff by July 31, 2017.

The Department will make regulatory changes regarding the development of a person-centered Service Plan. Current statutes and regulations for individuals with intellectual and developmental disabilities require an interdisciplinary team (IDT) be convened by the CCB. The IDT often consists of case managers and providers employed by the same agency. Proposed statute changes would change this requirement to comply with CMS regulation regarding person-centered Service Plans. The estimated implementation date for any necessary regulatory changes is March 2018.

Below is updated language related to conflict of interest firewall and current milestones:

- Across the waivers there are regulations for case management agencies to ensure an individual is provided choice in providers for services identified in the Support Plan. 10 CCR 2505-10, 8.602.5 outlines the process for case managers to ensure individuals are afforded choice in providers. The Support Plan requires case managers to document that individuals have been afforded

choice in Long Term Services and Supports programs for which he/she is eligible, as well as document choice in provider agency and the method by which that choice occurred. The Support Plan also provides information on the individual's roles and responsibilities, as well as the case manager's while informing an individual about the compliant process, contact information at the CMA, and the individual's appeal rights. It is also specified in the Support Plan that it is the responsibility of the case manager to disclose any conflict of interest. Upon completion of the Support Plan, individuals and/or guardians are required to sign the Support Plan, indicating agreement with it, including being informed of all information contained within it. A copy is also provided to the individual and/or guardian. A Notice of Action form is required when there is an adverse action impacting an individual's access to services. The form is standardized for all CMAs and is contained in the BUS. This form is sent to the individual and/or guardian when adverse action occurs and includes information on the appeal process, to include how to request an appeal. CMAs are required to maintain logs for complaints and grievances and resolutions. It is required that agencies conduct trend analysis of complaints and grievances and make modifications as needed to processes and procedures. The complaint and grievance log is expected to include issues expressed by individuals related to choice of providers and conflict of interest. This information is submitted to the Department for further analysis, which may lead to remediation with specific agencies or implementation of new regulations or requirements to address trends identified among several agencies. The contract for CCBs requires that the agencies provide written disclosure statement to any clients when they are providing services and case management and provides guidance about what the disclosure needs to convey.

- The Business Continuity Plans required to be submitted by July 1, 2018 will assist in the development of future firewalls. The Business Continuity Plans require CCBs to create policies and procedures when the CCB provides both direct services and case management to the same individual (if approved), as well as organizational charts indicating the separation of case management from direct services.
- As part of the rule promulgation process for new case management agency and case manager qualifications, the Department is including any changes necessary to ensure firewalls exist to mitigate any potential conflict.
- The third-party entity to assist in choice of case management agency, will ensure individuals know if he or she is choosing a CMA that also provides direct services and if chosen, that CMA cannot be the service provider as well.
- In 2017 the statutory definition of interdisciplinary team (IDT) was changed to align with federal regulation regarding who is present during the development of a person-centered Support Plan. Regulatory changes will be made in the fall of 2018 to align with federal regulation and state statute

During the 2017 Colorado Legislative Session, House Bill 17-1343 became law, requiring the separation of case management from direct HCBS waiver services for individuals with intellectual and developmental disabilities (I/DD) enrolled in one of the HCBS waivers for individuals with I/DD. Pursuant to House Bill 17-1343, the below milestones are in process or completed:

- June 9, 2017 letter sent to Community Centered Boards notifying them of the four options to comply with requirements as well as information necessary from those agencies wishing to seek an exception to the federal regulation
- July 1, 2017 Department received 10 requests to seek an exception to the federal regulation
- 3rd and 4th quarters of calendar year 2017 Department worked with contractor to develop new qualifications for case management agency and case manager, to include stakeholder feedback
- December 29, 2017 Department sent Business Continuity Plan requirements to all Community Centered Boards
- Business Continuity Plans due to the Department by July 1, 2018, which includes the selection of one of the four options for compliance
- Anticipated date to begin rule promulgation process September 2018, which will include new qualifications for case management agency, case manager as well as definition of conflict-free case management
- Anticipated date for third-party entity to provide choice in case management agency is July 1, 2019
- Department to review all Business Continuity Plans for adequacy by June 30, 2019
- No later than June 30, 2020 Community Centered Boards must complete any necessary changes to its business operations that are required to implement business continuity plans
- No later than June 30, 2021, at least 25% of individuals must be served through a system of conflict-free case management
- No later than June 30, 2022, all individuals must be served through a system of conflict-free case management

The Department is working to ensure a seamless transition process for the individuals that are currently in conflict as well as the individuals that are currently enrolling into conflict. The Department's goal is to ensure a minimal amount of disruption to the delivery of services to members throughout the process. The Department is working towards obtaining a 3rd party enrollment broker that will facilitate choice for each HCBS participant. The enrollment broker will identify all individuals receiving services with conflict and will be working to undo the conflict. The goal start date for the 3rd party choice enrollment broker is July 1, 2019. Once the 3rd party choice enrollment broker has started work, the Department will be able to establish final transition rates for individuals in conflict.

In circumstances where a CCB additionally functions as an OHCDS, this arrangement will be conflict free unless there is only one case management provider in the area. In these instances where the case management provider is the only available option for OHCDS services, the case management provider will have the same safeguards in places as those for non-OHCDS services.

In areas where there is a rural exception to Conflict Free Case Management, the Department will implement the following safeguards:
1. The Department will develop policies regarding a transition to a new CMA. The policies will ensure that transitions occur thoughtfully and may include: Not allowing new individuals to choose an agency in conflict; transitioning current individuals who choose the new CMA or transitioning at their annual Service Plan time. The Department will also consider the level of conflict an individual is in, based on service type or amount of services.
2. The Department will develop policies regarding a transition to a new direct service provider. The policies will ensure that transitions occur thoughtfully and may include: Not allowing new individuals to choose an agency in conflict; transitioning current individuals who choose the new direct service provider, or transitioning at their annual Service Plan time. In addition, the Department will develop policies that ensure firewalls are in place for those individuals in rural areas who refuse to select a new agency, to ensure they are regularly offered informed choice in direct service providers.

The Department requests a 2022 COI compliance date for this waiver but anticipates coming into compliance sooner. Based on the large number of participants throughout the state who are in conflict and the need to expand provider capacity the additional time may be needed.

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 Department holds administrative contractual agreements with 20 non-state, private, non-profit corporations called Community Centered Boards (CCBs) to act as the single entry point agencies to perform Home and Community Based (HCBS) waiver operational and administrative services including intake, verification of target criteria, completion of the level of care assessment, enrollment, utilization review and quality assurance. These agencies also operate as Organized Health Care Delivery Systems and contract with other service providers for the provision of services under this HCBS waiver. These local non-governmental non-state entities also provide Targeted Case Management and waiver services through Medicaid Provider Agreements.

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 report and determines if child meets specific targeting criterion 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 HCBS-CES waiver.

The QIO will be responsible for 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. The QIO conducts desk reviews of case files from all twenty (20) Community Centered Boards.

The Department's Audits & Compliance Division has contracted with a vendor to conduct post-payment reviews of Medicaid paid services of individuals receiving benefits under the HCBS Waiver program. Retrospective audits occurring under the HCBS Waiver Post Payment Review contract focus on claims submitted by providers for any service rendered, billed, and paid as a benefit under a HCBS Waiver. The vendor is also required to 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:

☒ **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 20 non-state private non-profit corporations to act as the single entry point agencies to perform Home and Community Based waiver operational and administrative services including intake,screening, enrollment, utilization review and quality assurance. These agencies also operate as Organized Health Care Delivery Systems and contract with other service providers for the provision of services under this HCBS waiver. These local non-governmental non-state entities also provide Targeted Case Management and waiver services through Medicaid Provider Agreements

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 regularly 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 Community Centered Boards (CCB). As a part of the overall administrative and programmatic evaluation, the Department conducts annual monitoring for each CCB. 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 QIO 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: job descriptions (to assure appropriateness of qualifications), release of information forms, prior authorization forms, complaint logs and procedures, service provider choice forms, tracking worksheets and/or databases, agency case review tool, professional medical information (to assure licensed medical professional completion) and all other pertinent client signature pages including intake forms and service plan agreements. The programmatic review also evaluates agency specific resource development plans, community advisory activity, and provider and other community service coordination. Should the QIO find that a CMA is not in compliance with policy or regulations, the agency is required to take corrective action. Technical assistance is provided to CMAs via phone and e-mail. 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 includes: client referrals, screening, Level of Care (LOC) assessments, individualized service plans, case notes, reassessment documentation, and all other case management activities. Additionally, the BUS is used to track and evaluate timelines for assessments, reassessments, and notice of action requirements to assure that processes are completed according to Department prescribed schedules. The Department reviews a sample of client files to measure 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 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 included 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.

Under the Post Payment Review Contract, the Department requires the Contractor to develop and implement an internal quality control process to ensure that all deliverables and work product—including audit work and issuance of findings to providers—are complete, accurate, easy to understand and of high quality. The Department reviews and approves this process prior to the Contractor implementing its internal quality control process.

As part of payment structure within the Contract, the Department calculates administrative payments to the Contractor based on its audit work and quality of its audit findings. These payments are in addition to the base payment the Contractor receives for conducting its claim audits. Under the Contract, administrative payments are granted when at least ninety percent (90%) 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 Contractor at the Department’s discretion, including if work product has declined in quality or administrative payments are not being approved. The Contractor 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 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 Contractor, 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 Contractor’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 for changes to this process as it sees fit to improve work performance, which the Contractor is required to incorporate in its process.

The Department evaluates, calculates and approves administrative payments when the Contractor 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 Division 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 Post Payment Review Contract 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 Audits & Compliance Division Director, the Finance 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.1 # and % of CMA desk reviews and/or onsite monitor visits completed by Dept during the perf period to ensure all contract obligations have been met on a 4yr cycle N:# of CMA desk review and/or onsite visits by Dept during perf period to ensure all contract

obligations have been met on a 4yr cycle D:# of CMA desk review and/or onsite visits required by Dept during perf period on 4yr cycle

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
Monitoring Check-List

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: 25% of Department approved Case Management Agencies, based on a 4 year cycle.
	☐ **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.2 # and % of reports submitted by CDPHE as required in the Interagency Agreement (IA) that are reviewed by Dept showing cert surveys are conducted ensuring providers meet Dept standards N:# of reports submitted by CDPHE per IA that are reviewed by Dept showing cert surveys are conducted ensuring providers meet Dept standards D:Total # of reports required to be submitted by DPHE as required

Data Source (Select one):
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:

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

Data Aggregation and Analysis:

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

Performance Measure:
A.3 # and % of deliverables submitted by the QIO for CMA Perf. & Quality Rev (PQR), reviewed by the Dept demonstrating performance of delegated functions as specified in the contract. N: # of dlvbs submitted by QIO for CMA PQRs, reviewed by the Dept. demonstrating perf. of delegated functions as specified in the contract D: Total # of dlvbs for CMA PQRs as specified in the contract

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
A.4 # and % of deliverables submitted to the Dept by the QIO for CIR Management reviewed by the Dept demonstrating performance of delegated functions N: # of deliverables submitted to the Dept by QIO for CIR Management reviewed by the Dept demonstrating performance of delegated functions. D: Total # of QIO deliverables for CIR Management 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: QIO	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
A.5 # and % of deliverables submitted to the Dept by QIO for QIS client reviews reviewed by the Dept demonstrating performance of delegated functions N: # of deliverables submitted to the Dept by QIO for QIS client reviews reviewed by the Dept. demonstrating performance of delegated functions D: Total # of QIO deliverables for QIS client reviews 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: QIO	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
A.6 Number and Percent of fiscal intermediary service level agreements reviewed by the Dept demonstrating financial monitoring of the 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**

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

Performance Measure:
A.14 # and % of deliverables submitted by the Post Payment Review (PPR) vendor that are reviewed by the Department demonstrating performance of delegated functions. N: # of deliverables submitted by the PPR vendor that are reviewed by the Department demonstrating performance of delegated functions. D: Total # of deliverables for PPR 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: Post Payment Review 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**	☐ **Weekly**	☒ **100% Review**

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

Data Aggregation and Analysis:

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

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

Performance Measure:
A.16 Number and percent of quality inspections for every active Home Modification provider in the program 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 quality inspections for Home Modifications 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**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
A.17 # and percent of inspections for Home Mods>$8000 completed by DOLA-DOH during the performance review period in accordance with the contract N:# of inspections for Home Mods>$8000 completed by DOLA-DOH during the perf review period in accordance with the contract D:# of inspections >$8000 required to be completed by DOLA-DOH during the perf review period in accordance with the contract

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

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

DOLA-DOH		
	☐ **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.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**

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

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

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

The Dept. maintains oversight of waiver contracts/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.1, A.20
Monitoring of CMAs is completed through tracking administrative contract deliverables. Regular reporting is required to assure appropriate compliance with Dept. policies, procedures and contractual obligations. The Dept. audits CMAs for administrative functions including qualifications of individuals performing assessments and service planning; process regarding evaluation of need, service planning, participant monitoring, case reviews, complaint procedures, provision of participant choice, waiver expenditures, etc.
A.2
The DPHE IA is to manage aspects of provider qualifications, surveys and complaints/critical incidents. The IA requires monthly/annual reports detailing: number and types of agencies surveyed, the number of agencies with deficiencies, types of deficiencies cited, date deficiencies were corrected, number of complaints received, investigated, and substantiated. Oversight is through monthly meetings and reports. Issues that impact the agreement, problems discovered at specific agencies or widespread issues and solutions are discussed.
A.3, A.4, A.5
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 PPR 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, A.17
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, A.17
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.

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.1, A.2, A.3, A.4, A.5, A.6, A.14, A.15, A.16, A.17, 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.1
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. If a compliance issue extends to multiple CMAs, the Dept. provides clarification through formal Policy Memos, formal training, or both. Technical assistance is provided to CMAs via phone and e-mail.

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

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

ii. Remediation Data Aggregation

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

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

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 Service Plan, 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 Service Plan 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	2203
Year 2	2333
Year 3	2436
Year 4	2508
Year 5	2582

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. 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 (see instructions)**
○ **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).

Answers provided in Appendix B-5-a 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 (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 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 (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-5-a 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 that you do not need to complete this section and therefore this section is not visible.

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:

CCBs employ staff to conduct the level of care evaluations. Staff is required to have:

A Bachelor's level degree of education, or five (5) years of experience in the field of developmental disabilities, or some combination of education and experience appropriate to the requirements of the position.

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 CCB case manager uses the Uniform Long-Term Care functional assessment form, also known as the ULTC-100.2, to determine the child's institutional level of care need, along with the Professional Medical Information Page (PMIP.) Regulations for the use of the ULTC 100.2 and PMIP, are set forth at 10 CCR 2505, §8.401. To qualify for services, an individual must demonstrate deficits in 2 of 6 Activities of Daily Living (ADL) or require at least moderate assistance in Behaviors or Memory/Cognition under Supervision. The ADLs include bathing, dressing, toileting, mobility, transferring, and eating. An individual is also required to be determined in need of long term care by medical professional that will attest to the fact that without long term care, the individual would need care in an institution. Copies of the ULTC 100.2 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:

The case manager performs a face to face assessment of the client's abilities to perform activities of daily living and need for supervision due to behavioral, memory or cognitive issues. Case managers are required to complete a client assessment within twelve months of the previous assessment. A re-assessment may be completed sooner if the client's condition changes, if required by program criteria, or if requested by the participant or the participant's parent or guardian. The assessment is conducted at the individual's place of residence through observation, client and collateral interviews (e.g. parents, legal guardian, and natural supports). The client's primary care provider and medical professionals may also provide information.

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 Benefits Utilization System (BUS.)The annual program evaluation includes review of a representative sample of participant records to ensure assessments are being completed correctly and timely.

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

Case Management Agencies are required to keep documentation retrievable electronically by utilizing the Benefits Utilization System (BUS). The BUS 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 # and % of new waiver enrollees with a Level of Care (LOC) assessment and determination indicating a need for institutional level of care prior to receipt of services N:# of new waiver enrollees who received a LOC assessment and determination indicating a need for institutional level of care prior to the receipt of services D:Total # of new waiver enrollees

Data Source (Select one):
Other
If 'Other' is selected, specify:
Benefits Utilization System (BUS) 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 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.1 # and % of new waiver participants who received a Level of Care (LOC) assessment and determination completed in accordance with State waiver policies N:# of new waiver participants who received a LOC assessment and determination completed in accordance with State waiver policies D:Total # of new waiver participants

Data Source (Select one):
Other
If 'Other' is selected, specify:
Benefits Utilization System (BUS)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:
B.c.2 # and % of new waiver participants in which the Level of Care (LOC) assessment and determination was applied appropriately according to Department regulations N:# of new waiver participants in which the LOC assessment and determination was applied appropriately according to Dept regulations D:Total number of new waiver participants.

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

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:
B.c.3 Number and percent of new waiver participants for whom a PMIP was completed according to Department regulations. N:Number of new waiver participants for whom a PMIP was completed as required. D:Total number of new waiver participants.

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% confidence interval
☒ **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 uses data from the Benefits Utilization System (BUS) and the Quality Improvement Review Tool as its primary method for discovery.

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.

Department contract managers and program administrators remediate problems as they arise based on the severity of the problem or by nature of the compliance issues in addition to annual data collection and analysis.

The Department delegates responsibility to 20 Case Management Agencies (CMAs) to perform waiver functions including case management, utilization review, and prior authorization.

If complaints are raised by the participant about the service planning process, case manager, or other CMA functions, case managers are required to document the complaint on the CMA complaint log and assist the participant to resolve the complaint. This complaint log comes to the Department on a quarterly basis. The Department is then able to review the log and note trends to discern if further remediation by the Department is necessary.

In addition to being available to the participant as needed, case managers are required to contact participants quarterly and inquire about the quality of services participants receive. If on-going or system-wide issues are identified by a CMA, the CMA administrator will bring the issue to the Department's attention for resolution. The participant may also contact the case manager's supervisor or the Department if they do not feel comfortable contacting the case manager directly. The contact information for the case manager's supervisor, the CMA administrator, and the Department are included on the copy of the service plan that is provided to the participant. The participant also has the option of lodging an anonymous complaint to case manager, CMA, or the Department.

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 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 assessment and care planning process, and at time of reassessment. Case managers identify the child’s needs and supports through completion of a functional assessment using the ULTC 100.2 and through the care 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 long term service plan is developed. Case managers complete a long term care service plan 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 Benefits Utilization System (BUS) 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**		

Service Type	Service		
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	Parent 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:**

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

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

Service Definition *(Scope):*

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

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:

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

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

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 which assist a client to recreate within their community. These services include recreational equipment that is adapted specific 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 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 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 most 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, movie, theater, concerts, professional or minor league sporting events, outdoors 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 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, and 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:**

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

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

Service Definition *(Scope):*

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

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.

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.

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

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

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:**

Service Definition *(Scope):*

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

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, that 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. 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 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.

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:**

Service Definition *(Scope):*

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

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.

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.

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):*

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):*

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:

Parent Education

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:**

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

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

The maximum annual allowance for Parent 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: Parent 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:**

Service Definition *(Scope):*

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

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 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 upkeep and maintenance of the modifications.

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: **Sub-Category 1:**

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

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.

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:

Community Centered Boards provide case management services

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)

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

- (●) **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- ( ) **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

Appendix C: Participant Services

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

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

◉ **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**

○ **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

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

☐ **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. The Department does not make payment to legally responsible persons for the provision of any CES waiver service. 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.

○ **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 Number and percent of waiver providers, by type, that met licensing standards or certification requirements at time of scheduled or periodic recertification survey
N: Number of licensed/certified waiver providers by type, that met licensing standards or cert requirements at time of scheduled or periodic recert survey D: Total waiver providers, by type, surveyed during per 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 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:
C.a.2 Number and percent of waiver providers enrolled within the performance period, by type, that have the required license or certification prior to serving waiver participants N: Number of newly enrolled waiver providers, by type, that have the required license or certification prior to serving waiver participants D: Total number of newly enrolled waiver providers, by type.

Data Source (Select one):
Other
If 'Other' is selected, specify:
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 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 provider standards N: Number of non-surveyed licensed/certified waiver providers, by type, that continually meet waiver provider standards D: Total number of non-surveyed licensed/certified waiver providers

Data Source (Select one):

Other
If 'Other' is selected, specify:
MMIS Data

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

Data Aggregation and Analysis:

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

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:

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 N: Number of surveyed CES waiver providers who meet Department waiver training requirements D: Total number of surveyed waiver providers

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

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: 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**

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:
C.c.2 Number and percent of CES waiver non-surveyed providers who meet department training requirements N: Number of CES waiver non-surveyed providers who meet Department training requirements D: Total CES waiver non-surveyed providers

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 =
☐ **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 Department maintains an interagency agreement with the Colorado Department of Public Health and Environment (CDPHE) to verify provider qualifications, conduct surveys, and investigate complaints/critical incidents. Providers who have obtained a satisfactory survey are referred to the Department for enrollment as a Medicaid provider. Each certified provider is re-surveyed according to the CDPHE schedule to ensure ongoing compliance.

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.

Deficient practice citations from the Colorado Department of Public Health and Environment (CDPHE) are issued to providers that are surveyed and found to not be in compliance with the established standards. Citations require, at minimum, a plan of correction. Providers that are unable to correct deficient practices within prescribed timelines are recommended for termination by CDPHE and are terminated by the Department.

In addition to CDHPE surveys, individual problems are discovered and addressed through service coordination and monitoring. Case managers inquire about the quality of services during the required quarterly contact. If an issue is reported, the case manager assists the participant in its resolution. This may include changing providers or assisting the participant in resolving the issue with the provider.

Participants, family members, and/or advocates who have concerns or complaints about providers may also contact the participant's case manager and/or the Department. Participants are provided with this information during the initial and annual service planning process using the "Client Roles and Responsibilities" and the Case Managers "Roles and Responsibilities" form. If on-going or system-wide issues are identified, the Department is notified for remediation.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

○ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

⦿ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☒ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

(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 $40,552.29 for all waiver services.

(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 $40,552.29 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:

Service Plan

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 required for Case Managers is a Bachelor's degree in a human behavioral science or related field of study.

If an individual does not meet the minimum requirement, the case management agency shall request a waiver from the Department and demonstrate that the individual meets one of the following:
- Experience working with long-term services and supports (LTSS) population, in a private or public agency, which can substitute for the required education on a year for year basis; or
- A combination of LTSS experience and education, demonstrating a strong emphasis in a human behavioral science field.

A copy of this waiver request with Department approval shall be kept in the case manager's personnel file.

Case manager supervisor educational experience:
The case management 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 Dept 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 direct impact on person-centered support planning and service delivery in Colorado. First, the Dept has submitted its transition plan for CFCM on June 2nd, 2017. Colorado House Bill 17-1343 requires the Department to be in full compliance by June 30, 2022, with at least 25% compliance no later than June 30, 2021. The Department is working to develop the system, to include new case management agencies and the ability for individuals to choose his or her case management agency. The anticipated date to begin transitioning individuals out of conflicted case management and direct service provision is July 1, 2019.

Colorado House Bill 17-1343 requires the separation of case management from the provision of direct services. Pursuant to legislation, the Dept is developing qualifications for CMA and CM, which will allow for the development of new agencies. Additionally, the Dept is developing a 3rd party entity who will assist an individual in making his or her choice of case management agency, so that all individuals are afforded choice. The Dept contracted with a vendor to provide recommendations for a case management model in Colorado for all HCBS waivers. Based on the recommendations, the Dept 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 Dept sent a letter in June of 2017 to all current CMAs notifying them of their four options to comply with federal and state statute and regulation. Additionally, all current CMAs must submit a Business Continuity Plan to the Dept 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 Dept on July 1, 2017. The Dept 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 person-centered service plan (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, Sequache, Archuleta, La Plata, Montezuma, Dolores, San Juan, Hinsdale, Ouray, San Miguel, Montrose, Delta, Gunnison, Garfield, Pitkin, Lake, Egale, 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 service plan 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. 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.

Standardized Service Plan Documents- CCBs are required to complete each participant's service plan on the Benefits Utilization System (BUS) and in the Bridge. The Service Plan 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 Dept of a representative sample of level of participant's care assessments and service plans. 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 Dept Oversight Committee to evaluated performance and identify the need for quality improvement projects.

All CCBs and case managers have received specific instructions from the Dept regarding processes to be implemented 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 choice from among qualified providers at the time of service plan development.

More information has been moved to and updated in the Mod I-AA Additional needed Information (Optional) Section.

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 Departments website. Information continues to be added in order to assist the client and/or family members to make informed decisions about waiver services, informal supports, and State Plan benefits. The waiver participant has the authority to determine who is included in the service planning process pursuant to C.R.S. 25-5-10 (28).

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

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 Managers are any qualified willing provider. Case management functions include the responsibility to document, monitor, and oversee the implementation of the person-centered support plan [10 C.C.R. 2505-10, Section 8.607]. The case manager meets face-to-face with the client and/or legal guardian to complete a comprehensive assessment, 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.

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 functional capacity using the Uniform Long Term Care (ULTC) 100.2 assessment tool.

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

As the person-centered support plan 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 support plan.
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 support plan defines the type of services, frequency, and duration of services needed. The support plan also documents that the client and/or legal guardian have been informed of the choice of providers and the choice to have services provided in the community or in 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 on-going case management such as assistance in coordinating services, conflict resolution or crisis intervention. The client may contact the case manager for on-going case management such as assistance in coordinating services, conflict resolution or crisis intervention.

The case manager reviews the ULTC 100.2 assessment and support plan with the client every six months. At this time the case manager may meet the client at the residence, monitoring service delivery, health and welfare. The review is conducted over the telephone, at the client's place of residence, place of service, or other appropriate setting as determined by the client's needs. This review includes the evaluation and assessing 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, effectiveness of services being provided, an informal assessment of changes in 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 function, case managers are required to document the complaint on the CMA complaint log and assist the client to resolve the complaint. Complaints that are raised by the client about the support planning process, case manager, or other CMA functions, are required to be documented on the CMA complaint log. The case manager and/or case manager's supervisor are also required to assist in resolution of the complaint.
This complaint log is reviewed by the Department on a quarterly basis. Department staff are 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, case manager's supervisor, the CMA administrator, and the Department is included on the copy of the Support Plan that is provided to the client. The client also has the option of lodging an anonymous complaint to 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 face-to-face reassessment, at a time and location chosen by the client, within twelve months of the initial client assessment or previous assessment. A reassessment shall be completed sooner if the client's condition changes or as needed by program requirements. Upon Department approval, the annual assessment and/or development of the person-centered support plan 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 person-centered support plan development process are available through the Medicaid agency.

The Support Plan also includes specific information on the participant's appeal rights and when the Support Plan 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 Support Plan to be implemented by June 2021 to comply with the Person Centered Planning requirements in the HCBS Setting Final Rule. This plan will include documenting individual strengths, preferences, abilities, and individually identify goals and how progress towards identified goals and how progress will measured. The future timeline and milestones for implementing this person-centered support plan is as follows:
- March 2019-April 2020: The Department pilots the new LTSS Assessment and Support Plan process in the field with case managers and LTSS participants
- August 2019: Support Plan 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 Support Plan
- November 2019-December Pilot: Case Managers complete comprehensive assessment and support planning process in the field and feedback meetings conducted
- December 2019-January 2020: The Department will analyze the data gathered from the Support Plan pilot and hold additional stakeholder meetings, as necessary.
- January 2020: Department will update the automation of the Support Plan based on feedback
- January-March 2020: The Department will collect data regarding additional time needed due to new Assessment and Support Plan

The new LTSS Assessment and Support Plan will begin to be used statewide in June 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 LTSS Assessment, as well as developing training for the all case management related functions in the Department's case management software.

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 is 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 level of care assessment (e.g., abuse, neglect, exploitation, mistreatment, behavior supports, eating, medical supports, etc.) are identified in the Support Plan. 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 Service Plan. 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 Service Plan and the Developmental Disabilities Section.

Back-up Plans- The Service Plan 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 Service Plan.

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

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 Service Plan development, individuals are afforded informed choice of all qualified service providers. This conversation occurs no less than annually at Service Plan 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):

HCPF developed a web-based system called the Benefits Utilization System (BUS) that contains the long-term care assessment document (ULTC-100.2), the Service Plan and the monthly case managment log notes. The case manager is required to enter the Service Plan into the BUS in order to receive prior authorization of services. CCB agencies are required to prepare Service Plans 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 Service Plans are reviewed for accuracy, appropriateness, and compliance with regulations.

The Service Plan shall include the participants 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 Service Plan reviews. During review, Service Plans and prior authorization request forms are compared with the documented level of care for appropriateness and adequacy. Targeted review of Service Plan 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 BUS, which is available to the clients 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 person-centered support plan development, implementation, and monitoring. Case managers are required to meet with clients annually face-to-face for support plan development. When scheduling to meet with the client and or client's legal guardian or representative, the case manager makes reasonable attempts to schedule the meeting at a time and location convenient for all participants. Once the support plan is implemented case managers are required to have face to face monitoring with the client quarterly to ensure the person-centered support plan continues to meet the client's goals, preferences, and needs. Case managers are also required to contact the client when significant changes occur in the client's physical or mental condition.

Case Managers are required to conduct quarterly face-to-face 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 Support Plan was adequate and met the needs of the individual. Additionally, case management monitoring includes follow-up to incident and critical incident reports, as well as using observation to document and discuss/address any concerns regarding health and welfare. The Department is providing training in the first quarter of FY18-19 to case managers specific to monitoring and the requirements for monitoring. The training will include 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 support plan that allows clients to indicate whether they have been provided with free choice of providers.

Participant access to non-waiver services in the person-centered support plan, including health services:
In 2007, the Department implemented a new service plan 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 support planning process using the Client Roles and Responsibilities and the Case Mangers Roles and Responsibilities form. The form provides information to the client about the following, but not limited to, case management responsibilities:
* Assists with coordination of needed services.
* Communicate with the service providers regarding service delivery and concerns
* Review and revise services, as necessary
* 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 clients 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 BUS.
Methods for systematic collection of information about monitoring results that are compiled, including how problems identified during monitoring are reported to the state:

The QIO will conduct annual internal programmatic reviews. The Department will require the QIO to conduct programmatic reviews using the Department prescribed Programmatic Tool. The tool is a standardized form with waiver specific components to assist the Department to measure whether or not CMAs remain in compliance with Department rules, regulations, contractual agreements and waiver specific policies. The Department will require that the QIO will complete a specified number of client reviews as determined by the sampling methodology detailed in the QIS.

In addition, the Department audits each CMA for administrative functions including: qualifications of the individuals performing the assessment and support planning, process regarding 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 on-going 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 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. As part of this effort, statute was changed in 2017 requiring the separation of case management from the provision of direct services. Pursuant to legislation, the Department is developing qualifications for CMA and CM, which will allow for the development of new agencies. Additionally, the Department is developing a 3rd party entity who will assist an individual in making his or her choice of case management agency, so that all individuals are afforded choice. 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 statute and regulation. 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 person-centered service plan (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, Sequache, 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 service plan 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 service plan development.

Standardized Service Plan Documents- CCBs are required to complete each participant's service plan on the Benefits Utilization System (BUS) and in the Bridge. The Service Plan 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 level of participant's care assessments and service plans. 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 Oversight Committee to evaluated performance and identify the need for quality improvement projects.

All CCBs 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 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 choice from among qualified providers at the time of service plan development. Documentation of the confirmation is maintained on the BUS. Lastly, all case managers

have been directed by the Department to monitor participants' satisfaction with choices in service providers at the time of service plan development and every quarter as required in quarterly face-to-face monitoring. Such monitoring must be documented in the service plan and in case manager contact notes maintained on the BUS. 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 Service Plan 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 Service Plan development and choice from 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 # and % of waiver participants in a rep sample whose Service Plans (SPs) address the needs identified in the Level of Care (LOC) eval and determination, through waiver & other non-waiver services N: # of participants in the sample whose SPs address the needs identified in the LOC eval and determination, through waiver & other non-waiver services D: Total # of waiver participants in sample

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

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

		Review
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% with a +/- 5% margin of error
☒ **Other** Specify: Quality Improvement Organization (QIO)	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
D.a.2 Number and percent of waiver participants in a representative sample whose SPs address the waiver personal participant's goals N: Number of waiver participants in the sample whose SPs address the waiver participant's personal goals D: Total number of waiver participants in the sample

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

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

Data Aggregation and Analysis:

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

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

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

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

☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% with a +/- 5% margin of error.
☒ **Other** Specify: Quality Improvement Organization (QIO)	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

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

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

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.***

Performance Measures

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

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

Performance Measure:
D.c.1 Number and percent of waiver participants in a representative sample whose SPs were revised, as needed, to address changing needs N: Number of waiver participants in the sample whose SPs were revised, as needed, to address changing needs D: Total number of waiver participants in the sample who needed a revision to their SP to address changing needs

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

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

☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% +/- 5%
☒ **Other** Specify: QIO	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
D.c.2. Number and percent of waiver participants in a representative sample with a prior Service Plan that was updated within one year N: Number of waiver participants in the sample with a prior SP and whose SP start date is within one year of the prior SP start date D: Total number of waiver participants in the sample with a prior SP

Data Source (Select one):
Other
If 'Other' is selected, specify:
Benefits Utilization System (BUS) 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% +/- 5%
☒ **Other** Specify: Quality Improvement Organization	☒ **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 service plan 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 service plan 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 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.c.4 Number and percent of participants in a representative sample with face to face visits completed by case managers once per quarter as required. N: # of participants in a representative sample with face to face visits completed by case managers once per quarter as required D: Total # of participants in the sample

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

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 service plan N: # of CES waiver participants and/or family members responding to the NCI survey who indicate they received services and supports outlined in their service plan 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**

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

Performance Measure:
D.d.2 Number and Percent of waiver participants in a rep sample whose type of services are delivered as specified in the service plan N: # of waiver participants in a rep sample whose type of services are delivered as specified in the service plan D: Total # of waiver participants in the sample

Data Source (Select one):
Other
If 'Other' is selected, specify:
Benefits Utilization System (BUS) 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 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:
D.d.3 Number and Percent of waiver participants in a rep sample whose scope of services are delivered as specified in the service plan N: # of waiver participants in a rep sample whose scope of services are delivered as specified in the service plan D: Total # of waiver participants in the sample

Data Source (Select one):
Other
If 'Other' is selected, specify:
Benefits Utilization System (BUS) 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 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**

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.d.4 Number and Percent of waiver participants in a rep sample whose amount of services are delivered as specified in the service plan N: # of waiver participants in a rep sample whose amount of services are delivered as specified in the service plan D: Total # of waiver participants in the sample

Data Source (Select one):
Other
If 'Other' is selected, specify:
Benefits Utilization System (BUS) 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 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:
D.d.5 Number and Percent of waiver participants in a rep sample whose duration of services are delivered as specified in the service plan N: # of waiver participants in a rep sample whose duration of services are delivered as specified in the service plan D: Total # of waiver participants in the sample

Data Source (Select one):
Other
If 'Other' is selected, specify:
Benefits Utilization System (BUS) and Medicaid Management Information System (MMIS) Data

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 = 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**

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.d.6 Number and Percent of waiver participants in a rep sample whose frequency of services are delivered as specified in the service plan N: # of waiver participants in a rep sample whose frequency of services are delivered as specified in the service plan D: Total # of waiver participants in the sample

Data Source (Select one):
Other
If 'Other' is selected, specify:
Benefits Utilization System (BUS) 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 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:

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

Performance Measures

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

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

Performance Measure:
D.e.1 Number and percent of waiver participants in a representative sample whose SPs document a choice between/among HCBS waiver services and qualified waiver service providers N: Number of waiver participants in the sample whose SPs document a choice between/among HCBS waiver services and qualified waiver service providers D: Total number of waiver participants in the sample

Data Source (Select one):
Other
If 'Other' is selected, specify:
Benefits Utilization System (BUS) 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 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:
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 uses information gathered by the Quality Improvement Organization, CMA annual program evaluations, and Benefits Utilization System (BUS) data as the primary methods for discovery. The Program Review Tool is used to conduct standardized record reviews on a statistically valid sample of waiver participants.

b. Methods for Remediation/Fixing Individual Problems

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

The CMA administrator or director provides information about remediation in the agency's annual report of findings. In some cases, a plan of correction may be required. For issues or problems that arise at any other time throughout the year, technical assistance may be provided to the CMA case manager, supervisor or administrator and a confidential report will be documented in the waiver recipient care file when appropriate.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- ○ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ◉ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ○ **Yes. The state requests that this waiver be considered for Independence Plus designation.**
- ○ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

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, decrease in services, discontinuation of services, or discontinuation from the waiver due to lack of receipt of services or not residing in the community.

Notification- Participants are notified of adverse action through 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 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. 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 county departments of social services child protection units. Requirements for reporting are located at 10 CCR 2505-10 8.608.8 .

Critical Incident: means an actual or alleged event that creates the risk of serious harm to the health or welfare of an individual receiving services; and it may endanger or negatively impact the mental and/or physical well-being of an individuals. Critical Incidents include but are not limited to: injury/illness; mistreat; 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

Mistreatment: “Mistreated” or “Mistreatment” means:

A. Abuse,
B. Caretaker Neglect
C. Exploitation
D. An act or omission that threatens the health, safety, or welfare of a person with intellectual or developmental disability, or
E. An act or omission that exposes the person with an intellectual or developmental disability to a situation or condition that poses an imminent risk of bodily injury.

Abuse means: The non-accidental infliction of physical pain or injury, as demonstrated by, but not limited to, substantial or multiple kin bruising, bleeding, malnutrition, dehydration, burns, bone fractures, poisoning, subdural hematoma, soft tissue swelling, or suffocation; Confinement or restraint that is unreasonable under generally accepted caretaking standards; or Subjection to sexual conduct or contact classified as a crime under the "Colorado Criminal Code", Title 18, C.R.S.

Neglect means: Neglect that occurs when adequate food, clothing, shelter, psychological care, physical care, medical care, habilitation, supervision, or other treatment necessary for the health and safety of a person is not secured for or is not provided by a caretaker in a timely manner and with the degree of care that a reasonable person in the same situation would exercise, or a caretaker knowingly uses harassment, undue influence, or intimidation to create a hostile or fearful environment for waiver participant.

Exploitation means: An act or omission committed by a person who: Uses deception, harassment, intimidation, or undue influence to permanently or temporarily deprive a person of the use, benefit, or possession of anything of value; Employs the services of a third party for the profit or advantage of the person or another person to the detriment of the person receiving services; Forces, compels, coerces, or entices a person to perform services for the profit or advantage of the person or another person against the will of the person receiving services; or Misuses the property of a person receiving services in a manner that adversely affects the person to receive health care or health care benefits or to pay bills for basic needs or obligations.
The Department uses a preponderance of evidence as the burden of proof to substantiate incidents of Abuse, Neglect, or Exploitation (ANE).

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; Any criminal offense that is committed by a person receiving services that results in immediate incarceration.

Damage to Consumer’s Property/Theft Deliberate damage, destruction, theft or use of a waiver recipient’s belongings or money. If incident is mistreatment by a caretaker that results in damage to 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 which necessitates medical care.

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

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

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 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.

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.

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 Service Plan 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 Service Plan 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 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 to 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 a 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 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 2505-10 806.8. 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 recurrence.

Response to Critical Incidents by The Department-The Department contacts 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, 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 formal request for response, technical assistance, Department investigation, 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 issues quarterly reports on Critical Incident data and trends to CMAs. All CMAs are required to submit quarterly Critical Incident trend and analysis to the Department. The Department requires follow-up as needed for identified areas of concern.

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 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. Since 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 to 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 contacts 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, 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 formal request for response, technical assistance, Department investigation, 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 issues quarterly reports on Critical Incident data and trends to CMAs. All CMAs are required by contract to submit quarterly Critical Incident trend and analysis to the Department. The Department requires follow-up as needed for identified areas of concern.

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 deficient practice is detected with critical incident reporting, the agency must correct the practice in order to obtain licensure or recertification.

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- Use of physical, mechanical and chemical restraints are 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, strait jackets, 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 which services are provided (e.g., Individual Service and Support Plans 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 a 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 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 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, 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 and seclusion 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), quarterly review of Case Management Agency (CMA) incident data and Program Quality on-site 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), crime against a person or death is reported immediately to the Department. Such incidents receive additional scrutiny by the Department staff that includes 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.

Quarterly Data Review of CMA Critical Incidents- CMAs are required to provide a data summary of all critical incident reports and complaints received by case managers on a quarterly basis. Reportable critical incidents that are included in that summary are data on the use of restraints. As described in Appendix H.1.d., the Department completes the quarterly review of CMA critical incident data. Outcomes of the IRT reviews of quarterly data include action items for additional follow-up in the form of additional data collection and analysis, remediation and quality improvement plans. Meetings and reviews of CMA incident data are completed on a quarterly basis.

Program Quality On-site Surveys- The Department conducts on-site 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 on-site regulatory survey of PASAs, which includes a specific review of the use of restrictive procedures (e.g., time-out, response-cost programs, etc.) to ensure the PASA's practices comply with the statutory and regulatory requirements specified in § 25.5-10-221 C.R.S. and 10 CCR 2505-10 § 8.608.2 et seq. (e.g., granting of informed consent for the use of the restrictive procedures, behavior assessments, written programs, direct care service providers training, etc.). Additionally, on-site surveys of CMAs include a specific review of the local HRC review activities, the composition of the participant's interdisciplinary team, and 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- As noted above, 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 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.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

The use of aversive or noxious stimuli are 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 a significant risk to 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. 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: Any rights suspension or restrictive procedure must comply with the HCBS Final Settings 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. All rights suspensions and restrictive procedures shall 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 relation 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 have 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 are required to successfully complete training on and be knowledgeable of client's rights and the procedural safeguards for protecting those rights.

When 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 client's Interdisciplinary Team (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 client's current circumstances, 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 The Department rules.

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, 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 are required to be trained specifically on 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 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 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, interview, 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-DD 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, or any use of restrictive 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), crime against a person or death is reported immediately to the Department. Such incidents receive additional scrutiny by the Department staff that includes review of the original written incident report to ensure restrictive interventions was used in compliance with statutory and regulatory requirements. The CIRS monitoring operates on a daily/continuous basis.

Quarterly Data Review of CMA Incidents- CMAs are required to provide a data summary of all incident reports and complaints received by case managers on a quarterly basis. Reportable incidents that are included in that summary are data on the use of restrictive interventions. As described in Appendix H.1.d., the Department completes the quarterly review of CMA incident data. Outcomes of the IRT reviews of quarterly data include action items for additional follow-up in the form of additional data collection and analysis, remediation and quality improvement plans. Meetings and reviews of CMA incident data are completed on a quarterly basis.

Program Quality On-site Surveys- The Department conducts on-site 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, on-site surveys of CMAs include a specific review of the local HRC review activities, the composition of the participant's interdisciplinary team, and 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.

Quarterly CIRs Reports are issued to the CMAs to inform CMA of trends. CIRs Trending and Analysis is a quarterly contract deliverable that is completed by the CMAs and as such is submitted to the Department. The Department compiles internal data points along with this contract deliverable to address and mitigate re-occurrence for CIRs. CIRs data is 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 on-site 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 which result in a risk to the health of 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 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.

Quarterly Data Review of CMA Incident Data- All CMAs are required to provide to the Department a data summary of all incident reports, including incident reports documenting medication errors, received by case managers, on a quarterly basis. Data is reported by provider, service type (e.g., habilitation, respite, etc), and the number and type of incidents requiring follow-up by a medical professional.

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 and/or family or guardian in a rep sample who received information/education on how to report abuse, neglect, exploitation (A.N.E.) & other critical incidents N: #of waiver participants in the sample documented to have received information/education on how to report A.N.E. & other critical incidents D: Total # of waiver participants in the sample

Data Source (Select one):
Other
If 'Other' is selected, specify:
Benefits Utilization System (BUS)

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 within the required timeframe as specified in the approved waiver. N: Number of all critical incidents that were reported within the required time frame as specified in the approved waiver D. Total number of all critical incidents reported

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 requiring follow-up completed within in the required timeframe. Numerator: number and percent of all critical incidents requiring follow-up completed within the required timeframe. Denominator: Number of critical incidents requiring follow- up

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**	☒ **Annually**

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

Performance Measure:
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.5 Number and percent of unexplained deaths where proper follow-up occurs N: # of unexplained deaths where proper follow-up occurs D: # of unexplained deaths

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**

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

Performance Measure:
G.a.6 Number and percent of waiver providers trained on how to identify, address, and seek to prevent A/N/E/D N: # of waiver providers trained on how to identify, address, and seek to prevent A/N/E/D D: Total # of waiver providers

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record of trainings

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

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

Performance Measure:
G.b.1 Number and percent of Case management agencies attending preventative strategies training related to identified trends in critical incidents N: Number CMAs attending preventative strategies training related to identified trends in critical incidents D: Total number of CMAs

Data Source (Select one):
Other

If 'Other' is selected, specify:
Record of trainings

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

Data Aggregation and Analysis:

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

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

Performance Measure:
G.b.2 Number and percent of waiver providers trained on preventative strategies related to identified trends in critical incidents N: Number providers trained on preventative strategies related to identified trends in critical incidents D: Total number of waiver providers

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record of training

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and**	☐ **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:
G.b.3 Number and percent of annual reports provided to Case Management Agencies (CMAs) on identified trends in critical incidents. N: Number of annual reports on identified trends in critical incidents provided to CMAs D: Total number of annual reports required for CMAs.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:
BUS Data and/or CDPHE Reports; Record Reviews

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:

Performance Measure:
G.b.4 Number and percent of preventable critical incidents reported that have been effectively resolved. N: Number of preventable critical incidents reported that have been effectively resolved. D: Total number of preventable critical incidents reported.

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
G.b.5 Number and percent of substantiated critical incident, by type, addressed appropriately. N: Number of substantiated critical incidents, by type, addressed appropriately. D. Total number of substantiated critical incidents, by type

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.b.6 Number and percent of critical incidents where the root cause has been identified N: Number of critical incidents where the root cause has been identified D. Total number of critical incidents

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

Performance Measure:
G.b.7 Number and percent of critical incident trends where system intervention has been implemented N: Number critical incident trends where system intervention has been implemented D: Total number of critical incident trends

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.b.8 Number and percent of critical incidents with shared root cause/trends reduced as a result of systemic intervention N: Number of critical incidents with a shared root cause/trend reduced as a result of systemic intervention D: Total number of critical incidents with a shared root cause/trend

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

Performance Measure:
G.c.1 Number and percent of participants with restrictive interventions where proper procedures were followed N: Number of participants with restrictive interventions where proper procedures were followed D: Number of participants with a restrictive intervention plan

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

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

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

Data Aggregation and Analysis:

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

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 N: Number of surveyed

providers that met requirements for use of physical or mechanical restraints D: Total number of surveyed providers

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

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

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

Performance Measure:
G.c.6 Number and percent of waiver participants who have a restrictive intervention plan as required N: # of waiver participants who have a restrictive intervention plan as required D: # of waiver participants who require a restrictive intervention plan

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:

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.

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, and provider survey reports as the primary methods for discovery for the health and welfare sub-assurances 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.
G.a.1
The Dept reviews the signature section in the BUS service plan that indicates 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 DPHE must be reported to the Dept. and DPHE and are responded to by DPHE. A hotline is set up for complaints about quality of care, fraud, abuse, and misuse of personal property. DPHE evaluates 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.5
Incidents of unexplained death are investigated by the CIR Team to determine if the death occurred due to a substantiated ANE critical incident.
G.a.6, G.b.1, G.b.2
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.5 Substantiated critical incidents, by type, are reviewed by the CIR Team/QIO to determine if these incidents have been addressed appropriately.
G.b.6, G.b.7, G.b.8
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.
G.c.1, G.c.2, G.c.6
The Dept monitors restrictive interventions to ensure all participants who need a restrictive intervention plan have one. The Dept. also monitors the inappropriate/ineffective use of restrictive interventions through the CIRS and provider survey reports. These incidents receive additional scrutiny by the Dept staff that includes review of the original written incident report to ensure restrictive intervention was used in compliance with statutory and regulatory requirements. The CIRS monitoring operates on a daily/continuous basis.
Oversight and discovery of restrictive interventions where proper procedures were not followed are completed through the review of complaints regarding services and supports and conducting on-site surveys of CMAs by Dept. staff and providers by DPHE.
Providers must demonstrate during the survey process that they have met requirements for the use of physical or mechanical restraints; met the due process requirements for implementing a suspension of rights; met the requirements for use of training and support plans with restrictive procedures.

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, G.b.5
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.5
The Department ensures that the appropriate authority is notified of any unexplained deaths that resulted from substantiated ANE.
G.a.6, G.b.1, G.b.2
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 DPHE 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, G.b.7, G.b.8
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
DPHE notifies the agencies of deficiencies and determines the appropriate remedial actions: training, technical assistance, Plan of Correction, license revocation.

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 Strategy 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 (DPHE), Critical Incident Reporting System (CIRS), annual programmatic and administrative evaluations, and stakeholder input, the Department's Office of Community Living Benefits and Services Division, in partnership with the 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 Benefits Utilization System (BUS). Work groups form as necessary to discuss prioritization and selection of system design changes.

Discovery and Remediation Information:
The Department maintains oversight over the CES 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 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 contracted with an independent Quality Improvement Organization (QIO) to complete the QIS Review Tool for the annual Case Management Agency (CMA) program case evaluations. Additionally, the Department performs an inter-rater reliability study of results provided by the QIO to determine accuracy of QIO reviews.

The Department uses standardized tools for level of care assessments, service planning, and critical incident reporting for waiver populations. Through use of the BUS, the data generated from assessments, service 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.

Waiver providers that are required by Medical Assistance Program regulations to be surveyed by DPHE, must complete the survey prior to certification to ensure compliance with licensing, qualification standards and 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 DPHE 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. In

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 DPHE. The Department engages in quarterly meetings with DPHE 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**

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☐ **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.

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 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 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 Division, Waiver 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..

Community Centered Boards (CCBs) 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, CCBs 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 CCBs, reviewing the Single Audits of all CCBs 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 is maintained through the Medicaid Management Information System (MMIS). The MMIS is designed to meet federal certification requirements for claims processing and submitted claims are adjudicated against MMIS edits prior to payment.

Duties of providers include a requirement of documentation of care, in/out times, and confirmation that care was provided per state rules and regulations. Additionally, there must be 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 which 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.

The Audits and Compliance Division within the Dept exists to monitor provider and member compliance with state and federal regulations and Dept policies. Internal reviewers conduct post-payment reviews (PPRs) of provider claims submissions to ensure accuracy of provider billing and compliance with regulations and Department billing policies. Auditing under the Audits & Compliance Division—including the number and frequency of providers reviewed, the percentage of claims reviewed, and the time period of the claims reviewed—varies with the review project conducted. 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. Dept 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 Audits and Compliance Division accepts and evaluates all referrals of possible fraud, waste, and abuse of a provider or member. The Audits and Compliance Division also works with law enforcement agencies on all possible fraud investigations, as well as suspensions and terminations of provider agreements.

The Audits and Compliance Division also oversees post-payment claims review contracts, including the Recovery Audit Contract program and the HCBS Waivers Program PPR Contract. As with the Dept's own reviewers, contractors are

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.

The purpose of the HCBS Waivers Program PPR Contract is 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. This contract conducts a PPR on a randomly selected sample of Medicaid paid services provided to individuals receiving benefits under the Department's HCBS Waivers program. The PPR includes 5,000 or more HCBS waiver claims at the header level reviewed each year. 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. Auditing under the HCBS Waivers Program Post Payment Review Contract will be desk reviews, however, the vendor is 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 under the contract will be reported to the Audits and Compliance Division 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.

Under the HCBS Waivers Program PPR Contract, the vendor is provided claims data on a state fiscal year basis and is directed to conduct a medical records review of those cases to verify that provider documentation substantiates the claims that were submitted to the Dept. The Dept provides the claims to the vendor, which is a statistically valid sample reflecting a 95 percent confidence level with no more than a 5 percent margin of error. the sample may be greater than the 95 percent confidence level with no more than a 5 percent margin of error at the discretion of the Dept. Additionally, claims selected for audit are based on a whole state fiscal years' worth and are selected to ensure that audit work does not interfere with provider timely filing rules. The vendor will divide the selected claims into review projects and deliver requests to providers for medical records and other documentation for those claims. For instance, the vendor is currently reviewing claims that were only rendered in State Fiscal Year 2015-2016. When claims in that time period are reviewed, the vendor will move on to claims rendered in State Fiscal Year 2016-2017.

Department reviewers and contractors utilize multiple regulation sources at the state and federal level to create review projects, as part of the Department's overall compliance monitoring of providers. As mentioned above, research and creation of annual work plans come from multiple sources, including reviewing fraud, waste, and abuse trends occurring locally and nationally, 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, under the HCBS Waivers Program Post Payment Review Contract, review projects will include whether providers are compliant with multiple HCBS Waiver programs. All Department reviewers and contractors are required to follow audit and recovery rules set forth in C.R.S. 25.5-4-301 and 10 C.C.R. 2505-10 Section 8.076.3.

For negotiated rates: As part of the Service Plan review and on-site survey processes detailed in Appendix D of this application, Department staff review the documentation of rate determination and service authorization activities conducted by case managers. Identification of rate determination practices that are inconsistent with Department policies may result in corrective action and/or recovery of overpayment.

The Department will operate an Electronic Visit Verification (EVV) system to document that a variety of HCBS services are provided to members. EVV will capture six points of data as required by the 21st Century Cures Act: individual receiving the service, attendant providing the service, service provided, location of service, date of service, and time that service provision begins and ends. The Department is implementing a hybrid or open EVV model. The state contracted with an EVV vendor for a state-managed solution. This solution is available to providers at no cost. Providers may also choose to utilize

an alternate EVV system procured and managed by the agency.

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

Homemaker
Respite (provided in the home or community)
Youth Day

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

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:
The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
I.a.1 Number and percent of waiver claims in a representative sample paid according to the reimbursement methodology in the waiver N: Number of waiver claims in the sample paid according to the reimbursement methodology in the waiver D: Total number of paid waiver claims in the sample

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
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% with a 5% margin of error*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

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

Performance Measure:
I.a.2 Number and percent of waiver codes that adhere to the approved reimbursement methodology. N: Number of waiver codes listed in the HCPF Billing Manual that adhere to approved reimbursement methodology D: Total number of waiver codes listed in the HCPF Billing Manual

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
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% with a 5% margin of error*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

Performance Measure:
I.a.3 Number and percent of paid waiver claims within a representative sample with adequate documentation that services were rendered N: Number of claims in the sample with adequate documentation of services rendered D: Total number of claims in the sample

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

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

		95% with a 5% margin of error
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

Performance Measure:
I.a.4 Number and percent of clients in a representative sample whose units billed did not exceed procedure code limit N: Number of clients in a representative sample whose units billed did not exceed procedure code limit D: Total number of waiver clients in the

sample

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Medicaid Management Information System (MMIS) Claims Data/PAR

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

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

Performance Measure:
I.b.1 Number and percent of claims paid where the rate is consistent with the approved rate methodology in the waiver application N: Number of claims paid where the rate is consistent with the approved rate methodology in the waiver application D: Total number of paid waiver claims in the sample

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
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% with a 5% margin of error*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

Performance Measure:
I.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

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% with a 5% margin of error*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

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

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

The information gathered for the annual reporting of the performance measures serves as the Department's primary method of discovery. The CMA independent audit results is an additional strategy employed by the Department to ensure the integrity of payments made for waiver services.

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 to the Medicaid Management Information System (MMIS) that are necessary for the remediation of any deficiencies identified by the annual reporting of performance measures.

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***

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
	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 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 Department's provider bulletin annually and posted to the Department's website.

The Department's adopted a 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, wage, and hours required conform to the program or service design and are in compliance with the Code of Colorado Regulations and statutes.

B. 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 are 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.

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

D. Capital Overhead Expense Expectations:
Identifies and incorporates additional capital expenses such as medical equipment, supplies, and IT equipment directly related to providing the service to Medicaid clients. 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 (Individual Day)*
3. *Homemaker (Basic or Enhanced)*
4. *Community Connector*
5. *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
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 needs, product required, and frequency of use. The Departments HCBS CES waiver administrator reviews and approves the market price determined and authorized by the case manager.

The Department requires case managers attempt to obtain at least three 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 implementation of the rate only legislative increases or decreases are applied. These legislative rate changes are often annual and reflect inflationary increases or decreases. Rates for the HCBS CES waiver are reviewed for appropriateness every five years with the waiver renewal.

The Department 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 Department'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 external website.

The Department 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 Department 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 acknowledgement of unique geographical considerations impacting access to care. Distinct rates by locality, county, metropolitan area, or other type of regional boundary will be implemented as the Department determines potential access to care considerations. Upon the subsequent waiver amendment or renewal, the Department will update the corresponding rate and any changes in methodology.

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from*

providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

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.

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	10667.30	56158.65	66825.95	229247.30	9034.09	238281.39	171455.44
2	11311.73	56175.50	67487.23	236055.94	9552.65	245608.59	178121.36
3	11812.53	56192.35	68004.88	243066.80	10100.97	253167.77	185162.89
4	12321.52	56209.21	68530.73	250285.88	10680.77	260966.65	192435.92
5	12875.52	56226.07	69101.59	257719.37	11293.85	269013.22	199911.63

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	2203	2243
Year 2	2333	2402
Year 3	2436	2530
Year 4	2508	2620
Year 5	2582	2713

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. As with enrollment, the Department believes this measure also might be plateauing. The highest ALOS has ever been is 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.

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 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 FY 2007-08 through FY 2017-18 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 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 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.

Rates included in the Department's Cost Neutrality Demonstration may not match the Department's published rate schedule. In order to accurately project total expenditures for a service, the avg. cost/unit may be adjusted to account for a particular rate being implemented for less than a 12 month period.

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. 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.

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 2015-16 and FY 2016-17). 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.

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	
Parent 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	
Adaptive Therapeutic Recreational Equipment and Fees Total:						223497.33
GRAND TOTAL:						23500051.66
Total Estimated Unduplicated Participants:						2203
Factor D (Divide total by number of participants):						10667.30
Average Length of Stay on the Waiver:						309

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
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
Community Connector	15 min	702	678.93	9.17	4370503.25	
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	
Parent Education Total:						28066.72
Parent Education	Session	74	1.00	379.28	28066.72	
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

GRAND TOTAL:	23500051.66
Total Estimated Unduplicated Participants:	2203
Factor D (Divide total by number of participants):	10667.30
Average Length of Stay on the Waiver:	309

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Youth Day Service-Individual	15 min	593	1149.54	5.55	3783308.57	
Youth Day Service-Day	Day	0	0.00	0.01	0.00	
Youth Day Service-Group	15 min	139	16.53	223.05	512495.29	
				GRAND TOTAL:		23500051.66
				Total Estimated Unduplicated Participants:		2203
				Factor D (Divide total by number of participants):		10667.30
				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:						3135115.61
Homemaker - Basic	15 min	434	931.66	4.49	1815488.58	
Homemaker - Enhanced	15 min	455	398.39	7.28	1319627.04	
Respite Total:						6525806.71
Respite Individual	15 min	785	1222.36	5.70	5469449.82	
Respite Day	Day	145	11.07	228.00	365974.20	
Respite Group	15 min	159	11.85	310.24	584538.70	
Respite Group Overnight Camp	Day	111	2.65	359.83	105843.99	
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	
				GRAND TOTAL:		26390255.45
				Total Estimated Unduplicated Participants:		2333
				Factor D (Divide total by number of participants):		11311.73
				Average Length of Stay on the Waiver:		311

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assistive Technology Total:						182441.16
Assistive Technology	Item	324	1.00	563.09	182441.16	
Community Connector Total:						4865980.54
Community Connector	15 min	752	705.64	9.17	4865980.54	
Hippotherapy Total:						412397.05
Hippo-Therapy	15 min	227	84.73	21.43	412178.41	
Hippo-Therapy Group	15 min	2	12.00	9.11	218.64	
Home Accessibility Adaptations Total:						830318.35
Home Accessibility Adaptations	Per Purchase	179	1.00	4638.65	830318.35	
Massage Therapy Total:						2320092.79
Massage Therapy	15 min	603	199.46	19.29	2320092.79	
Movement Therapy Total:						2527827.96
Movement Therapy - Bachelors	15 min	955	164.49	16.09	2527545.12	
Movement Therapy - Masters	15 min	1	12.00	23.57	282.84	
Parent Education Total:						30342.40
Parent Education	Session	80	1.00	379.28	30342.40	
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:						4706438.47
Youth Day Service-Individual	15 min	635	1149.54	5.70	4160760.03	
Youth Day Service-Day	Day	0	0.00	0.01	0.00	
Youth Day Service-					545678.44	

GRAND TOTAL:	26390255.45
Total Estimated Unduplicated Participants:	2333
Factor D (Divide total by number of participants):	11311.73
Average Length of Stay on the Waiver:	311

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Group	15 min	148	16.53	223.05		
		GRAND TOTAL:				26390255.45
		Total Estimated Unduplicated Participants:				2333
		Factor D (Divide total by number of participants):				11311.73
		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:						3555935.24
Homemaker - Basic	15 min	457	1054.52	4.49	2163801.22	
Homemaker - Enhanced	15 min	480	398.39	7.28	1392134.02	
Respite Total:						6903118.61
Respite Individual	15 min	826	1229.83	5.70	5790285.61	
Respite Day	Day	152	11.07	228.00	383641.92	
Respite Group	15 min	168	11.85	310.24	617625.79	
Respite Group Overnight Camp	Day	117	2.65	359.83	111565.29	
Adaptive Therapeutic Recreational Equipment and Fees Total:						255061.28
Adapted Therapeutic Recreation Equipment	Item	118	1.16	531.02	72686.02	
Adapted Therapeutic Recreation Fees	Item	306	4.84	123.14	182375.27	
Assistive Technology Total:						192013.69
Assistive Technology	Item	341	1.00	563.09	192013.69	
Community Connector						5326347.55
		GRAND TOTAL:				28775312.43
		Total Estimated Unduplicated Participants:				2436
		Factor D (Divide total by number of participants):				11812.53
		Average Length of Stay on the Waiver:				313

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:						
Community Connector	15 min	792	733.39	9.17	5326347.55	
Hippotherapy Total:						451139.27
Hippo-Therapy	15 min	239	88.04	21.43	450920.63	
Hippo-Therapy Group	15 min	2	12.00	9.11	218.64	
Home Accessibility Adaptations Total:						872066.20
Home Accessibility Adaptations	Per Purchase	188	1.00	4638.65	872066.20	
Massage Therapy Total:						2719188.81
Massage Therapy	15 min	635	221.99	19.29	2719188.81	
Movement Therapy Total:						2860760.21
Movement Therapy - Bachelors	15 min	1006	176.48	16.09	2856600.58	
Movement Therapy - Masters	15 min	1	176.48	23.57	4159.63	
Parent Education Total:						31859.52
Parent Education	Session	84	1.00	379.28	31859.52	
Specialized Medical Equipment and Supplies Total:						413868.57
Specialized Medical Supplies-Disposable	Item	1140	5.58	57.51	365832.61	
Specialized Medical Equipment	Item	115	1.40	298.36	48035.96	
Vehicle Modifications Total:						235238.02
Vehicle Modifications	Per Purchase	46	1.00	5113.87	235238.02	
Youth Day Service Total:						4958715.46
Youth Day Service-Individual	15 min	669	1149.54	5.70	4383540.88	
Youth Day Service-Day	Day	0	0.00	0.01	0.00	
Youth Day Service-Group	15 min	156	16.53	223.05	575174.57	
				GRAND TOTAL:		28775312.43
				Total Estimated Unduplicated Participants:		2436
				Factor D (Divide total by number of participants):		11812.53
				Average Length of Stay on the Waiver:		313

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:						3976328.16
Homemaker - Basic	15 min	473	1193.58	4.49	2534889.40	
Homemaker - Enhanced	15 min	497	398.39	7.28	1441438.76	
Respite Total:						7191127.15
Respite Individual	15 min	856	1237.35	5.70	6037278.12	
Respite Day	Day	158	11.07	228.00	398785.68	
Respite Group	15 min	174	11.85	310.24	639683.86	
Respite Group Overnight Camp	Day	121	2.65	359.83	115379.49	
Adaptive Therapeutic Recreational Equipment and Fees Total:						265074.66
Adapted Therapeutic Recreation Equipment	Item	122	1.16	538.04	76143.42	
Adapted Therapeutic Recreation Fees	Item	317	4.84	123.14	188931.24	
Assistive Technology Total:						198770.77
Assistive Technology	Item	353	1.00	563.09	198770.77	
Community Connector Total:						5731587.46
Community Connector	15 min	820	762.24	9.17	5731587.46	
Hippotherapy Total:						486401.91
Hippo-Therapy	15 min	248	91.48	21.43	486183.27	
Hippo-Therapy Group	15 min	2	12.00	9.11	218.64	
Home Accessibility Adaptations Total:						904536.75

GRAND TOTAL:	30902366.40
Total Estimated Unduplicated Participants:	2508
Factor D (Divide total by number of participants):	12321.52
Average Length of Stay on the Waiver:	315

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Accessibility Adaptations	Per Purchase	195	1.00	4638.65	904536.75	
Massage Therapy Total:						3135888.11
Massage Therapy	15 min	658	247.06	19.29	3135888.11	
Movement Therapy Total:						3179063.42
Movement Therapy - Bachelors	15 min	1042	189.35	16.09	3174600.44	
Movement Therapy - Masters	15 min	1	189.35	23.57	4462.98	
Parent Education Total:						32997.36
Parent Education	Session	87	1.00	379.28	32997.36	
Specialized Medical Equipment and Supplies Total:						428696.53
Specialized Medical Supplies-Disposable	Item	1181	5.58	57.51	378989.75	
Specialized Medical Equipment	Item	119	1.40	298.36	49706.78	
Vehicle Modifications Total:						240351.89
Vehicle Modifications	Purchase	47	1.00	5113.87	240351.89	
Youth Day Service Total:						5131542.25
Youth Day Service-Individual	15 min	692	1149.54	5.70	4534245.58	
Youth Day Service-Day	Day	0	0.00	0.01	0.00	
Youth Day Service-Group	15 min	162	16.53	223.05	597296.67	
				GRAND TOTAL:		30902366.40
				Total Estimated Unduplicated Participants:		2508
				Factor D (Divide total by number of participants):		12321.52
				Average Length of Stay on the Waiver:		315

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:						4463012.61
Homemaker - Basic	15 min	490	1350.97	4.49	2972269.10	
Homemaker - Enhanced	15 min	514	398.39	7.28	1490743.51	
Respite Total:						7480339.12
Respite Individual	15 min	886	1244.91	5.70	6287044.48	
Respite Day	Day	163	11.07	228.00	411405.48	
Respite Group	15 min	180	11.85	310.24	661741.92	
Respite Group Overnight Camp	Day	126	2.65	359.83	120147.24	
Adaptive Therapeutic Recreational Equipment and Fees Total:						276169.31
Adapted Therapeutic Recreation Equipment	Item	127	1.16	543.62	80086.10	
Adapted Therapeutic Recreation Fees	Item	329	4.84	123.14	196083.21	
Assistive Technology Total:						206090.94
Assistive Technology	Item	366	1.00	563.09	206090.94	
Community Connector Total:						6175036.74
Community Connector	15 min	850	792.23	9.17	6175036.74	
Hippotherapy Total:						521670.54
Hippo-Therapy	15 min	256	95.05	21.43	521451.90	
Hippo-Therapy Group	15 min	2	12.00	9.11	218.64	
Home Accessibility Adaptations Total:						937007.30
Home Accessibility Adaptations	Per Purchase	202	1.00	4638.65	937007.30	
Massage Therapy Total:						3612140.66
Massage Therapy	15 min	681	274.97	19.29	3612140.66	
Movement Therapy Total:						3527083.11
Movement Therapy - Bachelors	15 min	1079	203.16	16.09	3527083.11	
				GRAND TOTAL:		33244584.33
				Total Estimated Unduplicated Participants:		2582
				Factor D (Divide total by number of participants):		12875.52
				Average Length of Stay on the Waiver:		317

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Movement Therapy - Masters	15 min	0	203.16	23.57	0.00	
Parent Education Total:						34135.20
Parent Education	Session	90	1.00	379.28	34135.20	
Specialized Medical Equipment and Supplies Total:						443845.39
Specialized Medical Supplies-Disposable	Item	1223	5.58	57.51	392467.79	
Specialized Medical Equipment	Item	123	1.40	298.36	51377.59	
Vehicle Modifications Total:						250579.63
Vehicle Modifications	Per Purchase	49	1.00	5113.87	250579.63	
Youth Day Service Total:						5317473.80
Youth Day Service-Individual	15 min	717	1149.54	5.70	4698055.03	
Youth Day Service-Day	Day	0	0.00	0.01	0.00	
Youth Day Service-Group	15 min	168	16.53	223.05	619418.77	

GRAND TOTAL:	33244584.33
Total Estimated Unduplicated Participants:	2582
Factor D (Divide total by number of participants):	12875.52
Average Length of Stay on the Waiver:	317