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:
HCBS - Children's Habilitation Residential Program

C. Waiver Number:CO.0305
Original Base Waiver Number: CO.0305.

D. Amendment Number:

E. Proposed Effective Date: (mm/dd/yy)
01/01/24
Approved Effective Date of Waiver being Amended: 07/01/19

2. Purpose(s) of Amendment

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

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

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
☐ Waiver Application	
☐ Appendix A Waiver Administration	

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

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

- ☐ **Modify target group(s)**
- ☐ **Modify Medicaid eligibility**
- ☐ **Add/delete services**
- ☐ **Revise service specifications**
- ☐ **Revise provider qualifications**
- ☐ **Increase/decrease number of participants**
- ☐ **Revise cost neutrality demonstration**
- ☐ **Add participant-direction of services**
- ☐ **Other**

Specify:

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

1. Request Information (1 of 3)

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

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

HCBS - Children's Habilitation Residential Program

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.0305
Draft ID: CO.008.05.11

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

Regular Waiver

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

PRA Disclosure Statement

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

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

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

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

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

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

☐ **Nursing Facility**

Select applicable level of care

○ **Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**
If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

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

☒ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**
If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

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

◉ **Not applicable**

○ **Applicable**
Check the applicable authority or authorities:

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

☐ **Waiver(s) authorized under §1915(b) of the Act.**
Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

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

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

☐ **§1915(b)(2) (central broker)**

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

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

☐ **A program operated under §1932(a) of the Act.**
Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

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

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

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

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

The Home and Community Based Services Children's Habilitation Residential Program waiver (HCBS-CHRP) provides assistance to children and youth, age birth (0) through twenty (20)years of age who have been determined to have a developmental disability. These children and youth require high levels of service to remain in the community. The waiver serves as an alternative to placement in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)(as defined in 42 CFR §440.150).

The HCBS-CHRP waiver provides the following services to children residing in the home of a parent/guardian:

- Respite
- Hippotherapy
- Intensive Support Services
- Massage Therapy
- Movement Therapy
- Supported Community Connections
- Transition Support Services

Children/youth may receive Habilitation services in an appropriate foster or group home/center or Residential Child Care Facility where either the individual foster care provider or the Child Placement Agency (CPA) has acquired a Medicaid Provider number and have met the additional provider requirements according to the Colorado Department of Human Services staff manual, Volume 7, and the Health Care Policy and Financing, Volume 8. Habilitation services may be provided to a child who is still in the custody of their parent/s. Habilitation services will be provided in a licensed foster care home, group home or residential child care facility. These services will not be offered in the family home. Habilitative services are tailored to the individual child's needs and provided by the foster parents, staff, and/or CPA. The Habilitation services are structured to provide the child an opportunity to learn daily living skills, advocacy, social skills and, independent living skills in order to more successfully live within the community setting.

Targeted Case Management is performed by a Case Management Agency (CMA). The CMA enables people with long-term care needs to access appropriate long-term care services and ensure access to a state-wide network of providers. Functions of case management include intake/screening/referral, assessment of the child's needs, functional eligibility determination, service plan development, ongoing case management, and monitoring to assure service delivery, participant protections and quality assurance of services provided.

3. Components of the Waiver Request

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

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

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

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

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

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

- ○ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ◉ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

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

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

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

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

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

4. Waiver(s) Requested

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

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

- ○ **Not Applicable**
- ◉ **No**
- ○ **Yes**

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

- ◉ **No**
- ○ **Yes**

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

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

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

5. Assurances

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

J. Services for Individuals with Chronic Mental Illness. The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals

with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

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

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

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

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

The public comment period ran from 10/11/2023 through 11/09/2023:

The process is summarized as follows: The Department sent, via electronic mail, a summary of all proposed changes to all Office of Community Living (OCL) stakeholders. Stakeholders include clients, contractors, families, providers, advocates, and other interested parties. Non-Web-Based Notice: The Department posted notice in the newspaper of the widest circulation in each city with a population of 50,000 or more on 10/11/2023 and 10/25/2023. The Department employed each separate form of notice as described. The Department understands that, by engaging in both separate forms of notice, it will have met the regulatory requirements, CMS Technical Guidance, as well as the guidance given by the CMS Regional Office. The Department posted on its website the full waiver and a summary of any proposed changes to that waiver at https://hcpf.colorado.gov/hcbs-public-comment. The Department made available paper copies of the summary of proposed changes and paper copies of the full waiver. These paper copies were available at the request of individuals. The Department allowed at least 30 days for public comment. The Department complied with the requirements of Section 1902(a)(73) of the Social Security Act by following the Tribal Consultation Requirements outlined in Section 1.4 of its State Plan on 10/11/2023. The Department had the waiver amendment reviewed by the State Medical Care Advisory Committee (otherwise known as “Night MAC”) in accordance with 42 CFR 431.12 and Section 1.4 of the Department’s State Plan on 10/11/2023. In addition to the specific action steps described above, the Department also ensured that all waiver amendment documentation included instructions about obtaining a paper copy. All documentation contains language stating: “You may obtain a paper copy of the waiver and the proposed changes by calling (303) 866-3684 or by visiting the Department at 1570 Grant Street, Denver, Colorado 80203.”

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

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

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

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

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

7. Contact Person(s)

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

Last Name: Eggers

First Name: Lana

Title:

Waiver Administration & Compliance Unit Supervisor

Agency:
Colorado Department of Health Care Policy & Financing

Address:
1570 Grant Street

Address 2:

City:
Denver

State: **Colorado**

Zip:
80203

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

Fax:
(303) 866-2786

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

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Colorado**

Zip:

Phone:
Ext: ☐ **TTY**

Fax:

E-mail:

8. Authorizing Signature

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

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name: Flores-Brennan

First Name: Adela

Title: Medicaid Director

Agency: The Department of Health Care Policy & Financing

Address: 303 E 17th Ave

Address 2:

City: Denver

State: **Colorado**

Zip: 80203

Phone: (303) 866-3060 **Ext:** ☐ **TTY**

Fax: (303) 866-2786

E-mail: Adela.Flores-Brennan@state.co.us

Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

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

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

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

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

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

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

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

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix G Quality Improvement
Methods for Remediation/Fixing Individual Problems:

G.d.3 The Dept provides remediation training for CMAs annually to assist with improving compliance and then ensuring there is accurate RAE/CMA care coordination. The Dept compiles and analyzes CMA CAPs to determine a statewide root cause for deficiencies. Based on the analysis, the Dept. identifies the need to provide policy clarifications, and/or TA, design specific training, and determine the need for modifications to current processes to address statewide systemic issues.

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

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

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

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

J-2-c-i - Factor D Derivation:

Update for WY 4-5 for Amendment with the requested effective date of 1/1/2023:

The State is updating Appendix J to reflect the 2% ATB rate increase approved in the budget request for Long Bill HB22-1329 for the following services:
Habilitation - Foster Home Level 1-6
Habilitation - Group Home Level 1-6
Habilitation - Residential Child Care Facility Level 1-5
Respite Individual - In-Home Family
Respite Individual Day - In-Home Family
Respite Individual - In a Residential Setting
Transition Support Services - Wraparound Plan
Transition Support Services - Prevention and Monitoring
Transition Support Services - In-Home Support
Supported Community Connections
Hippotherapy - Individual
Hippotherapy - Group
Intensive Support Services - Wraparound Plan
Intensive Support Services - Prevention and Monitoring
Intensive Support Services - In-Home Support
Massage Therapy

Movement Therapy - Bachelor
Movement Therapy - Masters

-The State received approval through the Long Bill for the following Targeted Rate Increase:
Habilitation - Foster Home Level 1 - 17.009%
Habilitation - Foster Home Level 2 - 17.018%
Habilitation - Foster Home Level 3 - 17.012%
Habilitation - Foster Home Level 4 - 17.009%
Habilitation - Foster Home Level 5 - 17.019%
Habilitation - Foster Home Level 6 - 17.019%
Habilitation - Group Home Level 1 - 42.007%
Habilitation - Group Home Level 2 - 29.937%
Habilitation - Group Home Level 3 - 24.809%
Habilitation - Group Home Level 4 - 20.549%
Habilitation - Group Home Level 5 - 19.521%
Habilitation - Group Home Level 6 - 17.732%

-The State also received approval through the Long Bill to implement a $15 Base Wage Minimum. The following services received the following increases for this implementation:
Respite Individual - In-Home Family - 9.326%
Respite Individual Day - In-Home Family - 7.980%
Community Connector - Supported Community Connections - 6.035%

Notes:
The State received approval for the above rate increases through Appendix K CO.0305.R05.19, effective 7/01/2022.
The State estimates rates based on a weighting of the location in which services are rendered and the rates in each location. The State received a base wage adjustment for services outside of Denver County and updated the weighted rates for this service based on new utilization trends and the updated rates. Due to this weighting, rate increases may not align with the rate increases that were approved in the long bill for counties outside of Denver.

The Department's most recent submission includes adjustments to the rates that were approved by the Colorado Joint Budget Committee. The rates provided in the Appendix J submission align with the Department's fee schedule rates (https://hcpf.colorado.gov/provider-rates-fee-schedule) for HCBS Services. The department weights certain rates using utilization data for services that have multiple rates based on the location a service is rendered.

Respite - 15 min and Respite Day were replaced by Respite Individual - In Home Family, Respite Individual Day - In Home Family, and Respite Individual - In Residential Setting during amendment CO.0305.R05.11 with an approved effective date of July 1, 2021.

Update for WY 5 for Amendment with the requested effective date of 7/01/2023:
Factor D: 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.

The growth in expenditure in SFY 2020-21 is driven by high enrollment in SFY 2019-20 and SFY 2020-21; the addition of new services, including Residential Child Care Facilities (RCCF); and the long-term effects of targeted rate increases to RCCFs.

Historical growth rates: The source of data is 372 waiver reports. The Department reviews data from SFY 2007-08 through SFY 2019-20 but might only include certain SFYs in the development of trends. For example, the Department may look at data from SFY 2007-08 and beyond but apply a trend that only incorporates growth rates from SFY 2016-17 and SFY 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 SFY 2007-08

however the Department focuses on more recent data for trend development.

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

For the new Level 7 in both Habilitation: Foster Home and Habilitation: Group Home, the Department assumed 1 utilizer for each new service and will update estimates accordingly as actuals come in. The Department used the average units per user of all other Foster Home Levels and Group Home Levels to get the respective Level 7 utilization estimates.

The Department determined it was best to use the average cost per client for the growth rate as when using half the average cost per client growth rate, SFY 2021-22 estimates align with actual SFY 2021-22 Department expenditure data.

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

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

The 3% ATB increase is being implemented for the following services: Habilitation (Foster Home Levels 1-6, Group Home Levels 1-6, Residential Child Care Facility Levels 1-5), Respite (Individual - In Home Family, Individual Day - In Home Family, Individual - In Residential Setting, Individual Day - In Residential Setting), Transition Support Services, Community Connector, Hippotherapy, Intensive Support Services, Massage Therapy, Movement Therapy.

The base wage increase for services outside Denver County is being implemented for the following services: Habilitation (Foster Home Levels 1-6, Group Home Levels 1-6), Respite (Individual - In Home Family, Individual Day - In Home Family), Community Connector.

The Denver County minimum wage increase is being implemented for the following services: Habilitation (Foster Home Levels 1-6, Group Home Levels 1-6), Respite (Individual - In Home Family, Individual Day - In Home Family), Community Connector.

Update for the Amendment with the requested effective date of 1/1/2024:

The Department is updating Appendix J for the reformatting of Intensive Support and Transition Support services. The Department is removing the service heads and IS and TS and is making Wraparound services and Child & Youth Mentorship their own waiver services. There are no changes to the users, units/user, or rates.
The Department is also updating Appendix J for the addition of Respite provider specialties. Respite will be delegated into three specialties provided by a skilled, therapeutic, or unskilled provider type. This was approved by the passage of the Long Bill for SFY 23-24.

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 (IA) 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 CHRP service providers for Respite and Supported Community Connections. 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 CDPHE recommendation to HCPF for program approval.

HCPF maintains an IA with the Colorado Department of Human Services (CDHS) for licensure and monitoring of Habilitation and Respite facilities. This agreement allows CDHS to conduct surveys of and investigate complaints against CHRP providers of Habilitation and Respite facilities.

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

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

The Department contracts with a Fiscal Agent which maintains the Medicaid Management Information System (MMIS). The Fiscal Agent is responsible to process claims, assist in the provider enrollment and application process, maintain a call center, respond to provider questions and complaints, maintain the Electronic Visit Verification (EVV) System, and produce reports.

The Department contracts with a Quality Improvement Organization (QIO) for the management of the Critical Incident Reports (CIR) for the HCBS-CHRP waiver. The QIO is responsible for assessing the appropriateness of both provider and CMA response to critical incidents, for gathering, aggregating and analyzing CIR data, and ensuring that appropriate follow up for each incident is completed.

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

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

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

Appendix A: Waiver Administration and Operation

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

○ **Not applicable**

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

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

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

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

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

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

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

Appendix A: Waiver Administration and Operation

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

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

Appendix A: Waiver Administration and Operation

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

The Department of Health Care and Policy Financing (The Department) provides on-going oversight of the Interagency Agreement(IA) 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 IA 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 provides on-going oversight of the Interagency Agreement (IA) with the Colorado Department of Human Services (CDHS) through monthly reports. In addition, the Department is provided with monthly survey summary data including the number of agencies that have been surveyed, the number of agencies that have deficiencies, and types of deficiencies. The IA between the Department and CDHS requires that CDHS submits a monthly report of all critical incidents filed in their computer-based system to the Department. This report includes action taken by CDHS to follow-up on each critical incident. The Department uses this data to crosswalk critical incidents reported to the Department to ensure all incidents are reported and responded to appropriately.

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

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

The programmatic evaluation consists of a desk audit in conjunction with the Benefits Utilization System (BUS) to audit client files and assure that all components of the CCB contract have been performed according to necessary waiver requirements. The BUS is an electronic record used by each CCB to maintain client-specific data. Data include client referrals, screening, Level of Care (LOC) assessments, individualized service plans, case notes, reassessment documentation, and all other case management activities. Additionally, the BUS is used to track and evaluate timelines for assessments, reassessments, and a notice of action requirements to assure that processes are completed according to Department prescribed schedules. The Department reviews a sample of client files to measure the accuracy of documentation and track appropriateness of services based upon the LOC determination. Additionally, the sample is used to evaluate compliance with the aforementioned case management functions. The contracted case management agency submits deliverables to the Department on an annual and quarterly basis for review and determination of approval. Case management agencies are evaluated through quality improvement strategy reviews annually which is completed by a quality improvement organization. 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 including provider enrollment, provider publication, and provider training. The Department is able to request ad hoc reports as needed to monitor any additional issues or concerns.

The Department has oversight of the QIO contractor through different contractual requirements. Deliverable due dates

include monthly, quarterly, and annual reports to ensure the vendor is completing their respective delegated duties. The Department's Operations Division ensures that deliverables are given to the Department on time and in the correct format. Subject Matter Experts who work with the vendors review deliverables for accuracy.

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

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

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

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

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

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

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

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	☒	☐	☒

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

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

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **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.3 Number and percent of deliverables submitted to the Department by the Quality Improvement Organization (QIO) demonstrating performance of delegated functions N: # of deliverables submitted to the Department by the QIO demonstrating performance of delegated functions per the contract D: Total # of QIO deliverables mandated by the contract

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

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: 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 CHRP waiver N: Number of fiscal intermediary service level agreements reviewed by the Dept demonstrating financial monitoring of the CHRP waiver D: Total number of service level agreements required from the fiscal intermediary as specified in their contract.

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

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **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.14 # and % of deliverables submitted by the Recovery Audit Contractor (RAC) vendor that are reviewed by the Department demonstrating performance of delegated functions. N: # of deliverables submitted by the RAC vendor that are reviewed by the Department demonstrating performance of delegated functions. D: Total # of deliverables for RAC reviews mandated by the contract

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

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

Data Aggregation and Analysis:

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

Performance Measure:
A.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 states 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):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

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

	☐ **Continuously and Ongoing**	☒ **Other** Specify: Random Sample annually of 2 contracted entities (excluding CMAs)
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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.21 # and % of CDHS reports, per IA and reviewed by the Dept, showing CHRP Habil. and Respite facilities licensure and monitoring activities are conducted N: # of reports submitted by CDHS and reviewed by the Dept. showing CHRP Habilitation and Respite facilities licensure and monitoring activities are conducted D: Total # of reports required to be submitted CDHS as specified in the IA

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

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

Data Aggregation and Analysis:

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

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

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

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

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

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

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

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

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

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

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.21
The DHS IA is to manage aspects of provider qualifications, licensure surveys, monitoring and complaints/critical incidents for CHRP Habilitation and Respite facilities. 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 critical incidents/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.

b. Methods for Remediation/Fixing Individual Problems

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

A.2, A.3, A.6, A.14, A.19, A.20, A.21
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.

If deliverables do not meet contract requirements, the Department requires the contracted agency to correct the issue immediately and/or submit a corrective action plan. The Department conducts follow-up monitoring to assure corrective action implementation and ongoing compliance. In addition, the contracts allow the Department to withhold funding and/or terminate the contract due to noncompliance.

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

A.20
Delegated responsibilities of contracted agencies/vendors are monitored, corrected and remediated by the Department's Office of Community Living (OCL).

During routine annual evaluation or by notice of an occurrence, the Department 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 Department 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.

If problems are identified during a Case Management Agency (CMA) audit, the Dept. communicates findings directly with the CMA administrator, and documents findings in the CMA's annual report of audit findings, and if needed, requires corrective action.

The Dept. conducts follow-up monitoring to assure corrective action implementation and ongoing compliance. In addition, the contract with CMAs allows the Dept. to withhold funding and terminate a contract due to noncompliance.

If a compliance issue extends to multiple CMAs, the Dept. provides clarification through formal policy memos, formal training, or both. Technical assistance is provided to CMAs via phone and e-mail.

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

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)**			

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ 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	20	☐
	☐	Intellectual Disability			☐
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

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

Eligibility is also limited to children and/or youth who have been determined to have an intellectual and developmental disability by the child's local Community Centered Board, are at risk of placement in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)(as defined in 42 CFR §440.150)as determined by the Level of Care Eligibility Determination Screen (LOC Screen), and are at risk of, or in need of, out of home placement.

“Intellectual and Developmental Disability” means a disability that manifests before the person reaches twenty-two years of age, that constitutes a substantial disability to the affected person, and that is attributable to an intellectual and developmental disability or related conditions, including Prader-Willi syndrome, cerebral palsy, epilepsy, autism, or other neurological conditions when the condition or conditions result in impairment of general intellectual functioning or adaptive behavior similar to that of a person with an intellectual and developmental disability. Unless otherwise specifically stated, the federal definition of “developmental disability” found in 42 U.S.C.sec.150001 et seq., does not apply (C.R.S. 25.5-10-202 (26) (a).

“Person with an intellectual and developmental disability” means a person determined by a community centered board to have an intellectual and developmental disability and shall include a child with a developmental delay. (C.R.S. 25.5-10-202 (26) (b).

“Child with a developmental delay” means A person less than five years of age with delayed development as defined by the rule of the state board, or a person less than five years of age who is at risk of having a developmental disability as defined by rule of the state board. (C.R.S. 25.5.10-202 (26) (c) (I) and (II).

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:

Transition Process for Youth in Child Welfare

Each County Department of Human/Social Services and Community Centered Board (CCB) is expected to maintain a working relationship that will facilitate coordination in the referral of individuals and ensure a smooth transition for eligible youth.

Eligible youth may transition from the foster care system into adult services at age 18, depending on what is in the best interest of the youth. The youth has the option to remain in foster care until age 21 or transition into adult DIDD services at 18 or thereafter. This process provides flexibility with options to choose the appropriate adult waiver or other services, to meet his or her needs.

Once a youth is determined eligible for disability services, the transition process will begin as early as possible. Ideally, transition planning will begin when the youth is fourteen (14) years of age. This timeframe also coincides with transition planning through the school districts under the Individuals with Disabilities Education Act (IDEA).

The County is responsible to provide available information about the youth to the CCB to include; application for services; psychological testing; current individualized education plan; medical records; therapy evaluations; a copy of the social security card, birth certificate, and Medicaid card. County staff is expected to apply for supplemental security income (SSI) benefits for the individual. If the individual is receiving SSI benefits prior to age 18, the County will ensure that adult, long-term SSI benefits have been applied for when the youth has reached the age of 18.

The Case Management Agency (CMA) is responsible for the development of a Person-Centered Support Plan (PCSP) for eligible youth in conjunction with the County Department, the child's parent, local school district, guardian ad litem, and others as appropriate. The PSCP will identify the specific services that are necessary to address the long-term needs of the youth. The CCB will ensure that the youth is placed on the appropriate waitlist for adult services, updating the Community Contract and Management System (CCMS) database.

At age 17, the County and CCB will verify if there are any financial concerns that could impact Medicaid eligibility. The financial concerns might be a trust; life insurance; stocks or bonds; burial plan; or parent retirement benefits. The County will review the youth's long-term medical needs/care for items that are currently covered under Early and Periodic, Screening Diagnosis and Treatment (EPSDT). The County, CCB, school district, and others as appropriate will determine the need for vocational resources and work opportunities.

At age 17.5, the County and CCB will meet to delineate roles and responsibilities to facilitate the final transition process. The youth will be provided a choice around where he or she would like to reside.

At 17.5 years of age, the County and CCB will verify Medicaid and SSI eligibility and obtain a copy of the most recent SSI annual award letter. The CCB will schedule and invite appropriate parties to participate in the Supports Intensity Scale Assessment (SIS) including the eligible youth, County Department caseworker, the youth's parent, guardian ad litem, CCB case manager, and other appropriate parties that know the youth and will contribute relevant information to SIS questions. The SIS is a comprehensive, structured instrument designed to assess the status, adaptive functioning, and service needs of the individual. It captures functional limitations, adaptive behavior skills, problem behaviors, diagnostic status, residential placement, habilitation and support services, social, leisure, and daytime activities for the individual. Its purpose is to assist in the screening, monitoring, managing, planning, and evaluating service needs for individuals with developmental disabilities. The CCB will send out Request for Proposals (RFPs) to adult service providers for residential and/or day programs. Three months prior to the youth's 18th birthday, the CCB will meet with the County, school district, biological parents (if involved), and others as appropriate to review the transition plan to ensure the final transition. The CCB will verify that all documentation has been obtained. The CCB will continue to send RFPs until placement and services are secured. The County and CCB will assist the youth to tour possible placements and make service option decisions. The County will terminate the youth from Child Welfare services one day prior to the youth's 18th birthday. The youth has the option to continue public education until age 21 or graduate at 18 if all academic requirements have been met pursuant to district policy. If the individual chooses to transition to adult services at 18, the CCB will enroll the individual into adult services when the youth's eligibility is determined and when it is in the best interest of the youth. Individuals have the option but are not required to move to adult services. However, if they did not elect to move at 18, they would move by age 21.

Transition Process for Youth Not in Child Welfare

Youth enrolled in the CHRP waiver may choose to transition to adult services between the ages of 18-21 when it is their best interest to transition. When the youth reaches the age of 17 years, the case manager will start the transition process by informing the youth, their parents, and/or legal guardians of the Adult Home and Community Based Services waivers and other adult services for which the youth may be eligible for when they reach 18 years of age. A plan of action will be developed with the youth, parents, and/or legal guardians for the timeframe for the desired transition. This plan will be revisited with the youth, parents, and/or legal guardians at least annually at the Continued Stay Review. The youth must transition from the CHRP waiver at age 21.

Appendix B: Participant Access and Eligibility

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

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

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

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

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

    Specify the percentage: [ ]

  - ( ) **Other**

    Specify:

    [ ]

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

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

  [ ]

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

  - ( ) **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

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

Specify the formula:

○ **May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.**

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	81
Year 2	97
Year 3	144
Year 4	230
Year 5	260

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

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

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

◉ **Not applicable. The state does not reserve capacity.**

○ **The state reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

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

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

◉ **The waiver is not subject to a phase-in or a phase-out schedule.**

○ **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

◉ **Waiver capacity is allocated/managed on a statewide basis.**

○ **Waiver capacity is allocated to local/regional non-state entities.**

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

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

Children and youth ages birth (0) through twenty (20) are eligible for the CHRP waiver if the child, has been found eligible for developmental disability services through the respective Community Centered Board, has extraordinary needs that put the child at risk of or in need of out of home placement, and meets Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)(as defined in 42 CFR §440.150).

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:

Children eligible for participation in the waiver for whom foster care maintenance payments are being made by the County Departments of Human/Social Services are mandated under federal law to receive Medicaid benefits under article CSR 25.5-5-101, 1902(a)(10)(A)(i)(I) of the Social Security Act and 42 CFR 435.145.

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

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

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

Select one and complete Appendix B-5.

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

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

CFR §435.217

Check each that applies:

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

Select one:

○ **300% of the SSI Federal Benefit Rate (FBR)**
○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

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

Specify dollar amount:

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

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

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

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

Select one:

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

☒ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b

State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

Select one:

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

(*select one*):

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

Specify the percentage:

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

Specify dollar amount:

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

Specify percentage:

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

Specify:

○ **The following dollar amount**

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

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

Specify:

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

○ **Other**

Specify:

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

◉ **Not Applicable**

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

Specify:

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

○ **SSI standard**

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

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

Specify:

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

◉ **Not Applicable (see instructions)**

○ **AFDC need standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

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

Specify:

○ **Other**

Specify:

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

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

Select one:

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

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

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

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

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

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

  Specify formula:

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

  Specify:

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

Select one:

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

  Explanation of difference:

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

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

Select one:

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

need waiver services is: 1

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

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

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

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

- ( ) **Directly by the Medicaid agency**
- ( ) **By the operating agency specified in Appendix A**
- (●) **By a government agency under contract with the Medicaid agency.**

Specify the entity:

Community Centered Boards

- ( ) **Other**

Specify:

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

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

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

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

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

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

Agency supervisor educational experience:

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

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

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

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

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

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

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

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

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

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

Specify the other schedule:

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

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

Specify the qualifications:

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

The CMA is required to track the re-evaluation due dates and complete them on a timely basis for each client. The CMA ensures timely reevaluation through electronically generated reports from the state's case management IT system. The CCB is required to track the re-evaluation due dates and complete them on a timely basis for each participant. The Department has two processes to assure timeliness.

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

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

For additional information relating to sampling methodology, please refer to Global Quality Improvement Strategy.

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 electronically retrievable documentation by using the State's case management IT system to input all information relating to case management activity. The database is housed at HCPF and all documentation is accessible to monitoring staff and program administrators. A sample of case management agencies is monitored annually for compliance with record maintenance.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the State to

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

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the State to

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

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

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

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

Data Aggregation and Analysis:

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

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

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

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

		Confidence Interval = 95% confidence level with +/- 5% margin of error
☒ **Other** Specify: Case Management Agency	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

Case managers complete a LOC Screen. The LOC Screen measures six defined Activities of Daily Living (ADL) and the need for supervision for behavioral or cognitive dysfunction. ADLs include bathing, dressing, toileting, mobility, transferring, and eating. For initial LOC Screens, the Professional Medical Information Page (PMIP) is also required to be completed by a treating medical professional who verifies the participant's need for institutional level of care.

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

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

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

b. Methods for Remediation/Fixing Individual Problems

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

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

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

ii. Remediation Data Aggregation

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

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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 evaluation and Person-Centered Care Planning process, and at time of reevaluation. Case managers identify the child's needs and supports through completion of a LOC Screen using the LOC Screen and through the Person-Centered Support Planning process with the participant and/or legal representative. Based on LOC Screen and discussion with the child's parents and/or legal guardian or representative, a PCSP is developed. All forms completed through the Person-Centered Support Planning process are available for signature through digital or wet signatures based on the member's preference. Case managers complete a PCSP information and summary form that is reviewed with the child's parents and/or legal guardian or legal representative and provides the child's parents and/or legal guardian or representative with a choice of providers as well as choice of whether these services will be provided in the community or in an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID).

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Both written and electronically retrievable copies of freedom of choice documentation are maintained at the Case Management Agency and in the State's case management IT system which is accessible by the Department.

Appendix B: Participant Access and Eligibility

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

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

The CCB agencies employ several methods to assure meaningful access to waiver services by Limited English Proficiency persons. The CCB agencies either employ or have access to Spanish and other language speaking persons to provide translation to participants. Documents include a written statement in Spanish instructing participants how to obtain assistance with translation. For languages where there are no staff who can translate on site, translation occurs by first attempting to have a family member translate, or aligning with specific language or ethnic centers such as the Asian/Pacific Center, or by using the Language Line available through 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	**Habilitation**		
Statutory Service	**Respite**		
Statutory Service	**Wraparound Services**		
Other Service	**Child and Youth Mentorship**		
Other Service	**Community Connector**		
Other Service	**Hippotherapy**		
Other Service	**Massage Therapy**		

Service Type	Service		
Other Service	Movement Therapy		

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:

Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02011 group living, residential habilitation
Category 2:	**Sub-Category 2:**
02 Round-the-Clock Services	02031 in-home residential habilitation
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Habilitation services are provided to clients that require additional care for the client to remain safely in a home-like setting. The client must demonstrate the need for such services above and beyond those of a typical child of the same age. These services are designed to assist participants in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. Habilitation services under the waiver differ in scope, nature, supervision arrangements, and/or provider type (including provider training and qualifications) from any other services in the State plan.

Habilitation is a twenty-four (24) hour service and includes the following activities.

Independent living training, which may include personal care, household services, infant and childcare when the client has a child, and communication skills.

Self-advocacy training and support includes assistance and teaching of appropriate and effective ways to make individual choices, accessing needed services, asking for help, recognizing abuse, neglect, mistreatment, and/or exploitation of self, responsibility for one's own actions, and participation in all meetings.

Cognitive services, which may include working with the waiver participant to better understand and comprehend cause and effect and the correlation between behaviors and consequences. It may also take the form of repetitive directions, staying on task, levels of receptive language capabilities, and retention of information.

Communication services includes assistance with additional concepts and materials to enhance communication.

Emergency assistance includes safety planning, fire and disaster drills, and crisis intervention.

Community access support 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, including community education or training, and volunteer activities. Community Connections includes providing a wide variety of opportunities to develop socially appropriate behaviors, 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.

Transportation services are part of what is encompassed within Habilitation service and are not duplicative of the non-emergent medical transportation that is authorized in the State Plan. Transportation services are more specific to supports provided by kinship family foster care homes, foster homes, group homes, and residential child care facilities to access activities and function of community life.

Supervision which ensures the level of supervision necessary to keep the waiver participant safe in the home and in the community. Levels of supervision would include line-of-sight, one-on-one, room-to-room, and within sight distance (yard). Behavioral needs would include, but not be limited to, the waiver participants physical and verbal aggressiveness, sexual inappropriateness, victimization, property destruction, self-harm, suicidal, stealing. Medically fragile waiver participants could require, in addition to the behavioral needs, monitoring of medical equipment, feeding tubes, seizures, and other life threatening medical issues if not being provided by the state plan.

Implementation of recommended follow-up counseling, behavioral, or other therapeutic interventions. Implementation of physical, occupational or speech therapies delivered under the direction of a licensed or certified professional in that discipline.

Medical and health care services that are integral to meeting the daily needs of the client and include such tasks as routine administration of medications or tending to the needs of clients who are ill or require attention to their medical needs on an ongoing basis.

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

The Department does not provide payment to providers for the maintenance and supervision of children who are in the state's custody.

Relatives can only provide the Habilitation services when the waiver participant resides in the home of a Kinship Family Foster Care Home or Host Home.

Payment for services is limited to what has been authorized on the PAR. Enrolled Medicaid providers may only bill for services listed on the PAR through the MMIS. In some instances, relatives and/or legal guardians may be the provider of certain services identified in the service planning process. When a relative or legal guardian does provide services, they must be employed by an approved and enrolled Medicaid provider who is able to bill for services. Providers are responsible for ensuring billed services have been rendered. Additionally, the Department conducts post-payment reviews (PPR) of providers.

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	Residential Child Care Facility
Agency	County Department of Human Services - Child Welfare
Agency	Medicaid Enrolled Provider
Agency	Specialized Group Facility
Individual	Foster Parent
Agency	Kinship Family Foster Care Home
Agency	Child Placement Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Habilitation

Provider Category:

Agency

Provider Type:

Residential Child Care Facility

Provider Qualifications

License *(specify):*

Any agency providing this service must meet all applicable state licensing requirements. This may include RCCFs who are also designated as a Qualified Residential Treatment Program (QRTP).

Certificate *(specify):*

Other Standard *(specify):*

Any individual providing a service within the facility must have training and/or experience commensurate with the service or support being provided as specified in the Colorado Department of Human Services Quality Standards for 24-hour child care.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Colorado Department of health Care Policy & Financing (HCPF) and the Colorado Department of Human Services (CDHS)

Frequency of Verification:

Verification of provider qualifications is completed upon Medicaid enrollment and every five years through provider revalidation and through the CDHS survey process initially and annually thereafter.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Habilitation

Provider Category:

Agency

Provider Type:

County Department of Human Services - Child Welfare

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Any individual providing this service must have the training and/or experience with the service or support being provided.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy & Financing (HCPF) and the Colorado Department of Human Services (CDHS).

Frequency of Verification:

Verification of provider qualifications is completed upon Medicaid enrollment and every five years through provider revalidation and through CDHS contracting process initially and annually thereafter.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Habilitation

Provider Category:

Agency

Provider Type:

Medicaid Enrolled Provider

Provider Qualifications

License *(specify):*

Any agency providing this service must meet all applicable State licensing requirements

Certificate *(specify):*

Agency approved to provide Residential Habilitation services in the Home- and Community-Based Services- Developmental Disabilities (HCBS-DD) waiver

Other Standard *(specify):*

Services can be provided in a foster care home certified by the County Department of Human Services or a Host Home if the child/youth is not in Child Welfare.

Verification of Provider Qualifications

Entity Responsible for Verification:

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: Statutory Service
Service Name: Habilitation

Provider Category:

Agency

Provider Type:

Specialized Group Facility

Provider Qualifications

License *(specify):*

Any agency providing this service must meet all applicable State licensing requirements.

Certificate *(specify):*

Other Standard *(specify):*

Any individual providing a service within the group facility must have the training and/or experience commensurate with the service or support being provided as specified in the Colorado Department of Human Services Quality Standards for 24-hour child care.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Colorado Department of Health Care Policy & Financing (HCPF) and the Colorado Department of Human Services (CDHS)

Frequency of Verification:

Verification of provider qualifications is completed upon Medicaid enrollment and every five years through provider revalidation and through the CDHS survey process initially and annually thereafter.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Habilitation

Provider Category:

Individual

Provider Type:

Foster Parent

Provider Qualifications

License *(specify):*

Certificate *(specify):*

The certifying authority must receive at least three written statements which describe the applicant's character, interpersonal relations, and ability to provide care for foster children from references provided by the applicant, at least to from a source/person who are not related to the applicant and who have known the applicant one year or longer. Certifying representatives may contact others who may have knowledge or information regarding the applicant's character or suitability. Certificates shall not be granted to applicants who are less than twenty-one years of age on the date of application or who lack adequate physical stamina to care for children.

Other Standard *(specify):*

Each foster parent in the family foster care home shall demonstrate an interest in, and a knowledge of, foster children and a concern for their proper care and well-being. The family foster care home parents shall be able to provide a foster child's proper physical, mental and character development. The foster parent shall demonstrate stability in family relationships within the home where family foster care is to be provided. Introductory training for all foster parents shall include, at a minimum, 27 hours of initial core training consisting of at least 12 hours prior to placement of a child and the remaining hours to be completed within 3 months after placement, including orientation to emergency and safety procedures and the general and specific duties and responsibilities of being a foster parent. A training development plan for each foster parent documents strengths and competencies of the foster parent and identifies areas for additional training. Training and competency based training in the following areas are included: Home emergency and safety procedures including but not limited to fire evacuation drills, tornado drills, flood evacuation on at least a semiannual basis; principles and practices of child care, including developmentally appropriate practices; administrative procedures and overall program goals; acceptable behavior management techniques, including appropriate discipline; positive and constructive methods of dealing with foster child, including but not limited to physical structuring of the environment and de-escalation of crisis situations; appropriate boundaries (physical and emotional) between foster parents and foster children while in placement at the family foster care home and after discharge; annual review of regulations.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy & Financing (HCPF) and the Colorado Department of Human Services (CDHS)

Frequency of Verification:

Verification of provider qualifications is completed upon Medicaid enrollment and every five years through provider revalidation and through the CDHS survey process initially and annually thereafter.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Habilitation

Provider Category:

Agency

Provider Type:

Kinship Family Foster Care Home

Provider Qualifications

License *(specify):*

NA

Certificate *(specify):*

Certified by either a county department or a child placement agency upon the request and approval of the county department with custody of a child or youth.

Other Standard *(specify):*

The purpose is to provide twenty-four (24) hour care for a child or youth under the age of eighteen (18) years of age. Waiver participants who are in Child Welfare may continue to receive the services up to twenty-one (21) years of age when ordered by the court.

Kin are persons ascribed by the family as having a family-like relationship, or they may be individuals that have a prior significant relationship with the child or youth. These relationships take into account cultural values and continuity of significant relationships.

Verification of Provider Qualifications

Entity Responsible for Verification:

County department or Child Placement Agency

Frequency of Verification:

Initial approval and when ordered by the court

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Habilitation

Provider Category:

Agency

Provider Type:

Child Placement Agency

Provider Qualifications

License *(specify):*

Any agency providing this service must meet all applicable State licensing requirements.

Certificate *(specify):*

Other Standard *(specify):*

Any individual providing this service must have training and/or experience commensurate with the service or support being provided.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy & Financing (HCPF) and the Colorado Department of Human Services (CDHS)

Frequency of Verification:

Verification of provider qualifications is completed upon Medicaid enrollment and every five years through provider revalidation and through CDHS survey process initially and annually thereafter.

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:
09 Caregiver Support	09011 respite, out-of-home
Category 2:	**Sub-Category 2:**
09 Caregiver Support	09012 respite, in-home
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Respite services are 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 services may be provided in a certified foster home, licensed respite care facility, in the community, or in the family home. Overnight, out-of-home respite services may be provided in a certified foster home, kinship home, Group Home or Residential Child Care Facility (RCCF).

Federal financial participation is not to be claimed 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.

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.

During the time when respite care is occurring, the respite home may not exceed six foster children or a maximum of 8 total children with no more than 2 children under the age of 2. The respite home must be in compliance with all other applicable rules for family foster care homes.

Payment for services is limited to what has been authorized on the PAR. Enrolled Medicaid providers may only bill for services listed on the PAR through the MMIS. In some instances, relatives and/or legal guardians may be the provider of certain services identified in the service planning process. When a relative or legal guardian does provide services, they must be employed by an approved and enrolled Medicaid provider who is able to bill for services. Providers are responsible for ensuring billed services have been rendered. Additionally, the Department conducts post-payment reviews (PPR) of providers.

When respite is furnished for the relief of a foster care provider, foster care services may not be billed during the period that respite is furnished. Respite care may not be furnished for the purpose of compensating relief or substitute staff for a waiver residential 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	Specialized Group Facility
Agency	Residential Child Care Facility
Agency	County Department of Human Services - Child Welfare
Individual	Foster Home
Agency	Child Placement Agency
Agency	Medicaid Enrolled Provider
Individual	Kinship Foster Care Homes
Agency	Provider Licensed Child Care Center

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Specialized Group Facility

Provider Qualifications

License *(specify):*

Any agency providing this service must meet all applicable State licensing requirements.

Certificate *(specify):*

Other Standard *(specify):*

Any individual providing a service within the group facility must have the training and/or experience commensurate with the service or support being provided as specified in the Colorado Department of Human Services Quality Standards for 24-hour child care.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Colorado Department of Health Care Policy & Financing (HCPF) and the Colorado Department of Human Services (CDHS)

Frequency of Verification:

Verification of provider qualifications is completed upon Medicaid enrollment and every five years through provider revalidation and through the CDHS survey process initially and annually thereafter.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Residential Child Care Facility

Provider Qualifications

License *(specify):*

Any agency providing this service must meet all applicable state licensing requirements. This may include an RCCF that is designated as a Qualified Residential Treatment Program (QRTP).

Certificate *(specify):*

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

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

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

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

Other Standard *(specify):*

Any individual providing a service within the facility must have the training and/or experience commensurate with the service or support being provided as specified in the Colorado Department of Human Services Quality Standards for 24-hour child care.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Colorado Department of Health Care Policy & Financing (HCPF) and the Colorado Department of Human Services (CDHS)

Frequency of Verification:

Verification of provider qualifications is completed upon Medicaid enrollment and every five years through provider revalidation and through the CDHS survey process initially and annually thereafter.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

County Department of Human Services - Child Welfare

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

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

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

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

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

Other Standard *(specify):*

Any individual providing this service must have the training and/or experience with the service or support being provided.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy & Financing (HCPF) and the Colorado Department of Human Services (CDHS).

Frequency of Verification:

Verification of provider qualifications is completed upon Medicaid enrollment and every five years through provider revalidation and through CDHS contracting process initially and annually thereafter.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

Foster Home

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Any individual providing this service must meet all applicable State certification requirements.

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

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

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

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

Other Standard *(specify):*

Any individual providing this service must have training and/or experience commensurate with the service or support being provided.

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.

During the time when respite care for a foster child is occurring, the respite home may not exceed six foster children or a maximum of 8 total children with no more than 2 children under the age of 2. The respite home must be in compliance with all other applicable rules for family foster care homes.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy & Financing (HCPF) and the Colorado Department of Human Services (CHDS)

Frequency of Verification:

Verification of provider qualifications is completed upon Medicaid enrollment and every five years through provider revalidation and through the CDHS survey process initially and annually thereafter.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Child Placement Agency

Provider Qualifications

License *(specify):*

Any agency providing this service must meet all applicable State licensing requirements.

Certificate *(specify):*

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

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

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

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

Other Standard *(specify):*

Any individual providing this service must have training and/or experience commensurate with the service or support being provided.

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.

During the time when respite care is occurring, the respite home may not exceed six foster children or a maximum of 8 total children with no more than 2 children under the age of 2. The respite home must be in compliance with all other applicable rules for family foster care homes.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Colorado Department of Health Care Policy & Financing (HCPF) and the Colorado Department of Human Services (CDHS)

Frequency of Verification:

Verification of provider qualifications is completed upon Medicaid enrollment and every five years through provider revalidation and through the CDHS survey process initially and annually thereafter.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Medicaid Enrolled Provider

Provider Qualifications

License *(specify):*

Any agency providing this service must meet all applicable State licensing requirements

Certificate *(specify):*

An agency certified to provide Respite as a Program Approved Service Agency for the Home and Community Based Services- Children's Extensive Supports (HCBS-CES) wavier.

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

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

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

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

Other Standard *(specify):*

Any individual providing this service must be at least 18 years of age and must have training and/or experience commensurate with the service or support being provided

Verification of Provider Qualifications

Entity Responsible for Verification:

the Department of Health Care Policy & Financing (HCPF)

Frequency of Verification:

HCPF 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: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

Kinship Foster Care Homes

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

Certified by either a county department or a child placement agency upon the request and approval of the county department with custody of a child or youth.

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

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

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

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

Other Standard *(specify):*

The purpose is to provide temporary relief to the primary caregiver.

Waiver participants who are in Child Welfare may continue to receive the service up to twenty-one (21) years of age when ordered by the court.

Kin is persons ascribed by the family as having a family-like relationship, or they may be individuals that have a prior significant relationship with the child or youth. These relationships take into account cultural values and the continuity of significant relationships.

Verification of Provider Qualifications

Entity Responsible for Verification:

The County Department or Child Placement Agency

Frequency of Verification:

Initial approval and when ordered by the court

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Provider Licensed Child Care Center

Provider Qualifications

License *(specify):*

Any agency providing this service must meet all applicable State licensing requirements.

Certificate *(specify):*

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

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

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

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

Other Standard *(specify):*

Any individual providing a service within the facility must have the training and/or experience commensurate with the service or support being provided as specified in the Colorado Department of Human Services Quality Standards for 24-hour child care.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Colorado Department of Health Care Policy & Financing (HCPF) and CDHS

Frequency of Verification:

Verification of provider qualifications is completed upon Medicaid enrollment and every five years through provider revalidation and through the CDHS survey process initially and annually thereafter.

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:

Case Management

Alternate Service Title (if any):

Wraparound Services

HCBS Taxonomy:

Category 1:

10 Other Mental Health and Behavioral Services

Sub-Category 1:

10030 crisis intervention

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

Wraparound Services align strategies, interventions, and supports for the child/youth and family when a child/youth transitions to the family home from out of home placement, from a Residential Child Care Facility (RCCF) to a group home, from an RCCF to a foster care home, or from a group home to a foster care home.

Wraparound services which include the wraparound plan and prevention and monitoring are available to members in a crisis event or series of events, and/or state of being greater than normal severity that becomes outside the manageable range for the child/youth and/or their caregivers and poses a danger to self, family, and/or community. Crisis may be self-identified, family identified, and/or identified by an outside party. A child or youth does not have to experience a crisis in order to utilize this service.

Wraparound Plan:
The Wraparound Plan incorporates supports, services, strategies, and goals from other service/treatment plans in place and serves as a single plan for all supports the child/youth needs to transition and maintain stabilization after out of home placement. The plan will include:

a. Environmental Modification(s)
b. Strategies for transition risk factors.
c. Strategies for crisis triggers.
d. Support needs in the family home.
e. Respite services.
f. Learning new adaptive or life skills.
g. Counseling/behavioral interventions to support stabilize the individual emotionally and behaviorally and decrease the frequency and duration of future behavioral crises.
h. Medication management and stabilization.
i. Physical health.
j. Identification of training needs and connection to training for family members, natural supports, and paid staff.
k. Determination of criteria for stabilization in the family home.

Prevention and Monitoring:
1. The Wraparound Plan occurs at a frequency determined by the child/youth's needs. Prevention and monitoring includes: visits to the child/youth's home, review of documentation, and coordination with other professionals and/or members of the team to determine progress.

2. The Wraparound Plan shall be revised as needed in order to avert a crisis or crisis escalation to maintain stabilization after the transition to the family home.

3. Follow-up after completion of the Wraparound Plan shall be determined on an individual basis.

4. Follow-up services post completion of the Wraparound Plan include status reviews of the child/youth's stability and monitoring of predictive and increased risk factors that could indicate a return to crisis or out of home placement.

5. On-going monitoring and prevention services after completion of the Wraparound Plan may be provided based on individual needs to support the child/youth and their family in connecting to additional resources needed to prevent future crisis or out of home placement.

The Wraparound Facilitator:
The Wraparound Facilitator will provide the Case Management Agency any changes to the Wraparound Plan. The case manager will review changes and determine if a change to the Person-Centered Plan is warranted.

1. Identification of how the plan will fade out once child/youth has stabilized.

2. The Wraparound Facilitator is responsible for the development and implementation of the Wraparound Plan. The plan is guided and supported by the child/youth, their family, and their Wraparound Support Team.

3. The Wraparound Support Team is selected by the child/youth and their family and may be composed of case managers, residential habilitation staff, medical professionals, behavioral health professionals, therapeutic support

professionals, representatives from education, and other relevant parties involved in supporting/treating the child/youth or their family. All service providers and supports on the Wraparound Support Team adhere to the Wraparound Plan to meet the needs of their specific focus for treatment.

4. The development and implementation of the Wraparound Plan should begin while the child/youth is receiving residential services in an out of home placement.

5. Revision of strategies will be a continuous process by the Wraparound support team in collaboration with the individual until the individual is stabilized in their home.

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

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

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

Services covered under Medicaid EPSDT, for a covered mental health diagnosis in the Medicaid State Plan, covered by a third-party source or available from a natural support shall not be reimbursed. Services provided under Targeted Case Management in the State Plan shall not be reimbursed.

To prevent duplication of services, the Wraparound facilitator will not have access to the systems related to the functions of the Case Manager. This prevents the Wraparound facilitator from conducting the support planning process, authorizing services, and other functions specified in the Targeted Case Management state plan benefit.

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

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

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

☒ **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	County Department of Human Services- Child Welfare
Agency	Residential Child Care Facility
Agency	Child Placement Agency
Agency	Medicaid Enrolled Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Wraparound Services

Provider Category:

Agency

Provider Type:

County Department of Human Services- Child Welfare

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

Agency

a. Certified as a Medicaid provider of services.

Wraparound Facilitator

b. Bachelor’s degree in a human behavioral science or related field of study;

OR

An individual who does not meet the minimum educational requirement may qualify as a Wraparound Facilitator under the following conditions: Experience working with Long-Term Services and Supports (LTSS) populations, in a private or public social services agency may substitute for the required education on a year for year basis.

When using a combination of experience and education to qualify, the education must have a strong emphasis in a human behavioral science field.

AND

c. Certification in a wraparound training program.

i. Training must encompass:

1. Trauma informed care
2. Youth mental health first aid
3. Crisis supports and planning
4. Positive Behavior Supports, behavior intervention, and de-escalation techniques
5. Cultural and linguistic competency
6. Family and youth servicing systems
7. Family engagement
8. Child and adolescent development
9. Accessing community resources and services
10. Conflict resolution
11. Intellectual and developmental disabilities
12. Mental health topics and services
13. Substance abuse topics and services
14. Psychotropic medications
15. Motivational interviewing
16. Prevention, detection and reporting of mistreatment, abuse, neglect, and exploitation

AND

d. Complete re-certification in wraparound training at least every other year or as dictated by wraparound training program.

Other Standard *(specify):*

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

•HIPAA compliant platforms;

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

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

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

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

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

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

Indicate client choice to use telehealth and indicate the choice in the member's service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy & Financing (HCPF).

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Wraparound Services

Provider Category:

Agency

Provider Type:

Residential Child Care Facility

Provider Qualifications

License *(specify):*

Any agency providing this service must meet all applicable State licensing requirements

Certificate *(specify):*

Agency

a. Certified as a Medicaid provider of services.

Wraparound Facilitator

b. Bachelor’s degree in a human behavioral science or related field of study;

OR

An individual who does not meet the minimum educational requirement may qualify as a Wraparound Facilitator under the following conditions: Experience working with Long-Term Services and Supports (LTSS) populations, in a private or public social services agency may substitute for the required education on a year for year basis.

When using a combination of experience and education to qualify, the education must have a strong emphasis in a human behavioral science field.

AND

c. Certification in a wraparound training program.

i. Training must encompass:

1. Trauma informed care
2. Youth mental health first aid
3. Crisis supports and planning
4. Positive Behavior Supports, behavior intervention, and de-escalation techniques
5. Cultural and linguistic competency
6. Family and youth servicing systems
7. Family engagement
8. Child and adolescent development
9. Accessing community resources and services
10. Conflict resolution
11. Intellectual and developmental disabilities
12. Mental health topics and services
13. Substance abuse topics and services
14. Psychotropic medications
15. Motivational interviewing
16. Prevention, detection and reporting of mistreatment, abuse, neglect, and exploitation

AND

d. Complete re-certification in wraparound training at least every other year or as dictated by wraparound training program.

Other Standard *(specify):*

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

•HIPAA compliant platforms;

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

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

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

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

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

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

Indicate client choice to use telehealth and indicate the choice in the member's service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy & Financing (HCPF)

Frequency of Verification:

HCPF 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: Statutory Service
Service Name: Wraparound Services

Provider Category:

Agency

Provider Type:

Child Placement Agency

Provider Qualifications

License *(specify):*

Any agency providing this service must meet all applicable State licensing requirements

Certificate *(specify):*

Agency

a. Certified as a Medicaid provider of services.

Wraparound Facilitator

b. Bachelor’s degree in a human behavioral science or related field of study;

OR

An individual who does not meet the minimum educational requirement may qualify as a Wraparound Facilitator under the following conditions: Experience working with Long-Term Services and Supports (LTSS) populations, in a private or public social services agency may substitute for the required education on a year for year basis.

When using a combination of experience and education to qualify, the education must have a strong emphasis in a human behavioral science field.

AND

c. Certification in a wraparound training program.

i. Training must encompass:

1. Trauma informed care
2. Youth mental health first aid
3. Crisis supports and planning
4. Positive Behavior Supports, behavior intervention, and de-escalation techniques
5. Cultural and linguistic competency
6. Family and youth servicing systems
7. Family engagement
8. Child and adolescent development
9. Accessing community resources and services
10. Conflict resolution
11. Intellectual and developmental disabilities
12. Mental health topics and services
13. Substance abuse topics and services
14. Psychotropic medications
15. Motivational interviewing
16. Prevention, detection and reporting of mistreatment, abuse, neglect, and exploitation

AND

d. Complete re-certification in wraparound training at least every other year or as dictated by wraparound training program.

Other Standard *(specify):*

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

•HIPAA compliant platforms;

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

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

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

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

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

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

Indicate client choice to use telehealth and indicate the choice in the member's service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy & Financing (HCPF)

Frequency of Verification:

HCPF 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: Statutory Service
Service Name: Wraparound Services

Provider Category:

Agency

Provider Type:

Medicaid Enrolled Provider

Provider Qualifications

License *(specify):*

Any agency providing this service must meet all applicable State licensing requirements

Certificate *(specify):*

Agency

a. Certified as a Medicaid provider of services.

Wraparound Facilitator

b. Bachelor’s degree in a human behavioral science or related field of study;

OR

An individual who does not meet the minimum educational requirement may qualify as a Wraparound Facilitator under the following conditions: Experience working with Long-Term Services and Supports (LTSS) populations, in a private or public social services agency may substitute for the required education on a year for year basis.

When using a combination of experience and education to qualify, the education must have a strong emphasis in a human behavioral science field.

AND

c. Certification in a wraparound training program.

i. Training must encompass:

1. Trauma informed care
2. Youth mental health first aid
3. Crisis supports and planning
4. Positive Behavior Supports, behavior intervention, and de-escalation techniques
5. Cultural and linguistic competency
6. Family and youth servicing systems
7. Family engagement
8. Child and adolescent development
9. Accessing community resources and services
10. Conflict resolution
11. Intellectual and developmental disabilities
12. Mental health topics and services
13. Substance abuse topics and services
14. Psychotropic medications
15. Motivational interviewing
16. Prevention, detection and reporting of mistreatment, abuse, neglect, and exploitation

AND

d. Complete re-certification in wraparound training at least every other year or as dictated by wraparound training program.

Other Standard *(specify):*

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

•HIPAA compliant platforms;

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

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

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

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

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

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

Indicate client choice to use telehealth and indicate the choice in the member's service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy & Financing (HCPF)

Frequency of Verification:

HCPF 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:

Child and Youth Mentorship

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10030 crisis intervention
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Support includes implementation of therapeutic and/or behavioral support plans, building life skills, providing guidance to the child/youth with self-care, learning self-advocacy, and protective oversight. Type, frequency, and duration of service are determined by the Wraparound Plan. Service may be provided in the child/youth's home or community as determined by the Wraparound Plan. Child and Youth Mentorship may be provided individually, or in conjunction with the Wraparound Service.

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

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

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

Services covered under Medicaid EPSDT, for a covered mental health diagnosis in the Medicaid State Plan, covered by a third-party source or available from a natural support shall not be reimbursed. Services provided under Targeted Case Management in the State Plan shall not be reimbursed.

To prevent duplication of services, the Wraparound facilitator will not have access to the systems related to the functions of the Case Manager. This prevents the Wraparound facilitator from conducting the support planning process, authorizing services, and other functions specified in the Targeted Case Management state plan benefit.

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

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	County Department of Human Services- Child Welfare
Agency	Child Placement Agency
Agency	Medicaid Enrolled Provider
Agency	Residential Child Care Facility

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Child and Youth Mentorship

Provider Category:

Agency

Provider Type:

County Department of Human Services- Child Welfare

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

1. Agency

a. Certified as a Medicaid provider of Child and Youth Mentorship.

2. Child & Youth Mentorship Direct Support Professional

a. Be at least 18 years of age and graduated from high school or earned a high school equivalency degree

AND

b. Have the interpersonal skills needed to effectively interact with persons with developmental disabilities and the ability to:

i. Communicate effectively, complete required forms and reports
ii. Follow verbal and written instructions
iii. Provide services in accordance with the Service Plan
iv. Perform the required job tasks.

AND

c. Complete at least 40 hours of training in Crisis Prevention, De-escalation, and Intervention.

i. Training must encompass:

1. Trauma informed care
2. Youth mental health first aid
3. Positive Behavior Supports, behavior intervention, and de-escalation techniques
4. Cultural competency
5. Family systems and family engagement
6. Child and adolescent development
7. Mental health topics and services
8. Substance abuse topics and services
9. Psychotropic medications
10. Prevention, detection, and reporting of mistreatment, abuse, neglect, and exploitation
11. Intellectual and developmental disabilities
12. Child/youth specific training

AND

d. Complete annual refresher courses on the above training topics.

Other Standard *(specify):*

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

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

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

•Provide prior authorization for all services to be rendered using Telehealth; and
Indicate client choice to use telehealth and indicate the choice in the member's service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy & Financing (HCPF).

Frequency of Verification:

Verification of provider qualifications is completed upon 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: Child and Youth Mentorship

Provider Category:

Agency

Provider Type:

Child Placement Agency

Provider Qualifications

License *(specify):*

Any agency providing this service must meet all applicable State licensing requirements

Certificate *(specify):*

1. Agency

a. Certified as a Medicaid provider of Child and Youth Mentorship.

2. Child & Youth Mentorship Direct Support Professional

a. Be at least 18 years of age and graduated from high school or earned a high school equivalency degree

AND

b. Have the interpersonal skills needed to effectively interact with persons with developmental disabilities and the ability to:

i. Communicate effectively, complete required forms and reports
ii. Follow verbal and written instructions
iii. Provide services in accordance with the Service Plan
iv. Perform the required job tasks.

AND

c. Complete at least 40 hours of training in Crisis Prevention, De-escalation, and Intervention.

i. Training must encompass:

1. Trauma informed care
2. Youth mental health first aid
3. Positive Behavior Supports, behavior intervention, and de-escalation techniques
4. Cultural competency
5. Family systems and family engagement
6. Child and adolescent development
7. Mental health topics and services
8. Substance abuse topics and services
9. Psychotropic medications
10. Prevention, detection, and reporting of mistreatment, abuse, neglect, and exploitation
11. Intellectual and developmental disabilities
12. Child/youth specific training

AND

d. Complete annual refresher courses on the above training topics.

Other Standard *(specify):*

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

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

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

•Provide prior authorization for all services to be rendered using Telehealth; and
Indicate client choice to use telehealth and indicate the choice in the member's service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy & Financing (HCPF)

Frequency of Verification:

HCPF 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: Child and Youth Mentorship

Provider Category:

Agency

Provider Type:

Medicaid Enrolled Provider

Provider Qualifications

License *(specify):*

Any agency providing this service must meet all applicable State licensing requirements

Certificate *(specify):*

1. Agency

a. Certified as a Medicaid provider of Child and Youth Mentorship.

2. Child & Youth Mentorship Direct Support Professional

a. Be at least 18 years of age and graduated from high school or earned a high school equivalency degree

AND

b. Have the interpersonal skills needed to effectively interact with persons with developmental disabilities and the ability to:

i. Communicate effectively, complete required forms and reports
ii. Follow verbal and written instructions
iii. Provide services in accordance with the Service Plan
iv. Perform the required job tasks.

AND

c. Complete at least 40 hours of training in Crisis Prevention, De-escalation, and Intervention.

i. Training must encompass:

1. Trauma informed care
2. Youth mental health first aid
3. Positive Behavior Supports, behavior intervention, and de-escalation techniques
4. Cultural competency
5. Family systems and family engagement
6. Child and adolescent development
7. Mental health topics and services
8. Substance abuse topics and services
9. Psychotropic medications
10. Prevention, detection, and reporting of mistreatment, abuse, neglect, and exploitation
11. Intellectual and developmental disabilities
12. Child/youth specific training

AND

d. Complete annual refresher courses on the above training topics.

Other Standard *(specify):*

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

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

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

•Provide prior authorization for all services to be rendered using Telehealth; and
Indicate client choice to use telehealth and indicate the choice in the member's service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy & Financing (HCPF)

Frequency of Verification:

HCPF 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: Child and Youth Mentorship

Provider Category:

Agency

Provider Type:

Residential Child Care Facility

Provider Qualifications

License *(specify):*

Any agency providing this service must meet all applicable State licensing requirements

Certificate *(specify):*

1. Agency

a. Certified as a Medicaid provider of Child and Youth Mentorship.

2. Child & Youth Mentorship Direct Support Professional

a. Be at least 18 years of age and graduated from high school or earned a high school equivalency degree

AND

b. Have the interpersonal skills needed to effectively interact with persons with developmental disabilities and the ability to:

i. Communicate effectively, complete required forms and reports
ii. Follow verbal and written instructions
iii. Provide services in accordance with the Service Plan
iv. Perform the required job tasks.

AND

c. Complete at least 40 hours of training in Crisis Prevention, De-escalation, and Intervention.

i. Training must encompass:

1. Trauma informed care
2. Youth mental health first aid
3. Positive Behavior Supports, behavior intervention, and de-escalation techniques
4. Cultural competency
5. Family systems and family engagement
6. Child and adolescent development
7. Mental health topics and services
8. Substance abuse topics and services
9. Psychotropic medications
10. Prevention, detection, and reporting of mistreatment, abuse, neglect, and exploitation
11. Intellectual and developmental disabilities
12. Child/youth specific training

AND

d. Complete annual refresher courses on the above training topics.

Other Standard *(specify):*

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

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

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

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

Indicate client choice to use telehealth and indicate the choice in the member's service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy & Financing (HCPF)

Frequency of Verification:

HCPF verification of provider qualification is completed upon initial enrollment and every five years through provider revalidation.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Connector

HCBS Taxonomy:

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

Service Definition *(Scope):*

Community Connector services are provided one-on-one to deliver instruction for documented severe behavior problems that are being demonstrated by the waiver participant while in the community, i.e. physically or sexually aggressive to others and/or exposing themselves. This service is not duplicative of State Plan benefits or those services offered by the Behavioral Health Organization. These activities are conducted in a setting within the community where participants interact with non-disabled individuals (other than the individual that is providing the service to the participant). Community Connectors is an additional service provided by a Medicaid provider to work with the child one-on-one while in the community. The targeted behavior, measurable goal(s), and work plan must be clearly articulated in the Service Plan.

The state makes payment to parents when the care is determined extraordinary and only when the parent is qualified to furnish services.

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

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

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

The number of units available for Community Connector is 520 hours or up to 2080 units per Service Plan year.

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

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

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-CHRP waiver and shall not be reimbursed.

Community Connector may not be delivered to a participant by the same provider who delivers the participant's Habilitation service.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Child Placement Agency
Agency	Medicaid Enrolled Provider

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:

Child Placement Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

An individual providing this service must have training and/or experience commensurate with the service or support being provided and be at least 18 years of age.

This service shall not be performed by a person who is employed by the same CPA who provides oversight to the child's current foster home.

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

the Department of Health Care Policy & Financing and the Colorado Department of Human Services

Frequency of Verification:

Verification of provider qualifications is completed upon 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: Community Connector

Provider Category:

Agency

Provider Type:

Medicaid Enrolled Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

An agency certified to provide Community Connector as a Program Approved Service Agency for the Home and Community Based Services- Children’s Extensive Supports (HCBS-CES) wavier.

Other Standard *(specify):*

Any individual providing this service must have training and/or experience commensurate with the service or support being provided and be at least 18 years of age.

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

•HIPAA compliant platforms;

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

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

•Professionals do not practice outside of their respective scope;

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

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

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

Indicate client choice to use telehealth and indicate the choice in the member's service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy & Financing (HCPF) and the Department of Public Health & Environment (CDPHE)

Frequency of Verification:

Verification of provider qualifications is completed upon Medicaid enrollment and every five years through provider revalidation and through the CDPHE survey process 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. Hippotherapy cannot be available under the regular Medicaid State Plan, EPSDT or from a third-party source.

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	Medicaid Enrolled Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Hippotherapy

Provider Category:

Agency

Provider Type:

Medicaid Enrolled Provider

Provider Qualifications

License *(specify):*

The service to be delivered must meet all applicable State licensing requirements.

Physical Therapists (Hippotherapy) must be licensed by the Department of Regulatory Agencies, Division of Registrations as required by the Physical Therapy Practice Act (C.R.S. 12-41)

Certificate *(specify):*

The services to be delivered must meet all applicable State certification requirements.

Physical Therapists (Hippotherapy) must be licensed by the Department of Regulatory Agencies, Division of Registrations as required by the Physical Therapy Practice Act (C.R.S. 12-41)

An agency certified to provide Hippotherapy as a Program Approved Service Agency for the Home and Community Based Services- Children's Extensive Supports (HCBS-CES) waiver.

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

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	Medicaid Enrolled Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Massage Therapy

Provider Category:

Agency

Provider Type:

Medicaid Enrolled Provider

Provider Qualifications

License *(specify):*

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

Massage Therapists must be registered by the Department of Regulatory Agencies, Division of Registrations as required by the Massage Therapy Practice Act (C.R.S. 12-35.5)

Certificate *(specify):*

The service to be delivered must meet all applicable state certification requirements.

Massage Therapists must be registered by the Department of Regulatory Agencies, Division of Registrations as required by the Massage Therapy Practice Act (C.R.S. 12-35.5)

An agency certified to provide Massage Therapy as a Program Approved Service Agency for the Home and Community Based Services- Children's Extensive Supports (HCBS-CES) waiver.

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: Service Specification

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

Service Type:

Other Service

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

Service Title:

Movement Therapy

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

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

Service Definition *(Scope):*

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

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

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

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

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

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

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

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medicaid Enrolled Provider

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:

Medicaid Enrolled Provider

Provider Qualifications

License *(specify):*

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

Mental Health Therapists (Movement therapy) must be licensed by the Department of Regulatory Agencies, Division of Registrations as required according to C.R.S. 12-43.

Certificate *(specify):*

The service to be delivered must meet all applicable State certification requirements.

Mental Health Therapists (Movement therapy) must be licensed by the Department of Regulatory Agencies, Division of Registrations as required according to C.R.S. 12-43.

An agency certified to provide Movement Therapy as a Program Approved Service Agency for the Home and Community Based Services- Children's Extensive Supports (HCBS-CES) waiver.

Other Standard *(specify):*

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

•HIPAA compliant platforms;

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

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

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

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

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

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

Indicate client choice to use telehealth and indicate the choice in the member's service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

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: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☒ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☒ **As an administrative activity.** *Complete item C-1-c.*
- ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

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

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

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

Appendix C: Participant Services

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

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

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

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

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

For providers licensed by the Colorado Department of Human Services (CDHS) the County ensures that no child is placed in a setting that has not been licensed or certified. The Department has access to review annual licenses or certifications. In order to be licensed or certified, each applicant for an original license or certificate for a foster care home, or original license for a center, facility, or agency and any adult who resides in the licensed or certified facility must submit to the Colorado Applicant Background Services (CABS) Program a complete set of fingerprints.

At the time the annual declaration of compliance is submitted to the DHS, a criminal record check is required only for adults living at the licensed facility who have not previously obtained one. Because the CBI provides the DHS with ongoing notification of arrests, owners, applicants, licensees, and persons who live in the licensed facility who have previously obtained a criminal record check are not required to obtain additional criminal record checks.

Each owner, employee, and newly hired employee of a facility or agency must submit to CBI a complete set of fingerprints to obtain any criminal record held by the CBI. The results of the criminal record check must be maintained at the home, center, facility, or agency and must be available for review upon request by a licensing specialist.

Employees and volunteers who are transferring from one child care facility to another or from a school district to a child care facility are not required to be re-fingerprinted if they complete the following process:

a. New employees must obtain their CBI clearance letter or a photocopy of their processed fingerprint card from their former employer or school district. They must attach it to a new fingerprint card, the top portion of which they have completed. The new fingerprint card must include the new employer's address and the new employer's license I.D. number in the box labeled MNU. "Transfer - Child Care" must be inserted in the "Reason Fingerprinted" block. The CBI clearance letter (or photocopy of the old fingerprint card) and the new fingerprint card must be sent with the fee to the Colorado Bureau of Investigation.
b. New employees who cannot obtain the CBI clearance letter or photocopy of the processed fingerprint card from their former employer must have their fingerprints retaken and follow the process of a new employee transfer.
c. When an individual leaves employment, the facility must submit to CBI, a completed Notification of Name Removal form to request the removal of the individual's name from their facility license number in the CBI database.

Licensees must send a copy of an employee's or a resident's criminal record check to his/her new employer upon written request from that employer.

Any adult volunteer, working as a staff member to meet the required staff-child ratio or staff qualifications, who works 14 days or more in a calendar year, must submit to CABS a complete set of fingerprints. The results of the criminal record check must be maintained at the facility or agency and must be available for inspection by a licensing specialist.

Requests for a criminal record check must be submitted to the CBI within 5 working days of the day that the individual begins to work at the facility or agency.

For the purposes of these rules, "convicted" means a conviction by a jury or by a court and shall also include a deferred judgement and sentence agreement, a deferred prosecution agreement, a deferred adjudication agreement, an adjudication, and a plea of guilty or nolo contendere.

A child placement agency shall not employ or certify an individual who has been convicted of:

a. Child abuse, as specified in Section 18-6-401, C.R.S.
b. A crime of violence, as defined in Section 16-11-309, C.R.S.
c. Any felony offenses involving unlawful sexual behavior, as defined in Section 18-3-412.5, C.R.S.
d. Any felony, the underlying factual basis of which has been found by the court on the record to include an act of domestic violence, as defined in Section 18-6-800.3, C.R.S.
e. Any felony involving physical assault, battery, or a drug related/alcohol-related offense within the five years preceding the date of application for a license or certificate.

f. Any offense in any other state, the elements of which are substantially similar to any of the elements previously listed in a-e.

g. Has been determined to be insane or mentally incompetent by a court of competent jurisdiction and, should a court enter pursuant to Part 3 or Part 4 of Article 14 of Title 15, C.R.S. or Section 27-10-109(4) or 27-10-125, C.R.S., an order specifically finding that the mental incompetency or insanity is of such degree that the applicant is incapable of operating a family child care home, foster care home, child care center, or child placement agency, the record of such determination and entry of such order being conclusive evidence thereof.

Any individual who is obtaining a criminal record check and who has lived in Colorado for 24 or fewer months must request that the CBI obtain a criminal, record check from the Federal Bureau of Investigation (FBI). These requirements fall under the Child Care Licensing Act C.R.S. 26-6-107 and 26-6-104 (7).

For all CABS fingerprint checks required including those confirming a criminal history as well as those confirming no criminal history, the DHS will conduct a comparison search on the State Judicial Department's ICON system. The ICON search, based on name, date of birth, and any other available criminal history data that the DHS deems appropriate, is used to determine the type of crime(s) for which a person was arrested or convicted and the disposition thereof.

Medicaid enrolled providers not licensed by CDHS 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 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, program supervisors, managers, and directors. The scope of the criminal investigations includes statewide and federal databases. Colorado Department of Public Health and Environment reviews compliance with requirements for criminal history and background investigations initially and every three years through certification surveys.

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):

The Colorado Department of Human Services (CDHS) is responsible for maintaining the abuse registry. For providers licensed by CDHS, all abuse registry screenings are conducted as part of the pre-employment check. The State requires a check of the "Records and Reports" to determine if the person was founded for abuse to the child. In addition, the work of the Audit Division provides the foundation for fiscal and programmatic accountability for all aspects of CDHS. County departments of human/social services, and a wide range of other government, not-for-profit, and for-profit entities that receive funds through CDHS, as the pass through agency for Federal funds.

Appendix C: Participant Services

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

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

Appendix C: Participant Services

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

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is

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

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

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

A parent may be paid to furnish extraordinary care through the Community Connector service. Extraordinary care is determined by assessing whether an individual who is the same age without a disability needs the requested level of care, the activity is one that a parent would not normally provide as part of a normal household routine and the activity is one that a parent is not legally responsible to provide and is necessary to assure the health and welfare of the participant and to avoid institutionalization.

A parent may not provide more than 10 hours of Community Connector in a seven-day period.

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

- ☐ **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: Habilitation and Respite services. The Department does not make payment to legally responsible persons for the provision of any CHRP 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.

- ○ **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:

CHRP provider candidates express their interest to County and/or Child Placement Agency personnel. The interested party is directed to the State Medicaid Agency website (HCPF), where they can review the process of how to become a provider and complete the application electronically. All interested parties must meet the requirements necessary for the specific waiver service. This will be determined by reviewing a certificate, license, or other proof of their ability to perform the service.

The enrollment application is designed to address requirements for providers who render specific types of services. Providers who have questions about how to complete the application may contact the fiscal agent for technical assistance. The Department processes new provider applications on an average of 5 business days. Provider enrollment updates are processed on an average of 2-3 business days. Both of these time frames are dependent on the volume of applications and/or requested updates. The Department rejects applications that are in a Returned to Provider (RTP) status for six months. An RTP status indicates that the provider agency did not provide the necessary documentation.

The provider is also informed about the availability of trainings that will help them navigate the Medicaid Management Information System (MMIS) when filing claims.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

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

Performance Measures

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

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

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

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
C.a.2 # & % of waiver providers enrolled within the perfce period, by type, that have the reqd prof'l licensure or cert prior to serving waiver participants N: # of waiver providers enrolled within the perfce period, by type, that have the reqd prof'l licensure or certification prior to serving waiver participants D: Total # of waiver providers enrolled within the performance period, by type.

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

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

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

Data Aggregation and Analysis:

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

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

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

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

Data Aggregation and Analysis:

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

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.

Performance Measure:
C.b.1 Number and percent of non-surveyed non-licensed/non-certified providers that initially and continually meet waiver requirements Numerator: Number of non-surveyed non-licensed/non-certified providers that initially and continually meet waiver requirements Denominator: Total number of non-surveyed non-licensed/non-certified waiver providers

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

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

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

Data Aggregation and Analysis:

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

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

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
C.c.2 Number and percent of CHRP waiver non-surveyed providers who meet department training requirements in accordance with state requirements and the approved waiver N: Number of CHRP waiver non-surveyed providers who meet Department training requirements in accordance with state requirements and the approved waiver D: Total CHRP waiver non-surveyed providers

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

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:

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

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

The 24-hour licensing unit investigates providers of Habilitation and out-of-home Respite services for reported or suspected non-compliance with regulatory requirements, including complaints. This unit also conducts annual on-site licensing surveys for providers of Habilitation and out-of-home Respite services. In addition, the unit provides ongoing oversight, training, completes ongoing site visits, reviews, responds, and investigates reports that arise including violations to state regulations, and provides technical assistance to care providers to ensure that regulatory standards, including training requirements, are met.

All approved residential child care facilities must be licensed by the CDHSes, and also be certified by either a county Dept. or a child placement agency.

C.a.1
Providers who are interested in providing HCBS services that are required by Medical Assistance Program regulations to be surveyed prior to certification to ensure compliance with licensing and qualification standards and requirements. Certified providers are re-surveyed according to the CDPHE schedule to ensure ongoing compliance. The CDHS 24-hour Licensing Unit conducts annual on-site licensing surveys for providers of Habilitation and out-of-home Respite services.

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

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

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

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

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

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

C.c.2
Dept. regulations for provider general certification standards require provider agencies to maintain a personnel record for each employee and supervisor that includes documentation of qualification and required training completed. The Department reviews personnel records as part of their provider certification/revalidation activities.

b. Methods for Remediation/Fixing Individual Problems

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

the methods used by the state to document these items.

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

CHRP residential providers found to have violations of standards are provided a list of the deficiencies and are required to submit an acceptable Plan of Correction and demonstrate progress implementing the plan to the 24-hour Licensing Unit. CHRP residential waiver providers with serious violations affecting the health and safety of participants are required to correct the violations immediately and submit documentation of corrections.

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

C.a.1, C.a.2, C.a.6
The Department initiates termination of the provider agreement for any provider who is in violation of any applicable certification standard, licensure requirements, or provision of the provider agreement and does not adequately respond to a corrective action plan within the prescribed period of time.

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

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

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

C.c.1
The Department reviews CDPHE/DHS provider surveys to ensure plans of correction are followed up on and waiver providers are trained in accordance with Department regulations.

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

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

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

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

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

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

when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

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

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

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

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

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Person-Centered Support Plan (PCSP)

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

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

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

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

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

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

The minimum qualifications for HCBS Case Managers that conduct the person-centered service plan is:
1. A bachelor's degree; or
2. Five (5) years of experience in the field of LTSS, which includes Developmental Disabilities; or
3. Some combination of education and relevant experience appropriate to the requirements of the position.
4. Relevant experience is defined as:
a. Experience in one of the following areas: long-term care services and supports, gerontology, physical rehabilitation, disability services, children with special health care needs, behavioral science, special education, public health or non-profit administration, or health/medical services, including working directly with persons with physical, intellectual or developmental disabilities, mental illness, or other vulnerable populations as appropriate to the position being filled; and
b. Completed coursework and/or experience related to the type of administrative duties performed by case managers may qualify for up to two (2) years of required relevant experience.
Safeguards to assure the health and welfare of waiver participants, including response to critical events or incidents, remain unchanged.

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

☐ **Social Worker**
Specify qualifications:

☐ **Other**
Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

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

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.

A PCSP meeting is scheduled by the case manager so that all parties involved, including the parent and child, are informed and actively participating in the service plan development process.

When scheduling the PCSP meeting, the case manager makes reasonable attempts to schedule the meeting at a time convenient for the child/youth, and the child's parents as well as other applicable individuals such as the legal guardian, guardian ad litem, county caseworker, and foster parent to complete a comprehensive assessment of the child's needs, preferences, goals, and health status. Each invitee has the opportunity to invite individuals of their choice to actively participate in the assessment process unless that individual has been specified as inappropriate by the Court. To facilitate person-centered practices, CMAs may use phone or other technological contact to engage in the development and monitoring of the PCSP. During each certification period, one in-person monitoring will be required with up to three additional monitoring contacts either in person, on the phone, or through other technological contact based on the member's preference of engagement.

The choice of services and providers for the waiver benefit package is assured by facilitating a service plan meeting to which all parties involved in the child welfare case are invited. The case manager will advise the child's parents, and/or appropriate entity as listed above, of a range of services and supports for which the child is eligible in advance of the PCSP development.

The case manager will work with the attending parties to develop backup plans and document those ideas on the PCSP. The child must be seen at the time of the initial assessment and at the re-determination to ensure that the child is in the home.

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

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

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

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

All forms completed through the assessment and care plan process are available for signature through digital or wet signatures based on the member’s preference.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Case management functions include the responsibility to document, monitor, and oversee the implementation of the PCSP [10 C.C.R. 2505-10, Section 8.607]. The case manager meets with the client and/or legal guardian to complete a Level of Care Eligibility Determination (LOC Screen), making reasonable attempts to schedule the meeting at a time and location convenient for all participants. The Colorado Code of Regulations (10 CCR 2505-108.607.4 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. To facilitate person-centered practices, CMAs may use phone or other technological contact to engage in the development and monitoring of the PCSP. For each certification period, the level of care determination or redetermination will be in person (unless a documented safety risk is met as provided below).

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

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

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

To facilitate person-centered practices, CMAs may use phone or other technological contact to engage in the development and monitoring of the PCSP.

The client and/or legal guardian have the authority to select and invite individuals of their choice to actively participate in the PCSP development process. The client and the client's chosen group of participants provide the case manager with information about the client's needs, preferences, and goals.

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

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

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

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

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

finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation."

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

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

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

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

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

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

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

State laws, regulations, and policies that affect the PCSP development process are available through the Medicaid agency.

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

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

- March 2019-April 2020: The Department pilots the new LOC Screen, Assessment, and PCSP process in the field with case managers and LTSS participants
- August 2019: The 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 a 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 the new Assessment and Support Plan

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

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Risk assessment and mitigation are completed by the Case Manager.

Risk Assessment and Mitigation- The initial step of risk assessment includes completion of the Inventory for Client and Agency Planning 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 in these collateral documents are documented within the support plan by the Case Manager.

Risks are assessed as part of Person-Centered Support Planning and are documented in the client's electronic record. Case managers are required to provide the child's parents and /or other applicable individuals such as the legal guardian, county caseworker, and foster parent with all of the choices available to address the risks to the client for long-term care including whether to continue living in the community or in an ICF/MR. The identified risks are discussed with the parties present and a plan is developed to address or reduce the risks, if necessary.

Back-up Plans- The support 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.

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

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

CMAs are required to provide clients with a choice among qualified and willing providers. This choice is explained to participates upon initial enrollment onto the waiver and on an ongoing basis at the time of each PCSP development. A client may select providers of his/her choice. 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 that contains the LOC Screen, the PCSP, and the monthly case management log notes. The case manager is required to enter the PCSP into the State's case management IT system in order to receive prior authorization of services. CMAs are required to prepare PCSP according to the Department and CMS waiver requirements. The Department monitors the CMA annually for compliance. A sample of documentation including individual PCSP is reviewed for accuracy, appropriateness, and compliance with regulations.

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

Appendix D: Participant-Centered Planning and Service Delivery

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

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☒ **Medicaid agency**
- ☐ **Operating agency**
- ☒ **Case manager**
- ☐ **Other**

Specify:

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.

The CMA is responsible for implementing the PCSP and monitoring the utilization of services and the client's health and welfare.

The CMA is required to meet the waiver participant for the LOC screen and redetermination and provide documentation of the visit in the log note section of the state's case management IT system. The CMA is also responsible for ensuring that the waiver participant receives services through natural resources, third-party resources, and the State Plan.

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

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

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

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

Case Managers are required to conduct monitoring with all individuals. PCSP monitoring includes the following:
- Troubleshooting and documenting when an individual is not able to receive the services authorized
- Ensuring that services are furnished in accordance with the state plan
- Ensuring that services meet the participant's needs
- Ensuring the contingency plan documented on the PCSP was adequate and met the needs of the individual
- Following up on the incident and critical incident reports
- Using observation to document and discuss/address any concerns regarding 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 choices to their clients. In order to ensure that clients continue to exercise a free choice of providers, the Department has added a signature section to the PCSP that allows clients to indicate whether they have been provided with a free choice of providers. All forms completed through the Person-Centered Support Planning process are available for signature through digital or wet signatures based on the member's preference.

Participant have access to non-waiver services in the PCSP, including health services.
In 2007, the Department implemented a new PCSP which includes a section for health services and other non-waiver services. At the same time, the Department added "acute care benefits" and "Behavioral Health Organizations" breakout sessions to the annual case managers training conference to ensure case managers have a greater understanding of the additional health services available to long-term care clients.

Methods for prompt follow-up and remediation of identified problems:
Clients are provided with this information during the initial and annual support planning process using the "Client Roles and Responsibilities" and the Case Manager's "Roles and Responsibilities" form. The form provides information to the client about the following, but not limited to, case management responsibilities:
• Assists with the coordination of needed services.
• Communicate with the service providers regarding service delivery and concerns
• Review and revise services, as necessary
• Notifying clients regarding a change in services

The form also states that clients are responsible for notifying their case manager of any changes in the client's care needs and/or problems with services. If a case manager is notified about an issue that requires prompt follow-up and/or remediation the case manager is required to assist the client. Case managers document the issue and the follow-up in the state's case management IT system.

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

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

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

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

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

b. Monitoring Safeguards. *Select one:*

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

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

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

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

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

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

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

Data Aggregation and Analysis:

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

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

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
D.a.3 Number and percent of waiver participants whose PCSPs address identified health and safety risks through a contingency plan Numerator: Number of waiver participants whose PCSPs address identified health and safety risks through a contingency plan Denominator: Total number of waiver participants reviewed

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

Performance Measures

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

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

Performance Measure:
D.c.1 Number and percent of waiver participants whose PCSPs were revised, as needed, to address changing needs Numerator: Number of waiver participants whose PCSPs were revised, as needed, to address changing needs Denominator: Total number of participants who required a revision to their PCSP to address changing needs that were reviewed

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

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

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

Performance Measure:
D.d.2 Number and percent of waiver participants whose scope and type of services are delivered as specified in the PCSP N: # of waiver participants whose scope and type of services are delivered as specified in the PCSP D: Total # of waiver participants in the sample

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

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

		95% confidence level with +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:

D.d.4 Number and percent of waiver participants whose amount of services are delivered as specified in the PCSP Numerator: Number of waiver participants whose amount of services is delivered as specified in the PCSP Denominator: Total number of waiver participants in the sample

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

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

Data Aggregation and Analysis:

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

Performance Measure:
D.d.5 Number and percent of waiver participants whose frequency and duration of services are delivered as specified in the PCSP Numerator: # of waiver participants whose frequency and duration of services are delivered as specified in the PCSP Denominator: Total # of waiver participants in the sample

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

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

		95% confidence level with +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

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

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

D.c.1
If PCSP revision need is indicated, the revision must be: included in the participant's record; supported by documentation in the applicable areas of the LOC Screen, Log notes, or CIRS, and address all service changes per Department policy, delivered to the participant or the participant's representative; and, signed by the participant or the legal guardian, as appropriate. The reviewers use the state's case management IT system and/or Bridge to discover deficiencies for this performance measure and report in the QI Review Tool.

D.c.2
The PCSP start date must be within one year of the prior PCSP start date, for existing, non-new waiver participants in the sample. Discovery data for this performance measure is pulled directly from the state's case management IT system.

D.d.2, D.d.4, D.d.5
The Department compares data collected from MMIS claims and the participant's service plan to discover deficiencies for this performance measure. Case managers are required to perform follow-up activities with participants and providers to ensure the PCSP reflects the appropriate services authorized in the amount necessary to meet the participant's identified needs.

D.e.1
PCSP Service and Provider Choice page must indicate that the participant has been provided a choice between/among HCBS waiver services and qualified waiver service providers. Discovery data for this performance measure is pulled directly from the state's case management IT system.

b. Methods for Remediation/Fixing Individual Problems

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

D.a.1, D.a.2, D.a.3, D.c.1, D.c.2, D.d.2-5, D.e.1
The Department provides comprehensive remediation training CMAs annually to assist with improving compliance with PCSP performance measures and in developing future individual PCSP. The remediation process includes a standardized template for individual CMA Corrective Action Plans (CAPs) to ensure all of the essential elements, including root-cause analysis, are addressed in the CAP. Time-limited CAPs are required for each performance measure when the threshold of compliance is at or below 85%. The CAPS must also include a detailed account of actions to be taken, staff responsible for implementing the actions, timeframes, and a date for completion. The Department reviews the CAPs, and either accepts or requires additional remedial action. The Department follows up with each CMA quarterly to monitor the progress of the action items outlined in their CAP.

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

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

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

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

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

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

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

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

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

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 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. The 803 forms completed are available for the case manager and case manager supervisor signature through digital or wet signatures.

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 intends to make 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 of Health Care Policy and Financing (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 Community Centered Board (CCB), Program Approved Service Agency (PASA), or other 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 2505-10 § 8.605.2 the 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 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 and apply to all persons receiving services for Individuals with Intellectual Disabilities through the Department, including waiver participants.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

The Department of Public Health and Environment, Health Facilities and Emergency Services Division (CDPHE) maintains a Complaint Hotline. This hotline is set up for complaints about care providers, fraud, abuse, and misuse of personal property. CDPHE evaluates the complaint and initiates an investigation. Most investigations will be initiated within three (3) days of CDPHE receiving a complaint or for complaints considered to be a severe risk to the client's health and welfare an investigation is initiated within twenty four (24) hours after the complaint is received. Investigations may lead to targeted surveys or full surveys of the agency involved. Investigation surveys may result in deficient practice citations for agencies, which are reported to the Department and require that a plan of correction be submitted to CDPHE within specified timelines. Immediate jeopardy situations require actions to correct the situation at the time of survey.

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 (CCBs), and Case Management Agencies (CMA) are required to report any incident in which a crime may have been committed to local law enforcement pursuant to Title 18 8 115, C.R.S. (Colorado Criminal Code - Duty To Report A Crime). The agencies, CCB, and CMA must also report any suspected incidents of abuse, neglect, or self-neglect to law enforcement and county departments of social services child protection units. Requirements for reporting are located at 10 CCR 2502-10 8.608.8.

Complaints may be submitted to CDPHE by email, online complaint form available on the CDPHE website, by phone, by mail, or by fax. CDPHE evaluates the complaint and initiates an investigation if appropriate. The investigation begins within twenty-four hours or up to three days depending upon the nature of the complaint and the risk to the client's health and welfare.

CDPHE submits monthly complaint reports to the Department. The reports provide the Department with information about the facility type, type of complaint, the source of the complaint, when the complaint will be investigated, and the investigation findings.

Complaints may be submitted to CDHS by email, phone, mail, or fax. CDHS evaluates the complaint and initiates an investigation if appropriate. CDHS also investigates service agencies when there are allegations of mistreatment, abuse, neglect, and exploitation in addition to Child Protective Services to determine if there was any failure of the agency to adhere to requirements that led or contributed to the allegation. CDHS makes complaint reports available to the Department through access to their web-based systems where this data is stored.

Critical Incidents are those incidents that create 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 individual. Critical Incidents categories that must be reported include but are not limited to: injury/illness; mistreatment/ abuse/neglect/exploitation; damage/theft of property; medication mismanagement; lost or missing person; criminal activity; unsafe housing/displacement; or death.

Critical Incident Types:

Mistreatment/Abuse/Neglect/Exploitation

• Abuse or child abuse or neglect means an act or omission in one of the following categories that threatens the health and welfare of a child:

• Any case in which a child exhibits evidence of skin bruising, bleeding, malnutrition, failure to thrive, burns, fracture of any bone, subdural hematoma, soft tissue swelling, or death and either: Such condition of death is not justifiably explained; the history given concerning such condition is at variance with the degree or type of such condition or death, or the circumstances indicate that such condition may not be the product of an accidental occurrence;

• Any case in which a child is subjected to unlawful sexual behavior as defined in section 16-22-102(9), C.R.S;

• Any case in which a child is a child in need of services because the child's parents, legal guardians, or custodian fails to take the same actions to provide adequate food, clothing, shelter, medical care, or supervision that a prudent parent would take.

• Any case in which a child is subjected to emotional abuse. Emotional abuse means an identifiable and substantial impairment of the child's intellectual or psychological functioning or development or a substantial risk of impairment of the child's intellectual or psychological functioning or development.

• Any act or omission described in section 19-3-102 (1)(a), (1)(b), or (1)(c), C.R.S.

• Any case in which, in the presence of a child, or on the premises where a child is found, or where a child resides, a controlled substance, as defined in section 18-18-102(5), C.R.S, is manufactured or attempted to be manufactured

• Any case in which a child is born affected by alcohol or substance exposure, except when taken as prescribed or recommended and monitored by a licensed health care provider, and the newborn child's health or welfare is threatened by substance use;

• Any case in which a child is subjected to human trafficking of a minor for involuntary servitude, as described in section 18-3-503, or human trafficking of a minor for sexual servitude, as described in section 18-3-504(2)

• In all cases, those investigating reports of child abuse shall take into account accepted child-rearing practices of the culture in which the child participates including, but not limited to, accepted work-related practices of agricultural communities. Nothing in this subsection (1) shall refer to acts that could be construed to be a reasonable exercise of parental discipline or to acts reasonably necessary to subdue a child being taken into custody pursuant to section 19-2-502

that are performed by a peace officer, as described in section 16-2.5-101, C.R.S., acting in the good faith performance of the officer's duties.

The Department uses a preponderance of evidence as the burden of proof to substantiate incidents of Mistreatment, Abuse, Neglect, or Exploitation (MANE).

Criminal Activity means A criminal offense that is committed by a person; A violation of parole or probation that potentially will result in the revocation of parole/probation.

Damage to Consumer's Property/Theft means Deliberate damage, destruction, theft, or use of a waiver recipient's belongings or money. If the incident is mistreatment by a caretaker that results in damage to the consumer's property or theft the incident shall be listed as mistreatment

Death Unexpected or expected

Injury/Illness to Client means: 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 Mis-Management means Issues with medication dosage, scheduling, timing, set-up, compliance, and administration or monitoring which results in harm or an adverse effect that necessitates medical care.

Missing Person means: A waiver recipient is not immediately found, their safety is at serious risk, or there is a risk to public safety.

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

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

Provider Reporting- The Department of Health Care Policy and Financing requires all service providers to report Critical Incidents to the Case Management Agency (CMA) immediately upon detection but no more than 24 hours after the incident occurrence. Service providers are to report Critical Incidents to the Community Centered Board via a written incident report either through electronic communication, fax, or by phone.

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

The Department's oversight for monitoring safeguards and standards is with the use of critical incident reports (CIRs) or complaint logs. The Department and the contract QIO review and track critical incident reports to ensure that a resolution is reached and the client's health and safety have been maintained.

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

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

In cases of emergency or evacuation, the case manager may authorize needed services using a temporary interim service plan, not to exceed 60 days. This plan will be developed when additional services, essential to the member's health and safety, related to the emergency situation are identified. The case manager will authorize the services using the most

effective means of written communication. Service providers may provide services authorized in this manner until the case manager is able to complete a service plan revision which will backdate to the date of the temporary interim service plan. This type of interim temporary plan will only be used for already enrolled waiver participants who have been determined eligible for the waiver pursuant to the eligibility process in the waiver.

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

The 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 includes information on the right to be free from mistreatment, abuse, neglect, and exploitation, how to recognize signs of mistreatment, abuse, neglect, and exploitation, and how to report mistreatment, abuse, neglect, and exploitation to the appropriate authorities. The information is provided to participants, guardians, involved family members, and authorized representatives in the form of a packet. The packet is provided by the CM and explained verbally at initial enrollment and annually thereafter. This information packet also includes information about the types and definitions of Critical Incident Reports and how to report a Critical Incident Report.

Additionally, the information will include the requirements of service provider agencies and CMAs for detecting and follow-up to suspicions and allegations of mistreatment, abuse, neglect, and exploitation.

The Department has developed Policies and Procedures for the Critical Incident Reporting System (CIRS). Similar resources are also available to clients and case managers about emergency backup and safety and prevention strategies.

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

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

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

The PCSP identifies concerns about mistreatment, abuse, neglect, mistreatment, and exploitation that were identified in the participant’s level of care assessment. The intellectual and developmental disabilities section of the PCSP has data fields to document the participant’s response to whether he/she feels safe in the home and whether he/she would like to learn self-advocacy skills. When requested by the participant and/or guardian, individual services and PCSP can be developed to teach the participant how to protect him/herself to prevent and report mistreatment, 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 the 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 mistreatment, abuse, neglect, or self-neglect of a waiver participant. Following the Law Enforcement or CPS investigation, the CMA is responsible for follow-up action. In these circumstances, the case manager will contact the waiver participant and/or representatives to determine the impact on the participant's ongoing health and welfare. This may include contacting provider agencies, representatives from CPS, or other involved parties to gather information. When appropriate, the CMA must conduct a review of any questions not resolved by law enforcement or county CPS investigation (e.g., provider training, program management supervision, etc.).

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

Response to Critical Incidents by CCBs-CCBs are required to investigate all allegations of mistreatment, abuse, neglect, and exploitation pursuant to the Department's Rule 10 CCR 2505-10 8.608.8. 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-Service providers must ensure the immediate and on-going health, safety, and welfare of waiver participants, provide access to victim’s supports when needed, and take follow-up action to address the Critical Incident and prevent a recurrence.

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

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

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

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

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

Notification of Outcomes of Investigations- All investigations completed by the Department are documented in a written investigation report. 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 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 mistreatment, abuse, neglect, or exploitation.

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

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

On-going oversight of Critical Incidents is the responsibility of the Department.

The Department conducts oversight through the following methods:

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

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

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

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

• Mistreatment (abuse, neglect, exploitation) in which immediate action must be taken to ensure an individual's health and safety, or if law enforcement has not been notified per Mandatory Reporting Requirements.

• Missing Person in which an individual with a line of sight supports/high care needs has not been found when CIR is submitted.

• Unsafe housing or displacement from a natural disaster, fire, or stemming from caretaker neglect, which leaves the individual without housing and needs immediate attention and housing to ensure health and safety.

• Death under suspicious circumstances that needs investigation, involves mistreatment, law enforcement, or where the cause of death is unknown and autopsy must be performed by a coroner.

• Injury/Illness in which no treatment has been sought, trends imply mistreatment, or those which have no immediate intervention noted to ensure the health and safety of an individual receiving services. DIDD Waivers also include Safety and Emergency Control Procedures resulting in serious injury caused by staff with no least restrictive measures utilized prior to holds/restraints or if mistreatment by staff is suspected.

• Medication Mismanagement in which error leads to an adverse medical crisis (or death) and needs immediate attention to ensure health and safety or mistreatment or theft/mistreatment by staff is a concern.

• Criminal Activity in which individual receiving services is incarcerated for a major serious offense such as homicide and needs immediate follow-up due to seriousness of charge and notification to the Department for possible media coverage of the event.

• Damage/Theft of Property to an individual receiving services self or property which results in a need for immediate action to ensure health and safety or must be reported to Law Enforcement

• Any other CIR in which immediate assurance of health and safety is crucial and has not been addressed by CMA/Agency/staff.

• Any CIR in which there is media involvement or coverage

• It should also be noted that Critical Incidents vary greatly, and the priority level may be subjective. This is also not an all-inclusive list due to variance in events.

o MEDIUM PRIORITY: those Critical Incidents that may have some immediate follow-up documented, but still need some sort of actions to ensure the health and safety of an individual receiving services or other questions relating to more immediate follow-up. These may be subjective and can vary in documentation and need for clarification.

o LOW PRIORITY: those Critical Incidents that have been remediated by CMA/agencies, have addressed immediate and long-term needs, have implemented services or supports to ensure health and safety, and those that have protocols in place to prevent a recurrence of a similar CIR. Critical Incidents that would be Low Priority would be:

• Death, expected. Resulting from long-term illness or natural causes, hospice or palliative care was utilized and documented.

• Missing Person in which the person was immediately found, had no injury and a plan was implemented to prevent a recurrence.

The Department takes remedial action to address with service providers and/or CCBs when needed for deficient practice

in reporting and management of Critical Incidents to ensure the health, safety, and/or welfare of waiver participants. This includes a formal request for response, technical assistance, Department investigation, the imposition of corrective action, termination of CCB contract, and termination of a service provider's Colorado Provider Participation Agreement/Program Approval for the HCBS-CHRP waiver.

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

The Department maintains Interagency Agreements (IA) with the Colorado Department of Human Services (CDHS) and the Colorado Department of Public Health and Environment (CDPHE) to conduct on-site licensure and re-certification surveys for HCBS-CHRP providers. If a deficient practice is detected with critical incident reporting, the agency must correct the practice in order to obtain licensure or recertification.

CDPHE submits a report monthly to HCPF on the number and type of providers surveyed and the findings. These reports provide data on the on-site licensure and re-certification and complaint surveys for HCBS-CHRP providers. If a deficient practice is detected with critical incident reporting, the agency must correct the practice in order to obtain licensure or recertification.

CDHS submits a report monthly to HCPF on the number and type of providers surveyed and the findings. These reports provide data on the on-site licensure and re-certification and complaint surveys for HCBS-CHRP Habilitation and Respite providers. If a deficient practice is detected with critical incident reporting, the agency must correct the practice in order to obtain licensure or recertification.

In addition, case managers are required to maintain records for all critical incidents that are reported or are known to case managers. The Department performs CMA monitoring through a review of critical incident and complaint reporting. All case managers must complete training on Critical Incident Reporting requirements within 120 days of the hire date per contract requirements.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

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

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

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

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

A service agency for the purpose of this section is defined as a licensed 24-hour child care facility, foster care home, child placement agency, and/or Medicaid enrolled provider.

Whenever possible, positive behavioral interventions such as a calming tool (e.g. blankets, brushes)are used to avoid restraints. Personal restraint is age-appropriate physical intervention by a staff member of a facility in an emergency situation to limit, restrict, or control the dangerous behavior of a child/youth by means of physically holding the child/youth. The physical holding of a child/youth is the only method of personal restraint allowed. The use of a mechanical restraint, including, but not limited to, the use of handcuffs, shackles, straight jackets, posey vests, ankle and wrist restraints, craig beds, vail beds, hospital cribs, and chest restraints is prohibited, except as otherwise allowed under Article 25.5-10-221, C.R.S.

A personal restraint is to be used only during periods of crisis or emergency for the child/youth, when the child/youth is a danger to him/herself and/or others, the child is beyond control, and when all other means to control and de-escalate the crisis or emergency has failed. The restraint shall not impede or inhibit the child/youth's ability to breathe in any manner, including placing excess pressure on the chest or back area. The restraint shall last only as long as is necessary to calm the child/youth, and for the child/youth to be able to follow adult direction and to not be a threat to self or others. If a service agency chooses to use physical restraints with waiver participants, the service agency shall restrain children/youth only in accordance with the rules for personal restraint. Personal restraint must never be used as a punitive form of discipline, as a form of treatment or therapy, or as a threat to control or gain compliance of a child/youth's behavior. A child/youth must be released from a personal restraint within fifteen minutes after the initiation of the restraint, except when precluded for safety reasons.

Upon admission the service agency, the parent(s), or guardian(s), or agency holding legal custody shall be notified and must give written consent for the child/youth to be restrained in conjunction with facility policy. No child/youth shall be restrained without specific written consent.

Each service agency choosing to use personal restraint to control a child/youth whose behavior is a danger to him/herself or others must have a written personal policy that is adopted and implemented by the service agency. At a minimum, the policy must include:

1. A nationally recognized, research-based type of de-escalation and personal restraint.
2. The staff members that are approved by the service agency to use personal restraint.
3. The type of training/certification that the approved staff members are required to have prior to restraining any child/youth.
4. The type and number of hours of ongoing training each staff member will be required to take.
5. What preventive/de-escalation techniques and positive behavioral intervention must be used by staff prior to any personal restraint.
6. How the facility observes and evaluates the use of personal restraint on a child/youth at the facility.
7. The type of written documentation the service agency maintains of each personal restraint that describes the details of the incident, the staff involvement, and the debriefing with the child/youth and staff following the restraint.
8. Evaluation of each personal restraint to determine appropriateness and effectiveness of preventive/de-escalation techniques used and effectiveness and appropriateness of the restraint itself.
9. The requirement that staff does not restrain children/youth in areas of the facility or environment that may pose a threat to the health and safety of the child including, but not limited to, soft, pliable surfaces, concrete, asphalt, or areas including broken glass.
10. Notification of the parent(s) or guardian(s) and child/youth in advance of the service agency's restraint policy and methodology.
11. How the service agency monitors the physical well-being of the child/youth during and after the restraint, including but not limited to breathing, pulse, color, and signs of choking or respiratory distress.
12. Emergency procedure, including first aid, that will be used if a child/youth or staff member is seriously injured during a restraint.
13. The requirement of staff to report to the county department of social services or local law enforcement any injury, bruising, or death that occurs as a result of the restraint pursuant to Colorado State law.
14. The internal review process of the service agency to assess carefully any injuries, bruising, or death.

All staff and foster care home providers that will be involved in personal restraint must complete a de-escalation/restraint training program that includes a competency test as a part of the training program in compliance with the nationally recognized, research-based type of restraint being used. Successful completion of the competency test is mandatory prior to any staff member being involved in a personal restraint. A supervisor of the facility must perform a periodic observation of each staff member performing a restraint. The supervisor will determine if the staff has completed the restraint in an appropriate manner. If the staff has not correctly performed the restraint they must either be immediately re-trained or restricted from performing any future restraints until training occurs. At least every six (6) months, each staff member involved in personal restraints must receive regular training to review and refresh their skills in positive behavior intervention, de-escalation, and personal restraint.

Each restraint incident shall be recorded and shall include the name of the child/youth, date and time of day, staff members involved, their position at the service agency, and their involvement in the restraint, and how long the restraint lasted. The record shall also include the precipitating incident(s) and the child/youth's behavior prior to the restraint, the specific actions that were taken to de-escalate the situation, and what effect the de-escalation techniques had upon the child. A description of the restraint shall include the child/youth's physical, emotional and behavioral condition before, during, and after the restraint. A description of the de-briefing and evaluation with the child/youth and staff will be a part of the record.

All records of restraints shall be reviewed by a supervisor of the service agency within 24 hours of the incident. If it appears that the child/youth is being restrained excessively, frequently in a short period of time, or frequently by the same staff member, the entire child/youth's individual plan must be reviewed according to policy and procedures. De-escalation techniques will be reviewed for effectiveness if it appears that anyone technique is causing an escalation in the behavior of a child/youth or a group of children/youth. Any de-escalation techniques which are found to be ineffective or counter-productive will be terminated at the earliest opportunity.

24-hour child care facilities, foster care homes, and child placement agencies must also ensure compliance with the Colorado Department Human Services rules regarding the use of restraints in at 10 CCR 2509-8.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The Department of Health Care Policy and Financing (the Department) is responsible for oversight as the single state Medicaid agency. State oversight of the use of restraints is the responsibility of the Department. The Department conducts oversight through the following methods to detect unauthorized use or inappropriate/ineffective restraints.

The Department maintains an Interagency Agreement with the Colorado Department of Human Services (CDHS) to monitor the use of restraints at licensed facilities. There is no preset schedule, however, regular announced and unannounced visits are made to the individual facilities and the Child Placement Agencies to review the documentation on the use of restraints. These record reviews include the appropriateness of the restraint, whether another de-escalation technique would have been more appropriate, whether there are patterns in using restraints, and whether a specific child(ren) appears to be subjected to restraint more often than other children in the facility. Not all facilities or Child Placement Agencies use restraints.

If there are problems or complaints concerning the care or treatment of a child in a purchased Residential Child Care Facility or Child Placement Agency placement, or a report of violations of child care standards, the County Department of Human/Social Services (CDHS) shall report the circumstances to the State licensing or certifying authority within 24 hours. If the nature of the complaint involves an allegation of abuse or neglect, a report to the local investigating authority shall be made within 24 hours. CDHS submits a report monthly to HCPF on the number and type of providers surveyed and the findings.

The Department maintains an Interagency Agreement with the Colorado Department of Public Health and Environment (CDPHE) to monitor the use of restraints for HCBS-CHRP 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 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.

Critical Incident Reporting System (CIRS) Monitoring- The web-based CIRS system operated by the Department includes a specific data field for recording if any critical incident involved the use of restraints. Therefore, any use of restraint in an allegation of serious abuse, medical crisis (i.e. needing emergency medical treatment), a crime against a person, or death is reported immediately to the Department. Such incidents receive additional scrutiny by the Department staff that includes a review of the original written incident report to ensure restraint was used in compliance with statutory and regulatory requirements. The CIRS monitoring operates on a daily/continuous basis.

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

Program Quality Surveys- The Department conducts regulatory surveys of CMAs that include a review of the agency's incident management practices, compliance with standards for incident reporting and review, and data analysis practices. Such surveys include a specific review of written incident reports documenting the use of restraints to ensure such reports contain the information required by 10 CCR 2505-10 § 8.608.4(A)(4) and 8.608.4(B) and that restraints are used only within the requirements specified in 10 CCR 2505-10 § 8.608.3 et seq. and 8.608.4 et seq. Additionally, surveys of CMAs include a specific review of the local HRC review activities, the composition of the participant's interdisciplinary team, and an investigation of allegations of abuse related to unreasonable restraint. When non-compliant use of restrictive procedures, restraints, or any use of seclusion is detected, deficiencies are cited and the responsible agency is required to submit a plan of correction.

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.

Appendix G: Participant Safeguards

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

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

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

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

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

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

The Department of Health Care Policy and Financing does not permit the use of cruel and aversive therapy, or cruel and unusual discipline.

The following restrictive interventions are allowable:
"Physical Restraint" means the use of bodily, physical force to involuntarily limit an individual's freedom of movement.

"Physical Management" means the physical act of placing one's hands on an individual. Physical management may be used to gain physical control in order to protect the individual or others from harm after all attempts to verbally direct or deescalate the individual have failed. Physical management may be utilized when an emergency situation exists.

Service providers including licensed 24-hour child care facilities, foster care homes, child placement agencies are prohibited from engaging in all cruel and aversive treatment or therapy. This includes, but is not limited to, the use of mechanical restraints, locked seclusion, and additionally including but not limited to, the following:

A. Any intervention designed to or likely to cause physical pain

B. Releasing noxious, or toxic, sprays, mists, or substances in proximity to the child/youth's face.

C. Any intervention that denies a child/youth's sleep, food, water, shelter, access to bathroom facilities, adequate bedding, or appropriate physical comfort.

D. Any intervention or type of treatment that subjects a child/youth to verbal abuse, ridicule, humiliation, or that can be expected to cause excessive emotional trauma.

E. Interventions that use a device, material, or object that is designed to simultaneously immobilize all four of the child/youth's extremities.

F. Any treatment intervention that deprives a child/youth of the use of his/her senses, including sight, hearing, touch, taste, or smell.

G. Use of rebirthing therapy or any therapy technique that may be considered similar to rebirthing therapy as a therapeutic treatment, as defined by Section 12-43-222(1)(t)(IV), C.R.S.

Rights modifications - Under the Statewide Transition Plan (STP), providers and case management agencies are moving toward compliance with the requirements of the HCBS Settings Final Rule, including that any rights suspension or restrictive procedure must comply with the HCBS Settings Final Rule requirements, pursuant to 79 Fed. Reg. 2948 and 42 C.F.R. § 441.301, § 25.5-10-118 C.R.S., and 10 CCR 2505-10 § 8.604.3. As of January 1, 2021, case managers were required to enter information about new and up-for-renewal rights modifications in the State's case management IT system. The Department is working with stakeholders to codify the federal settings criteria within state regulations, with the expectation that this codification will be effective by roughly Summer 2021. Under this codification, all rights suspensions and restrictive procedures will be treated as a rights modification under the Federal Rule, and thus requires informed consent. In order to implement a rights modification, the following criteria must be met:

A. Rights modifications are based on the specific assessed needs of the child/youth, not the convenience of the provider.

B. May only be imposed if the child/youth poses a danger to themselves or the community.

C. The case manager is responsible to obtain informed and other documentation related to rights modifications/ limitations and maintain these materials in their file as a part of the person-centered planning process.

D. Any rights modification must be supported by a specific assessed need and justified in the person-

centered service plan. The following requirements must be documented in the person-centered service plan:

a. Identify a specific and individualized need.

b. Document the positive interventions and supports used prior to any modifications to the person-centered service plan.

c. Document less intrusive methods of meeting the need that have been tried but did not work.

d. Include a clear description of the condition that is directly proportionate to the specific assessed need.

e. Include regular collection and review of data to measure the ongoing effectiveness of the modification.

f. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

g. Include the informed consent of the individual.

h. Include an assurance that interventions and support will cause no harm to the individual.

24-hour child care facilities, foster care homes, and child placement agencies must also ensure compliance with the Colorado Department Human Services rules regarding the use of restrictive interventions at 10 CCR 2509-8.

Discipline in Foster Care Homes and 24-hour Child Care Facilities

A. The family foster care home, certifying authority, or 24-hour child care facility shall have written policies and procedures regarding discipline that must be explained to all children/ youth, parent(s), guardian(s), staff, and placing agencies. These policies must include positive responses to a child's appropriate behavior.

B. Discipline shall be constructive or educational in nature and may include talking with the child/youth about the situation, praise for appropriate behavior, diversion, separation from the problem situation, and withholding privileges.

C. Basic rights shall not be denied as a disciplinary measure.

D. Separation when used as a discipline must be brief and appropriate to the child/youth's age and circumstances. The child/youth shall always be within hearing of an adult in a safe, clean, well-lighted, well-ventilated room in the family foster care home that contains at least 50 square feet of floor space. No child/youth shall be isolated in a bathroom, closet, or pantry.

E. Children/youth in care at the family foster care home or facility shall not discipline other children/youth.

F. A family foster care home or facility shall prohibit all cruel and unusual discipline including, but not limited to, the following:

1. Any type of physical hitting or any type of physical punishment inflicted in any manner upon the body of the child/youth, such as spanking, striking, swatting, punching, shaking, biting, hair pulling, roughly handling a foster child, striking with an inanimate object, or any humiliating or frightening method of discipline to control the actions of any child/youth or group of children/youth.

2. Discipline that is designed to, or likely to, cause physical pain.

3. Physical exercises such as running laps, push-ups, or carrying heavy rocks, bricks, or lumber when used solely as a means of punishment.

4. Assignment of physically strenuous or harsh work that could result in harm to the foster child.

5. Requiring or forcing a child/youth to take an uncomfortable position such as squatting or bending, or

requiring a foster child to stay in a position for an extended length of time such as standing with nose to the wall, holding hands overhead, or sitting in a cross-legged position on the floor, or requiring or forcing a foster child to repeat physical movements when used solely as a means of punishment.

6. Verbal abuse or derogatory remarks about the child/youth his/her family, his/her race, religion, or cultural background.

7. Denial of any essential/basic program service solely for disciplinary purposes.

8. Deprivation of meals or snacks, although scheduled meals or snacks may be provided individually.

9. Denial of visiting or communication privileges with family, clergy, attorney, or caseworker solely as a means of punishment.

10. Releasing noxious, toxic, or otherwise unpleasant sprays, mists, or aerosol substances in proximity to the child/youth's face.

11. Denial of sleep.

12. Requiring the child/youth to remain silent for a period of time inconsistent with the child/youth's age, developmental level, or medical condition.

13. Denial of shelter, clothing, or bedding.

14. Withholding of emotional response or stimulation.

15. Discipline associated with toileting, toileting accidents, or lapses in toilet training.

16. Sending a child/youth to bed as punishment. This does not prohibit a family foster care home or facility from setting individual bedtimes for children/youth.

17. Force-feeding a child/youth.

18. Physical management, restraint, and seclusion.

All staff and foster care home providers will receive at least annual training on the rights of children and youth and the use of restrictive interventions, including discipline.

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 Human Services (CDHS) to monitor the use of restrictive interventions at licensed facilities. There is no preset schedule, however, regular announced and unannounced visits are made to the individual facilities and the Child Placement Agencies to review the documentation on the use of restrictive interventions. These record reviews include the appropriateness of the intervention, whether another de-escalation technique would have been more appropriate, whether there are patterns in using interventions, and whether a specific child(ren) appears to be subjected to intervention more often than other children in the facility.

If there are problems or complaints concerning the care or treatment of a child in a purchased Residential Child Care Facility or Child Placement Agency placement, or a report of violations of child care standards, the County Department of Human/Social Services (CDHS) shall report the circumstances to the State licensing or certifying authority within 24 hours. If the nature of the complaint involves an allegation of abuse or neglect, a report to the local investigating authority shall be made within 24 hours. CDHS submits a report monthly to HCPF on the number and type of providers surveyed and the findings.

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-CHRP service providers not licensed by CDHS. CDPHE conducts on-site recertification surveys of service agencies that include a review of the agency’s incident management practices, compliance with standards for incident reporting, and review and data analysis practices. Such surveys include a specific review of written incident reports documenting the use of interventions to ensure such reports contain the information required by the Department. When non-compliant use of interventions is detected, deficiencies are cited and the responsible agency is required to submit a plan of correction. Program Quality on-site surveys are completed at least every three years. CDPHE submits a report monthly to HCPF on the number and type of providers surveyed and the findings.

Critical Incident Reporting System (CIRS) Monitoring- The web-based CIRS system operated by the Department includes a specific data field for recording if any critical incident involved the use of restrictive interventions. Therefore, any use of a restrictive intervention in an allegation of serious abuse, medical crisis (i.e. needing emergency medical treatment), a crime against a person, or death is reported immediately to the Department. Such incidents receive additional scrutiny by the Department staff that includes a review of the original written incident report to ensure restrictive interventions were used in compliance with statutory and regulatory requirements. The CIRS monitoring operates on a daily/continuous basis.

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

Program Quality Surveys- The Department conducts regulatory surveys of CMAs that include a review of the agency's incident management practices, compliance with standards for incident reporting and review, and data analysis practices. Such surveys include a specific review of written incident reports documenting the use of restrictive interventions to ensure such reports contain the information required by 10 CCR 2505-10 § 8.608.4(A)(4) and 8.608.4(B) and that restrictive interventions are used only within the requirements specified in 10 CCR 2505-10 § 8.608.3 et seq. and 8.608.4 et seq. Additionally, on-site surveys of CMAs include a specific review of the local HRC review activities, the composition of the participant's interdisciplinary team, and an investigation of allegations of abuse related to unreasonable restrictive interventions. When non-compliant use of restrictive procedures, restraints, or any use of seclusion is detected, deficiencies are cited and the responsible agency is required to submit a plan of correction.

The Critical Incident Reporting Team monitors data on a monthly and quarterly basis. Provider trends are relayed to the Department's Benefits Division to address and determine appropriate actions as needed.

CIRs data are tracked, trended, and analyzed by the Critical Incident Reporting Team on a monthly and quarterly basis. Specific provider trends are relayed to the Benefits division to address and determine what improvement strategies need to be implemented.

Appendix G: Participant Safeguards

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

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

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

24-hour child care facilities, foster care homes, and child placement agencies must also ensure compliance with the Colorado Department Human Services rules regarding the prohibition of seclusion at 10 CCR 2509-8.

State oversight of the unauthorized use of seclusion is the responsibility of the Department. The Department conducts oversight through the following methods to detect unauthorized use of seclusion.

The Department maintains an Interagency Agreement with the Colorado Department of Human Services (CDHS) to monitor the use of seclusion at licensed facilities. The CDHS 24 Hour Licensing and Monitoring Unit and/or Child Care Licensing Specialist are responsible for oversight. There is no preset schedule, however, regular announced and unannounced visits are made to the individual facilities and the Child Placement Agencies.

If there are problems or complaints concerning the care or treatment of a child in a Residential Child Care Facility or Child Placement Agency placement, or a report of violations of child care standards, the county department shall report the circumstances to the licensing or certifying authority within 24 hours. If the nature of the complaint involves an allegation of abuse or neglect, a report to the local investigating authority shall be made within 24 hours.

The Department maintains an Interagency Agreement with the Colorado Department of Public Health and Environment to monitor the use of seclusion for HCPS-CHRP service providers not licensed by CDHS. CDHP conducts on-site recertification surveys of service agencies. When 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.

The Department also monitors for the unauthorized use of seclusion through the Department's 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 unauthorized use of seclusion in an allegation of serious abuse, medical crisis (i.e. needing emergency medical treatment), a crime against a person, or death is reported within 24 business hours to the Department. Such incidents receive additional scrutiny by the Department staff that includes a review of the original written incident report to ensure restrictive intervention was used in compliance with statutory and regulatory requirements. The CIRS monitoring operates on a daily/continuous basis.

○ **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-CHRP waiver service providers must complete on-site monitoring 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.

24-hour child care facilities, foster care homes, and child placement agencies must also ensure compliance with the CDHS rules regarding monitoring of medication administration practices in at 10 CCR 2509-8.

The Department maintains an Interagency Agreement (IA) with the Colorado Department of Human Services (CDHS) to monitor medication administration for 24-hour licensed child care facilities and foster care homes.

CDHS will make announced and unannounced visits to each facility and perform a complete check of the records to identify if the facility is following all rules including the monitoring and administration of medications for each child. Staff verify there is adequate locked storage for the medications and that the administration is in a written record for each child. If a medication error occurs, a report is made and becomes a part of the child's records at the facility. If the medication error results in contact with medical personnel to assess the situation, a critical incident will be completed by the facility and sent to the 24-Hour Licensing and Monitoring Unit for assessment.

As part of the health inspection and survey process, CDPHE reviews medication administration procedures, storage of all medication, including controlled substances, medication audit and disposal practices, and reporting required for drug reactions and medication errors. If deficiencies are cited in any of these areas, CDPHE will follow-up with the provider to ensure compliance with the regulations.

In addition, the Department monitors Critical Incident Reports submitted by providers for instances of a critical incident resulting from a medication management issue.

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 (IA) with the Colorado Department of Human Services (CDHS) to monitor medication administration for 24-hour licensed child care facilities and foster care homes. They will make announced and unannounced visits to each facility and perform a complete check of the records to identify if the facility is following all rules including the monitoring and administration of medications for each child. Staff verify there is adequate locked storage for the medications and that the administration is in a written record for each child. If a medication error occurs, a report is made and becomes a part of the child's records at the facility. If the medication error results in contact with medical personnel to assess the situation, a critical incident will be completed by the facility and sent to the 24-Hour Licensing and Monitoring Unit for assessment. CDHS submits a report monthly to HCPF on the number and type of providers surveyed and the findings.

The Department maintains an Interagency Agreement with the Colorado Department of Public Health and Environment (CDPHE) to monitor medication administration for HCBS-CHRP service providers not licensed by CDHS. 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 theses 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).

Under Colorado's statute, the Colorado Department of Public Health and Environment (CDPHE) has established minimum requirements for course content, including competency evaluations, for medication administration. CDPHE approves and maintains a list of approved training entities of medication administration courses. CDPHE also maintains a current list of persons who have passed the competency evaluation by an approved training entity.

The following requirements must be met when service providers administer medications:

The participant's PCSP must indicate assistance with medication administration is needed and the service provider agency must provide staff members that are legally authorized to administer medications.

If the direct service provider or staff member is non-licensed, he/she must have passed a medication administration training course and competency test through an approved training entity (does not apply to Foster Care Home providers). A physician or dentist must prescribe all medications administered by staff.

When medications are administered to a participant, the service provider agency must ensure that a written record of medication administration is maintained, including time and amount of medication taken by the person receiving services.

Prescription and non-prescription medications can be administered only with the written order of a person with prescriptive authority and with written parental consent. The written order must include the following:

1. Child's name
2. Licensed prescribing practitioner's name, telephone number, and signature
3. Date authorized
4. Name of medication and dosage
5. Time of day medication is to be given
6. Route of medication
7. Length of time the medication is to be given
8. Reason for the medication (unless confidential)
9. Side effects or reactions to watch for
10. Special instructions

24-hour child care facilities, foster care homes, and child placement agencies must also ensure compliance with the Colorado Department of Human Services rules for medication administration in 10 CCR 2509-8

Medications must be kept in the original labeled container. Prescription medications must contain the original pharmacy label that lists numbers one (1) through seven (7) above. All over-the-counter medication must remain in its original container and labeled with the child's first and last name.

If medications need to be given on an ongoing, long-term basis, the authorization and consent forms must be re-authorized on an annual basis. Any changes in the original medication authorization require a newly written order by the prescribing practitioner and a change in the prescription label. Verbal orders taken from the licensed prescriber may be accepted only by a licensed registered nurse.

Medications must be kept in an area, locked, and inaccessible to children. Controlled medications must be counted and safely secured, and specific policies regarding their handling require special attention in the facility's policies. A written medication log must be kept for each child. This log is part of the child's records. The log must contain the following:

1. Child's full name
2. Name of the medication, dosage, and route
3. Time medication is to be given
4. Special instructions
5. Name and initials of the individuals giving the medication
6. Notation if the medication was not given and the reason

Topical preparations such as petroleum jelly, diaper rash ointments, sunscreen, bug sprays, and other ointments may be administered to children with written parental authorization. These preparations may not be applied to open wounds or broken skin unless there is a written order by the prescribing practitioner.

The contents of any medication container having no label or with an illegible label shall be destroyed immediately. Medication with a specific expiration date shall not be administered after that date. Each facility shall document the disposal of discontinued, outdated, or expired medications.

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:

If the severity of the error warrants, it is reported to the Department of Health Care Policy and Financing through a critical incident report.

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

All medication errors must be recorded in a written medication log.

A written medication log must be kept for each child. This log is part of the child's records. The log must contain the following:
- Child's name
- Name of the medication, dosage, and route
- Time medication is to be given
- Special instructions
- Name and initials of the individuals giving the medication
- Notation if the medication was not given and the reason

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

Medication errors that must be reported to the State are those that result in the filing of a critical incident.

○ **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 the ongoing monitoring of the performance of providers that administer medications. To identify problems in provider performance, to support remediation, and to support quality improvement activities, the Department employs the following monitoring methods:

Monitoring Through the Critical Incident Reporting System (CIRS)- As identified in Appendix G.3.iii, specific types of medication errors are required to be reported as a critical incident in the web-based CIRS. Such reports are reviewed by the Department staff as soon as possible upon receipt but always before the end of the next business day and as part of monthly IRT meetings. The CIRS allows the Department staff to issue specific directives to the Case Management Agencies (CMAs) to ensure remediation of identified problems. Specific provider trends identified immediately or through monthly and quarterly reports, are relayed to the Department's Benefits staff to address and determine if further improvement strategies are needed.

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

Program Quality On-site Surveys- CDPHE, on behalf of the Department conducts on-site regulatory surveys of providers and includes a review of the agency's medication administration practices. These surveys evaluate the practices of the agency to ensure a) unlicensed direct support service providers have met state requirements for training and certification; b physician's orders for all medications; c) safe storage of medications; d) appropriate documentation of medication administration, refusals and errors; and e) that participants have a sufficient supply of medications. CDPHE submits a report monthly to HCPF on the number and type of providers surveyed and the findings.

CDHS has additional responsibility for medication administration oversight of the providers it licenses. CDHS performs this oversight through announced and unannounced visits to the facilities and agencies and by doing thorough record checks of medication logs, verifying the credentials for staff who administer medication to waiver participants, and follow-up on critical incidents when a medication error is reported. CDHS submits a report monthly to HCPF on the number and type of providers surveyed and the findings.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
G.a.1 # and % of waiver participants &/or family/guardians who received info/education on how to identify & report abuse, neglect, exploitation (ANE), unexplained death & other critical incidents (CI) N: # of waiver participants &/or family/guardians who rcvd info/ed on how to id & report ANE, unexplained death & other CI D: Total # of waiver participants &/or family/guardians in the sample

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

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

Data Aggregation and Analysis:

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

Performance Measure:
G.a.2 Number and percent of all critical incidents that were reported by the Case Management Agency (CMA) within required timeframe as specified in the approved waiver N: Number of all critical incidents reported by the CMA within the required timeframe as specified in the approved waiver D: Total number of all critical incidents reported by the CMA

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
G.a.3 Number and percent of all critical incidents that were remediated N: Number of all critical incidents that were remediated D: Total number of critical incidents

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

Reco

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

Data Aggregation and Analysis:

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

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

Performance Measure:
G.a.4 # and % of complaints against licensed waiver providers reported to CDPHE involving allegations of ANE that were resolved according to CDPHE regs N: # of complaints against licensed waiver providers reported to CDPHE involving allegations of ANE resolved according to CDPHE regs D: Total complaints against licensed waiver providers reported to CDPHE involving allegations of ANE

Data Source (Select one):
Other
If 'Other' is selected, specify:
Monthly Complaint Reports Submitted by CDPHE

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and**	☐ **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.a.6 Number and percent of newly enrolled and revalidated waiver providers trained on how to identify, address, and seek to prevent critical incidents N: # of newly enrolled and revalidated waiver providers trained on how to identify, address, and seek to prevent critical incidents D: Total # of newly enrolled and revalidated waiver providers

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

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

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

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

Performance Measure:
G.b.3 Number and percent of annual reports provided to Case Management Agencies (CMAs) on identified trends in critical incidents N: Number of annual reports provided to the CMAs on identified trends in critical incidents D: Total number of annual reports required to be provided to CMAs

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:
State's case management IT System Data and/or CDPHE Reports; Record Reviews

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

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

Data Aggregation and Analysis:

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
State's case management IT System Data/Critical Incident Reports

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

Data Aggregation and Analysis:

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

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

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

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

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

	Ongoing	Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
G.c.2 Number and percent of providers surveyed during the performance period that met requirements for use of physical or mechanical restraints. Numerator: Number of providers surveyed during the performance period that met requirements for use of physical or mechanical restraints Denominator: Total number of providers surveyed during the performance period.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
G.c.3 Number and percent of providers surveyed in the performance period that met requirements for implementing Rights Modification Numerator: Number of surveyed providers surveyed in the performance period that met the requirements for implementing Rights Modification Denominator: Total number of providers surveyed during the performance period

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
G.c.4 Number and percent of providers surveyed that met the requirements for the use of training and support plans with restrictive procedures Numerator: Number of providers surveyed that met the requirements for use of training and support plans with restrictive procedures Denominator: Total number of providers surveyed

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other**	☒ **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.c.6 Number and percent of waiver participants with Restrictive Intervention Plans where proper procedures were followed in initially establishing the Restrictive Intervention Plan N:# of wvr participants w/ Restrictive Intervention Plan where proper procedures were followed in initially establishing the Restrictive Intervention Plan D:# of wvr participants w/ a Restrictive Intervention Plan

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

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

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

Data Aggregation and Analysis:

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

Performance Measure:
G.d.3 Number and percent of waiver participants who received care from a medical professional within the past 12 months Numerator: The number of participants who received care from a medical professional within the last 12 months Denominator: The total number of participants reviewed

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

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

Data Aggregation and Analysis:

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

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

The Dept. uses information entered into the State's case management IT system 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. Following the receipt of the initial critical incident report, the QIO reviews the documentation to determine if the instance was substantiated. If the documentation does not clearly state whether instance was substantiated, the QIO requests follow up by the CMA to gather the needed information from the parties involved.

G.a.1
The Dept reviews the signature section in the State's case management IT system PCSP 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.6
CMAs and providers are required to attend preventative strategies trainings. Training records of preventative strategies training are maintained by the Dept.

G.b.3
The Dept. examines data for specific trends to include individuals that have multiple CIRs; identifies participants who have more than one CIR in 30 days, more than three CIRs in six months, and more than five CIRs in 12 months. The Dept. produces critical incident trend reports to be provided to all CMAs at least annually. Records of the reports and dates provided are maintained by the Dept.

G.b.4
The Dept. examines data in the CIRS to determine when critical incidents were preventable and whether resolutions were effective.

G.b.6
Root cause identified/trends reduced as a result of systemic intervention data are tracked and analyzed by the CIR Team on a monthly and quarterly basis including through mortality review committee.

G.c.1, G.c.2, G.c.3, G.c.4, G.c.6
The Dept monitors restrictive interventions to ensure all participants who need a restrictive intervention plan have one. The Dept. also monitors the inappropriate/ineffective use of restrictive interventions through the CIRS and provider survey reports. These incidents receive additional scrutiny by the Dept staff that includes review of the original written incident report to ensure restrictive intervention was used in compliance with statutory and

regulatory requirements. The CIRS monitoring operates on a daily/continuous basis.
Oversight and discovery of restrictive interventions where proper procedures were not followed are completed through the review of complaints regarding services and supports and conducting on-site surveys of CMAs by Dept. staff and providers by DPHE and CDHS.
Providers must demonstrate during the survey process that they have met requirements for the use of physical or mechanical restraints; requirements for implementing a restrictive intervention; met the requirements for use of training and support plans with restrictive interventions.

G.d.3
CCBs must demonstrate that participants receive a medical evaluation at least annually unless a greater or lesser frequency is specified by the participant's primary physician. The service provider is responsible for scheduling and notifying the CCB of the physical. The CCB must provide the date of physical to the Dept. on an annual basis.

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 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. The Dept. reviews CMA's remediation action plan and confirms the appropriate steps have been taken to correct the deficiencies.
In addition to annual data collection and analysis, Dept. contract managers and program administrators remediate problems as they arise based on the severity of the problem or by nature of the compliance issue. For issues 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 Dept 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 Dept ensures that the appropriate authority is notified of any unexplained deaths that resulted from substantiated MANE.

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
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, G.c.3, G.c.4
CDPHE/DHS notifies the agencies of deficiencies and determines the appropriate remedial actions: training, technical assistance, Plan of Correction, license revocation.

G.c.6
The Dept. takes remedial action to address with 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, and/or termination of CMA contract.

Continued in Main Section, under Optional

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified

strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

This Quality Improvement Strategy (QIS) encompasses all services provided in the CHRP waiver. The waiver specific requirements and assurances are included in the appendices.
The Department draws from multiple sources when determining the need for and methods to accomplish system design changes. Using data gathered from Colorado Department of Public Health and Environment (CDPHE), Critical Incident Reporting System (CIRS), annual programmatic and administrative evaluations, and stakeholder input, the Department's Office of Community Living Benefits and Services Management Division, in partnership with the Case Management Quality and Performance unit and Office of Information Technology (OIT), uses an interdisciplinary approach to review and monitor the system to determine the need for design changes, including those to the state's case management IT system. Work groups form as necessary to discuss prioritization and selection of system design changes.
Discovery and Remediation Information:
The Department maintains oversight over the (specify waiver) waiver in its contracts/interagency agreements through tracking of contract deliverables on a monthly, quarterly, semi-annually, and yearly basis, depending on the details of each agreement. The Department has access to, and reviews all required reports, documentation and communications. Delegated responsibilities of these agencies/vendors are monitored, corrected, and remediated by the Department's Office of Community Living.
Colorado selects a representative random sample (unless otherwise noted in the waiver application) of waiver participants for annual review, with a confidence level of 95% margin of error +/-5%, from the total population of waiver participants. The results obtained reflect systemic performance to ensure the waiver is responsive to the needs of all individuals served. The Department trends, prioritizes, and implements system improvements (i.e., design changes) prompted as a result of an analysis of the discovery and remediation information obtained.
To ensure the quality review process is completed accurately, efficiently, and in accordance with federal standards, the Department contracts with an independent Quality Improvement Organization (QIO) to complete the QIS Review Tool for the annual Case Management Agency (CMA) program case evaluations. Additionally, the Department performs an inter-rater reliability study of results provided by the QIO to determine accuracy of QIO reviews.
The Department uses standardized tools for level of care (LOC) eligibility determinations, person centered support planning, and critical incident reporting for waiver populations. Through use of the state's case management system, the data generated from LOC eligibility determinations, Person Centered Support Plans, and critical incident reports, and concomitant follow-up are electronically available to CMAs and the Department, allowing effective access and use for clinical and administrative functions as well as for system improvement activities. This standardization and electronic availability provides comparability across CMAs, waiver programs, and allows on-going analysis. In addition, the Department is on track to implement a new case management system in the Spring of 2022 to streamline processes for identifying member needs and coordinating support. This new system will eliminate the need for case managers to complete documentation in multiple systems which will reduce the chance for errors and/or missing information.

Waiver providers that are required by Medical Assistance Program regulations to be surveyed by CDPHE, must complete the survey prior to certification to ensure compliance with licensing, qualification standards and training requirements. The Department is provided with monthly and annual reports detailing the number and types of agencies that have been surveyed, the number of agencies that have deficiencies and types of deficiencies cited, the date deficiencies were corrected, the number of complaints received, and complaints investigated, substantiated, and resolved. Providers who are not in compliance with CDPHE and other state standards receive deficient practice citations. Department staff review all provider surveys to ensure deficiencies have been remediated and to identify patterns and/or problems on a statewide basis by service area, and by program. The results of these reviews assist the Department in determining the need for technical assistance, training resources, and other needed interventions. The Department initiates termination of the provider agreement for any provider who is in violation of any applicable certification standard, licensure requirements, or provision of the provider agreement and does not adequately respond to a plan of correction within the prescribed period of time.
Following Medicaid provider certification, the fiscal agent enrolls all providers in accordance with program regulations and maintains provider enrollment information in Colorado Medicaid Management Information System (MMIS), the interChange. All provider qualifications are verified by the fiscal agent upon initial enrollment and in a revalidation cycle; at least every five years.
The MMIS, interChange, is designed to meet federal certification requirements for claims processing and submitted claims are adjudicated against interChange edits prior to payment. Claims are submitted through the Department's fiscal agent for reimbursement. The Department also engages in a post-payment review of claims to ensure the integrity of provider billings.

The information gathered from the Department's monitoring processes is used to determine areas that need additional training/technical assistance, system improvements, and quality improvement plans.
Trending:
The Department uses performance results to establish baseline data, and to trend and analyze over time. The Department's aggregation and root cause analysis of data is incorporated into annual reports that provide information to identify aspects of the system which require action or attention.
Prioritization:
The Department relies on a variety of resources to prioritize changes in the BUS. In addition to using information from annual reviews, analysis of performance measure data, and feedback from case managers, the Department factors in appropriation of funds, legislation and federal mandates.
For changes to the MMIS, interChange, the Department has developed a Priority and Change Board that convenes monthly to review and prioritize system modifications and enhancements. Change requests are presented to the Board, which discusses the merits and risks of each proposal, then ranks it according to several factors including implementation dates, level of effort, required resources, code contention, contracting requirements, and risk. Change requests are tabled, sent to the fiscal agent for an order of magnitude, or cancelled. If an order of magnitude is requested, it is reviewed at the next scheduled Board meeting. If selected for continuance, the Board decides where in the priority list the project is ranked.
The Department continually works to enhance coordination with CDPHE. The Department engages in quarterly meetings with CDPHE to maintain oversight of delegated responsibilities; report findings and analysis; provider licensure/certification and surveys; provider investigations, corrective actions and follow-up. Documentation of inter-agency meeting minutes, decisions and agreements will be maintained in accordance with state record maintenance protocol.
Quality improvement activities and results are reviewed and analyzed amongst benefit administrators, case management specialists, and critical incidents administrators.
Implementation:
Prior to implementation of a system-level improvement, the Department ensures the following are in place:
- o Process to address the identified need for the system-level improvement;
- o Policy and instructions to support the newly created process;
- o Method to measure progress and monitor compliance with the system-level improvement activities including identifying the responsible parties;
- o Communication plan;
- o Evaluation plan to measure the success of the system-level improvement activities post-implementation;
- o Implementation strategy.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Quality Improvement Committee**	☒ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system

design changes. If applicable, include the state's targeted standards for systems improvement.

Monitoring and Analyzing System Design Changes:
The process used to monitor the effectiveness of system design changes will include systematic reviews of baseline data, reviews of remediation efforts and analysis of results of performance measure data collected after remediation activities have been in place long enough to produce results. Targeted standards have not been identified but will be created on baseline data once the baseline data has been collected.
Roles and Responsibilities:
The Office of Community Living Benefit and Services Management Division and the Case Management and Quality Performance Division hold primary responsibility for monitoring and assessing the effectiveness of system design changes to determine if the desired effect has been achieved. This includes incorporation of feedback from waiver participants, advocates, CMAs, providers, and other stakeholders.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Office of Community Living's Waiver Administration and Compliance Unit will review the QIS and its deliverables with management on a quarterly basis and will provide updates to CMS when appropriate. Evaluation of the QIS is the responsibility of the Benefit and Services Management Division, Waiver Administration and Compliance Unit and the Case Management and Quality Performance Division, Quality Performance Section. This evaluation will take into account the following elements:
1. Compliance with federal and state regulations and protocols.
2. Effectiveness of the strategy in improving care processes and outcomes.
3. Effectiveness of the performance measures used for discovery.
4. Effectiveness of the projects undertaken for remediation.
5. Relevance of the strategy with current practices.
6. Budgetary considerations.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- (●) **No**
- ( ) **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ( ) **HCBS CAHPS Survey :**
- ( ) **NCI Survey :**
- ( ) **NCI AD Survey :**
- ( ) **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the*

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

(a) Pursuant to 2 CFR Part 200 - Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards Subpart F – Audit Requirements §200.502 (i), Medicaid payments to a sub-recipient for providing patient care services to Medicaid eligible individuals are not considered federal awards expended under this part unless a State requires the funds to be treated as federal awards expended because reimbursement is on a cost-reimbursement basis. Therefore, the Department does not require an independent audit of waiver service providers.

Case Management Agencies (CMAs) are subject to the audit requirements within 2 CFR Part 200 for all Medicaid administrative payments. To ensure compliance with components detailed in the OMB Uniform Guidance, CMAs contract with external Certified Public Accountant (CPA) firms to conduct an independent audit of their annual financial statements and conduct the Single Audit when applicable.

(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 the completion of appropriate service notes regarding service provision each visit. Documentation shall contain services provided, date and time in and out, and a confirmation that care was provided. Such confirmation shall be according to agency policy. The Department specifies requirements for providers that are then surveyed and certified by CDPHE. In order for personal care providers to render services, they must ensure that individuals are appropriately trained and qualified.

Regarding the post-payment review of claims:

The Compliance Division within the Department exists to monitor provider and member compliance with state and federal regulations and Department policies. Division internal reviewers conduct post-payment reviews of provider claims submissions to ensure accuracy of provider billing and compliance with regulations and Department billing policies. Auditing under the Program Integrity and Contract Oversight (PICO) Section, housed within the Division, varies with the review project conducted—including the number and frequency of providers reviewed, the percentage of claims reviewed, and the time period of the claims reviewed. Review projects range in size and focus (i.e. whether on provider type or service type) and can either be a claims data-only review or include records submitted by providers. PICO Section reviewers are responsible for conducting research and creating annual work plans of what review projects will be completed. Data samples and records to be reviewed are typically selected at random.

Additionally, the PICO Section accepts and evaluates all referrals of possible fraud, waste, and abuse of a provider or member. The PICO Section also works with law enforcement agencies on all possible fraud investigations, as well as suspensions and terminations of provider agreements.

The PICO Section also oversees post-payment claims review contracts, specifically the Recovery Audit Contractor (RAC) program. As with the PICO Section's internal reviewers, the RAC is responsible for conducting research and creating

annual work plans of what review projects will be completed under their respective scope of work. Data samples and records to be reviewed are typically selected at random, however, the RAC is allowed to utilize proprietary algorithms to select providers and claims to audit.

All audit and compliance monitoring activities conducted by PICO Section and the RAC program aim to ensure provider compliance with the requirements of the Provider Participation Agreement and the Health First Colorado Program, specifically the HCBS Waivers Program and as required under §1915(c) of the Social Security Act. Each year, PICO Section reviewers will select a provider claims sample of Medicaid-paid services provided to individuals receiving benefits under the Dept's HCBS Waivers program. The sample will include 5,000 or more HCBS waiver claims from a single state fiscal year, pulled at the claim header level, to be reviewed each year. Individual claim lines that fall under each header are included in the review. The provider claims sample will be a statistically valid sample, reflecting a 95 percent confidence level with no more than a 5 percent margin of error; however, the sample may be greater than the 95 percent confidence level with no more than 5 percent margin of error at the discretion of the Department.

HCBS waivers and procedure codes are governed by different state and federal rules, regulations, and policies; each claim will be reviewed for compliance in accordance with the rules, regulations, and policies that are applicable. PICO Section reviewers will audit the provider claims sample by conducting a medical records review of those claims to verify that provider documentation substantiates the claims that were submitted to the Department. The PICO Section will utilize the RAC to also conduct audits when practical to ensure all reviews for the claims sample are being conducted timely and efficiently. The scope of a review is determined by appropriate means such as state and federal rules, referrals, internal and RAC resources, prioritization of work plans and other reviews that may require immediate attention (such as fraud investigations) as well as data analysis and mining to determine the extent of an issue.

All PICO Section reviews and the RAC utilize multiple regulation sources at the state and federal level to create review projects, as part of the Department's overall compliance monitoring of providers. Research and creation of annual work plans come from multiple sources, including reviewing fraud, waste, and abuse trends occurring locally and nationally, preliminarily reviewing claims data, reviewing referrals and provider self-disclosures, and employing data analytics tools and algorithms to identify possible aberrancies. In accordance with 10 C.C.R. 2505-10 8.076.2, provider compliance monitoring includes, but is not limited to:

- *Conducting prospective, concurrent, and/or post-payment reviews of claims.*
- *Verifying Provider adherence to professional licensing and certification requirements.*
- *Reviewing goods provided and services rendered for fraud and abuse.*
- *Reviewing compliance with rules, manuals, and bulletins issued by the Department, board, or the Department's fiscal agent.*
- *Reviewing compliance with nationally recognized billing standards and those established by professional organizations including, but not limited to, Current Procedural Terminology (CPT) and Current Dental Terminology (CDT).*
- *Reviewing adherence to the terms of the Provider Participation Agreement.*

Depending on the type of review project completed, additional rules are included in the criteria of a review project. For instance, with regard to audits of HCBS Waiver services rendered by Medicaid providers, review projects by PICO Section reviewers and the RAC will include whether providers are compliant with multiple HCBS Waiver programs. All PICO Section and RAC reviews are required to follow audit and recovery rules set forth in C.R.S. 25.5-4-301 and 10 C.C.R. 2505-10 Section 8.076.3.

All reviews that are conducted will be desk reviews, however, the Department and its vendors are required to conduct on-site reviews as required under Colorado regulation. Under 10 C.C.R. 2505-10 Section 8.076.2.E., providers are given the option of an inspection or reproduction of the records by the Department or its designees at the providers' site. All identified overpayment recoveries and suspected false claims and/or fraud will be reported to the PICO Section for review, as well as any additional agencies, including the Colorado Medicaid Fraud Control Unit. Any identified overpayments stemming from the reviews will follow rules set forth in 10 C.C.R. 2505-10 Section 8.076.3.

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

Additional information located in Main B. Optional

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

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

i. Sub-Assurances:

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

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
I.a.1. Number and percent of waiver claims coded and paid according to the reimbursement methodology in the waiver N: Number of waiver claims coded and paid according to the reimbursement methodology in the waiver D: Total number of paid waiver claims in this sample

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Medicaid Management Information System (MMIS) Claims Data

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =*

		95% confidence level with +/- 5% margin of error
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
I.a.3 Number and percent of paid waiver claims with adequate documentation that services were rendered N: Number of claims with adequate documentation of services

rendered D: Total number of claims in the sample

Data Source *(Select one):*
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95% confidence level with +/- 5% margin of error*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
I.b.1 Number and percent of claims paid where the rate is consistent with the approved rate methodology in the approved waiver N: Number of claims paid where the rate is consistent with the approved rate methodology in the approved waiver D: Total number of paid waiver claims reviewed

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Medicaid Management Information System (MMIS) Claims Data

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***

☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95% confidence level with +/- 5% margin of error*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*

Performance Measure:
I.b.2 Number and percent of rates adjusted that demonstrate the rate was built in accordance with the approved rate methodology. N: Number of rates adjusted that demonstrate the rate was built in accordance with the approved rate methodology D: Total number of rates adjusted reviewed

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Medicaid Management Information System (MMIS) Claims Data

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95% confidence level with +/- 5% margin of error*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

ii. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

The information gathered for the annual reporting of the performance measures serves as the Department's primary method of discovery.
The state ensures that claims are coded correctly through a number of mechanisms:
1. Rates are loaded with procedure code and modifier combinations, thus any use of incorrect coding results in a claim paid at $0.00 or a denied claim,
2. System edits exist to ensure that only specific (appropriate provider types) are able to bill for waiver services,
3. Finally, performing a review of claims in conjunction with the Department's published billing manual identifies any incorrect coding which resulted in a paid claim.

Duties of providers include a requirement of documentation of care, in/out times, and confirmation that care was provided per state rules and regulations. Additionally, there must be the completion of appropriate service notes regarding service provision for each visit. Documentation shall contain services provided, date and time in and out, and a confirmation that care was provided. Such confirmation shall be according to agency policy. This is then reviewed by DPHE upon survey.

All waiver services included in the participant's service plan must be prior authorized by case managers. Approved Prior Authorization Requests (PARs) are electronically uploaded into the MMIS. The MMIS validates the prior authorization of submitted claims. Claims submitted without prior authorization are denied.

When a claim is billed to Medicaid, in addition to the five elements above, the MMIS is configured to check for a Prior Authorization Request (PAR) that matches the procedure code, allowed units, a date span, and billing/attending provider prior to rendering payment. The claims data reported in the quality performance measures were pulled and analyzed from the MMIS.

I.a.1
This performance measure ensures that claims paid for waiver services have utilized the correct coding for each of the waiver services offered. Correct coding is defined as the use of the correct procedure code and modifier combination for each service as determined by the Department. Correct coding ensures that services are paid only when the services are approved, authorized, and billed correctly.

I.a.3
The Department utilizes the client's Prior Authorization Request (PAR) as documentation of services rendered. Case managers monitor service provision to ensure that services are being provided according to the service plan. Case managers inform the Department of discrepancies between a provider's claim and what the participant reports occur or if the participant reports that the provider is not providing services according to the service plan. The Department initiates an investigation to determine if an overpayment occurred.

I.b.1
This performance measure ensures paid claims for waiver services are paid at or below the rate as specified in the Provider Bulletin and HCBS Billing Manual. In addition, the Department posts all rates in the Provider Fee Schedule portion of the external website for providers to access at their convenience. This performance measure allows the Department to identify any system issues or errors resulting in incorrect reimbursement for services rendered.

I.b.2
Benefits and Services Management Division staff review the rate adjustments to confirm that rates adhere to the approved rate methodology in the waiver.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.*

Waiver administrators coordinate with the Department's Claims Systems and Operations Division staff to initiate any edits to the Medicaid Management Information System (MMIS) that are necessary for the remediation of any deficiencies identified by the annual reporting of performance measures.

Benefits and Services Management Division staff initiate any edits to the Medicaid Management Information System (MMIS) that are necessary for the remediation of any deficiencies identified by the annual reporting of performance measures. Any inappropriate payments or overpayments identified are referred to the PICO Section for investigation as detailed in Appendix I-1 of the application.

I.a.1
Any incorrect coding which resulted in paid claims is remediated by the Department. The Benefits and Services Management Division staff collaborates with the Department's Rates Division and Health Information Office to initiate any edits to the MMIS that are necessary for remediation of any deficiencies identified by the annual reporting of performance measures.
In the event an overpayment is discovered, an accounts receivable balance is established with the provider. Overpayments are referred to the PICO Section for investigation as detailed in Appendix I-1 of the waiver application.

I.a.3
In the event an overpayment is discovered, an accounts receivable balance is established with the provider. Overpayments are referred to the PICO Section for investigation as detailed in Appendix I-1 of the waiver application.

I.b.1
Errors identified during claims data analysis as paying in excess of the Department's allowable rate may be attributed to wrong rates in prior authorization forms or additional system safeguards not being in place by the Department. PAR entry errors are addressed with CMAs to prevent future billing errors. The providers receiving overpayments are notified of payment errors and the Department establishes an accounts receivable balance to recover overpayments. The Department reviews errors to determine what additional safeguards are needed to prevent future overpayments.

I.b.2
Benefits and Services Management Division staff coordinate with the Department's Claims Systems and Operations Division staff to initiate any edits necessary to the MMIS for the remediation of deficiencies identified during the performance measure reporting.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☒ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- (●) ***No***
- ( ) ***Yes***

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

The Home and Community-Based Service (HCBS) waiver Children's Residential Habilitative Program (CHRP) utilizes Fee-for-Service (FFS) and negotiated market price rate methodologies. Each rate has a unit designation and reimbursement is equal to the rate multiplied by the number of units utilized. HCBS CHRP FFS rate schedules are published through the Department's provider bulletin annually and posted to the Department's website.

The Department has adopted a rate methodology incorporating the following factors for all services not included in the negotiated price methodology described below:

A. Indirect and Direct Care Requirements:
Salary expectations for direct and indirect care workers based on the Colorado mean wage for each position, direct and indirect care hours for each position, the full-time equivalency required for the delivery of services to HCBS Medicaid clients, and necessary staffing ratios. Wages are determined by the Bureau of Labor Statistics and are updated by the Bureau every two years. Communication with stakeholders, providers, and clients aids in the determination of direct and indirect care hours required for service delivery Finally, collaboration with policy staff ensures the salaried positions, wages, and hours required to conform to the program or service design and are in compliance with the Code of Colorado Regulations and statutes.

B. Facility Expense Expectations:
Incorporates the facility type through the use of existing facility property records listing square footage and actual value. Facility expenses also include estimated repair and maintenance costs, utility expenses, and phone and internet expenses. Repair and maintenance price per square foot is determined by industry standards and varies for facilities that are leased and facilities that are owned. Utility pricing includes gas and electricity which are determined annually through the Public Utility Commission which provides summer and winter rates and 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 the 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 CHRP FFS rates utilizing the methodology described above include:

1. *Hippotherapy*
2. *Wraparound Services (Wraparound Plan and Prevention and Monitoring)*
3. *Movement Therapy*
4. *Massage Therapy*
5. *Respite (Respite Individual - In Home Family - unskilled, Respite Individual Day - In Home Family - unskilled, Respite CNA - In Home Family - 4 hours or less, Respite CNA - In Home Family - 4 hours or more, Therapeutic Respite - In Home Family - 4 hours or less, Therapeutic Respite - In Home Family - 4 hours or more, Skilled Respite - In Home Family - 4 hours or less, Skilled Respite - In Home Family - 4 hours or more)*
6. *Supported Community Connection Services*
7. *Child and Youth Mentorship*
8. *Habilitation: Foster Home (1-6)*
9. *Habilitation: Group Residential Services (1-6)*
10. *Habilitation: Residential Child Care Facility Levels 1-5*

The HCBS CHRP waiver utilizes a negotiated market price methodology for services in which reimbursement will differ

by client, by product, and by frequency of use. The services utilizing the negotiated market price methodology include:

1. *Habilitation: Residential Child Care Facility*
2. *Habilitation: Foster Home Level 7*

Residential Habilitation rates for individuals with Support Level 7 are individually determined. Service providers submit information regarding the individual's direct care requirements and associated costs. Department staff reviews and incorporates these factors into the rate-setting model to determine an individualized rate.

Residential Child Care Facility: In rare circumstances, due to extreme behavioral or medical support needs, the needs of an individual cannot be completely captured within the 5 standard Support levels. These individuals are categorized into a 6th Support Level for which the Residential Child Care Facility Habilitation rate is individually determined based upon the specific needs of the individual. Residential Child Care Facility Habilitation services also include Support Level 6 rates to recognize increased direct-service costs for these individuals.

Residential Child Care Facility Habilitation rates for individuals with Support Level 6 are individually determined. Service providers submit information regarding the individual's direct care requirements and associated costs. Dept staff reviews and incorporates these factors into the rate-setting model to determine an individualized rate.

The Department's Waiver and Fee Schedule Rates Section is the responsible entity for rate determination. Oversight of the rate determination process is conducted internally by a review of the rates and methodology by internal staff in Policy, Budget, and members of leadership. The Department also hosts stakeholder feedback meetings in which the rates and rate determination factors are presented to external stakeholders such as providers, clients, and client advocacy groups in order to determine additional rate determination factors to be included in the rate methodology which were not captured during the initial rate-setting process.

After the implementation of the rate, only legislative increases or decreases are applied. These legislative rate changes are often annual and reflect inflationary increases or decreases. The rates for the HCBS CHRP waiver are reviewed for appropriateness every five years with the waiver renewal. The Department reviewed the rate-setting methodology in 2017.
Rates are communicated via Departmental notices in provider bulletins, and tribal notices and are made available on the Department's external website to be accessed by stakeholders and providers at any time.

The Department regularly assesses rate efficiency, economy, quality of care, and sufficiency of provider populations by monitoring and analyzing paid claims utilization multiple times throughout the state fiscal year. The Department also analyzes geographic provider density to ensure clients are able to access waiver services. In addition to these processes, the Department regularly solicits external stakeholder feedback in order to assess whether rates are efficient and economic, allow for a high quality of care to be provided, and are sufficient to maintain the provider population.

The state's process for soliciting public comment on rate determination methods involves a standardized and documented process consisting of the Presentation of Rate Setting Methodology to stakeholders prior to or during rate-setting and solicitation of feedback on methodology, a 30-day period to receive feedback from providers and community stakeholders, publishing of the rates as determined by the state's methodology in conjunction with a stakeholder presentation reviewing the methodology, providing guidance on documents that would be provided to stakeholders, stakeholder deliverable sent to providers following presentation included all services and the direct/indirect care hours, wage, BLS position, and capital equipment included and offered providers an extended (60 day) period to offer feedback. All feedback is reviewed and feedback that can be validated is incorporated into the rates. All information from the stakeholder process is posted on the Department's external website. Additional information on public input is located in Main 6-I.

The structure of Respite Service delivery was adjusted from a tiered, assessment-based reimbursement to a settings-based reimbursement to allow services to be delivered in the client's home or in residential settings. This change is budget neutral and is effective on 7/01/2019.

Rates for all services furnished under the CHRP waiver were last reviewed in 2019 as part of the change to the Dept.'s approved rate methodology.

The State will, upon identification of the need, prospectively implement a differential in the rate structure to account for

variance in minimum wage requirements and acknowledgment of unique geographical considerations impacting access to care. Distinct rates by locality, county, metropolitan area or other types of regional boundaries will be implemented as the Department determines potential access to care considerations. Upon the subsequent waiver amendment or renewal, the Department will update the corresponding rate and any changes in methodology.

The State will use 9817 ARP funds for the minimum wage rate increases through April of 2023 and then will utilize state general funds approved by legislation starting in April of 2023.

Respite - 15 min and Respite Day were replaced by Respite Individual - In Home Family, Respite Individual Day - In Home Family, Respite Individual - In Residential Setting during amendment CO.0305.R05.11 with an approved effective date of July 1, 2021.

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:*

eProviders may submit claims directly to the MMIS.

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. The CBMS requires that the start date of an approved level of care certification period be entered prior to a participant being able to receive waiver services. The level of care certification period can be for up to twelve months.

(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. Providers are required to maintain documents in accordance with the post-payment review process described in section I-1 of this waiver application.

When the Department recovers money from a provider based on inappropriate billings a Demand Letter is sent specifying the amount owed and the claims affected. The provider then has the right to request an informal reconsideration and/or an appeal. Once this process is complete the Department determines the final amount owed by the provider. From the amount demanded back, the Department returns the FFP by calculating the federal portion of each claim demanded. The FFP is returned.

The Dept operates an Electronic Visit Verification (EVV) system to document that a variety of HCBS services are provided to members.

Electronic Visit Verification (EVV) is a technology used to verify that home or community based service visits occur. The purpose of EVV is to ensure that services are delivered to people needing those services and that providers only bill for services rendered. EVV typically verifies visit information through a mobile application on a smart phone or tablet, a toll-free telephone number, or a web-based portal.

EVV captures six points of data as required by the 21st Century Cures Act: individual receiving the service, attendant providing the service, type of service provided, location of service delivery, date of service, and time that service provision begins and ends.

The Department implemented a hybrid or open EVV model. The State contracts with an EVV vendor for a state-managed solution. This solution is available to providers at no cost. Providers may also choose to utilize an alternate EVV system procured and managed by the provider agency. The State's EVV Solution and Data Aggregator for alternate vendor data transfer are available for use.

Services which must be electronically verified: As of August 3, 2020, , the Department implemented EVV for federally mandated and additional services that are similar in nature and service delivery. The Department mandates Electronic Visit Verification (EVV) per CCR 2505-10 Section 8.001. Required EVV waiver services include:
Respite

The Department also mandates EVV for the following State Plan Services:
Home Health
Hospice
Occupational Therapy
Pediatric Behavioral Therapies
Pediatric Personal Care
Physical Therapy
Private Duty Nursing
Speech Therapy

On February 1, 2022, the Department activated a pre-payment EVV claim edit. EVV-required services, excluding CDASS and hospice, require corresponding EVV records prior to payment. This has resulted in improved provider compliance and better oversight of service provision.

Provider agencies utilizing the State EVV Solution have access to a portal to view and modify visit activity, and in limited circumstances, create EVV records. All information entered via the provider portal is notated as manual entry or edit and is subject to Department audit.

In the event the caregiver is unable to collect EVV data at the time of service delivery, provider agencies will need to enter missing data. Within the State EVV Solution, an agency administrator may complete visit maintenance in the EVV Solution provider portal. The administrator will enter the missing data and select a reason code on why a manual entry was done. Manual entry may be entered on a case-by-case basis. Manual entries are subject to increased scrutiny by the Department and providers must maintain service records for these visits.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

- (●) ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***
- ( ) ***Payments for some, but not all, waiver services are made through an approved MMIS.***

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) ***Payments for waiver services are not made through an approved MMIS.***

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

  Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☒ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☐ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***

○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

- ◉ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- ○ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

- ○ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ◉ **No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- ○ **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ◉ **No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- ○ **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- ◉ **The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ○ **The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ○ ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ○ ***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

- ☒ ***Appropriation of State Tax Revenues to the State Medicaid agency***
- ☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

- ☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable***. *There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***

○ ***The following source(s) are used***

Check each that applies:

☐ ***Health care-related taxes or fees***

☐ ***Provider-related donations***

☐ ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ○ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- ◉ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

The rate setting methodology approved by Health Care Policy & Financing (the Department) that establishes the residential habilitation payment excludes all costs associated with room and board. All individuals receiving Residential Habilitation services are required to utilize their income to pay the provider the amount established by the Department, or the Colorado Department of Human Services for children in foster homes, to cover room and board. The Department's rules specifically exclude the costs of room and board.

The facility costs only include common space and do not include the actual residential space for the client (i.e. the client's room). Costs for raw food and meals are also not included in the rate setting methodology.

The Department does not include costs of food costs or for the living area when calculating the rate for Facility Based Respite Care; although 42 CFR §441.310(a)(2) does allow for the cost of room and board to be claimed when it is provided as part of respite services that are delivered in a facility that is not a private residence.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ○ ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing *(1 of 5)*

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***

○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

☐ ***Nominal deductible***

☐ ***Coinsurance***

☐ ***Co-Payment***

☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***

○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: 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	*30454.29*	*50578.24*	*81032.53*	*252650.48*	*10331.42*	*262981.90*	*181949.37*
2	*33879.76*	*51433.01*	*85312.77*	*272710.93*	*10995.73*	*283706.66*	*198393.89*
3	*43217.46*	*74650.78*	*117868.24*	*294364.18*	*11702.76*	*306066.94*	*188198.70*
4	*54655.63*	*41009.66*	*95665.29*	*317736.70*	*12455.25*	*330191.95*	*234526.66*
5	*76547.15*	*48703.78*	*125250.93*	*342964.99*	*13256.12*	*356221.11*	*230970.18*

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	***81***	*81*
Year 2	***97***	*97*
Year 3	***144***	*144*
Year 4	***230***	*230*
Year 5	***260***	*260*

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.*

Typically, the Department estimates the average length of stay (ALOS) on the waiver by reviewing historical data included in the annual 372 data report. Due to the forecasted extreme growth in enrollment in the CHRP waiver, the Department was not able to use historical 372 data to predict a trend for ALOS. Instead, the Department took the number of estimated new enrollments, assumed they would be added to the waiver in a monthly linear fashion through the fiscal year, and then calculated what the ALOS would be if that were the case.

The Department did not utilize specific years for the ALOS for CHRP because there has never been such growth in the waiver forecast which significantly impacts the ALOS. Instead, the Department assumed a linear ramp-up of enrollments and assumed the average ALOS for those that joined in July for a full year. For those that joined in January, for example, their ALOS was calculated to be half of the FY 2017-18 value of 262 (which results in 82). The Department calculated this for every month and calculated a weighted average to get to the ALOS.

Update for WYs 3-5 for Amendment with a requested effective date of 7/01/2021:
The Department estimated the average length of stay (ALOS) on the waiver by reviewing historical data included in the annual 372 data report. Given the large projected increases in CHRP enrollment, ALOS is expected to drop and then move quite a bit until enrollment levels out. The Department assumed monthly linear ramp-ups for enrollment each year and calculated ALOS based on monthly additions and existing enrollments. In 2019, the State changed the eligibility criteria surrounding CHRP enrollments, specifically regarding foster care youth eligibility. This eligibility change resulted in an influx of new clients onto the CHRP waiver. Because of the sporadic enrollments throughout SFY 2019-20, ALOS was artificially low. As the newly enrolled CHRP clients begin receiving services, the State anticipates that the ALOS will begin to return to pre-SFY 2019-20 levels. For WYs 3-5, The Department has selected an annual trend of 0.27%, which is equal to the average annual growth from SFY 2013-14 to SFY 2018-19, based on data from the CMS 372s.

Update for WYs 4-5 for Amendment with a requested effective date of 7/01/2022:
The Department estimated the average length of stay (ALOS) on the waiver by reviewing historical data included in the annual 372 data report. Given the large projected increases in CHRP enrollment, ALOS is expected to drop and then move quite a bit until enrollment levels out. The Department assumed monthly linear ramp-ups for enrollment each year and calculated ALOS based on monthly additions and existing enrollments. In 2019, the State changed the eligibility criteria surrounding CHRP enrollments, specifically regarding foster care youth eligibility. This eligibility change resulted in an influx of new clients onto the CHRP waiver. Because of the sporadic enrollments throughout SFY 2019-20, ALOS was artificially low. As the newly enrolled CHRP clients begin receiving services, the State anticipates that the ALOS will begin to return to pre-SFY 2019-20 levels. For WYs 4-5, The Department has selected an annual trend of 0.27%, which is equal to the average annual growth from SFY 2013-14 to SFY 2018-19, based on data from the CMS 372s.

Update for WY 5 for Amendment with the requested effective date of 7/01/2023:
The Department estimated the average length of stay (ALOS) on the waiver by reviewing historical data included in the annual 372 data report. Given the large projected increases in CHRP enrollment, ALOS is expected to drop and then move quite a bit until enrollment levels out. The Department assumed monthly linear ramp-ups for enrollment each year and calculated ALOS based on monthly additions and existing enrollments. In 2019, the State changed the eligibility criteria surrounding CHRP enrollments, specifically regarding foster care youth eligibility. This eligibility change resulted in an influx of new clients onto the CHRP waiver. Because of the sporadic enrollments throughout SFY 2019-20, ALOS was artificially low. As the newly enrolled CHRP clients begin receiving services, the State anticipates that the ALOS will begin to return to pre-SFY 2019-20 levels. For WY 5, The Department has selected an annual trend of 1.89%, which is equal to the average annual growth from SFY 2016-17 to SFY 2020-21, based on data from the CMS 372s.

The growth rate from FY 2015-16 to FY 2016-17 was 13.39%. The growth rate from FY 2016-17 to FY 2017-18 was -11.69%. The growth rate from FY 2017-18 to FY 2018-19 was 8.97%. The growth rate from FY 2018-19 to FY 2019-20 was -40.89%. The growth rate from FY 2019-20 to FY 2020-21 was 39.66%. The average of these five growth rates is 1.89%.

The Department estimated ALOS for SFY 2021-22 through SFY 2023-24 by averaging expected ALOS for new members and existing members.

The Department used SFY 2018-19 ALOS for existing clients and used SFY 2021-22 Department data for the number of new clients enrolled each month of SFY 2021-22. This produces an estimated ALOS of 267 days. Based on the number of

enrollments expected in SFY 2022-23, the Department calculated an ALOS of 280 days for new clients.

The Department trended forward by 1.89% from SFY 2021-22 to SFY 2022-23 and SFY 2022-23 to SFY 2023-24 in order to get the WY5 ALOS of 285.

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 uses the CMS 372 reports as the source of data to estimate the number of users, units per user, and cost per unit. The most recent 372 used was from SFY 2019-20. 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.

Certain years of data are not included because they are considered to be outliers based on out-of-date policy, sudden changes in utilization, new limits placed on services, or some other reason. By policy and procedure, these characteristics are used to determine when data is an outlier. The state will make available to CMS upon request, the specific characteristics of the data outlier of a specific service.

Historical growth rates: The source of data is 372 waiver reports. The Department reviews data from SFY 2007-08 through SFY 2019-20 but might only include certain SFYs in the development of trends. For example, the Department may look at data from SFY 2007-08 and beyond but apply a trend that only incorporates growth rates from SFY 2016-17 and SFY 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 SFY 2007-08 however the Department focuses on more recent data for trend development.

Graphical trends: In some cases, the Department will plot the data in a graph to try and discern a reliable trend. This could be done for the following forecast elements: number of utilizers or units per utilizer. Graphical trends would not be used for rates.

Rates included in the Department's Cost Neutrality Demonstration may not match the Department's published rate schedule. In order to accurately project total expenditures for a service, the avg. cost/unit may be adjusted to account for a particular rate being implemented for less than a 12-month period.

The following is a list of the services in CHRP with a description of their legislative rate reduction/increase. The following services received the (A) 1% reduction on 7/01/2020:

- *Habilitation-Foster Home Level 1*
- *Habilitation-Foster Home Level 2*
- *Habilitation-Foster Home Level 3*
- *Habilitation-Foster Home Level 4*
- *Habilitation-Foster Home Level 5*
- *Habilitation-Foster Home Level 6*
- *Habilitation-Group Home Level 1*
- *Habilitation-Group Home Level 2*
- *Habilitation-Group Home Level 3*
- *Habilitation-Group Home Level 4*
- *Habilitation-Group Home Level 5*
- *Habilitation-Group Home Level 6*
- *Respite-15 min In Family Home*
- *Respite-Day In Family Home*
- *Respite-15 min In Residential Setting*
- *Respite-Day In Residential Setting*
- *Transition Support Services-Wraparound Plan*
- *Transition Support Services-Prevention and Monitoring*
- *Transition Support Services-In-Home Support*
- *Community Connector-Supported Community Connections*
- *Hippotherapy-Individual*

• Hippotherapy-Group
• Intensive Support Services-Wraparound Plan
• Intensive Support Service-Prevention and Monitoring
• Intensive Support Service-In-Home Support
• Massage Therapy
• Movement Therapy-Bachelors
• Movement Therapy-Masters

Following is (B) the Residential Child Care Facility that will be effective on 1/1/2021:
[Note: The rates listed below will not match the Department's Cost Neutrality Demonstration. In order to accurately project total expenditures for the service, the avg. cost/unit is adjusted to account for the rate being implemented for less than a 12-month period.]

• Habilitation-Residential Child Care Facility Level 1: This rate is being increased from $83.09 to $510.35 on 1/1/2021.
• Habilitation-Residential Child Care Facility Level 2: This rate is being increased from $109.38 to $531.95 on 1/1/2021.
• Habilitation-Residential Child Care Facility Level 3: This rate is being increased from $128.86 to $559.95 on 1/1/2021.
• Habilitation-Residential Child Care Facility Level 4: This rate is being increased from $152.22 to $589.00 on 1/1/2021.
• Habilitation-Residential Child Care Facility Level 5: This rate is being increased from $168.17 to $620.00 on 1/1/2021.
• Habilitation-Residential Child Care Facility Level 6: This rate is being increased from $198.29 to $700.00 on 1/1/2021.

Update for WYs 3-5 for Amendment with requested effective date of 7/01/2021:
For each individual service, the Department considered the number of clients utilizing each service, the number of units per user, the average cost per unit, and the total cost of the service. The Department examined historical growth rates, the fraction of the total population that utilized each service, and graphical trends. Once the historical data was analyzed, the Department selected trend factors to forecast, the number of clients utilizing each service, the number of units per user, and the average cost per unit. Caseload, utilization per client, and cost per unit are multiplied together to calculate the total expenditure for each service and added to derive Factor D. For services that have multiple service levels, these service levels are shown separately.

The growth in expenditure in SFY 2020-21 is driven by high enrollment in SFY 2019-20 and SFY 2020-21; the addition of new services, including Residential Child Care Facilities (RCCF); and the long-term effects of targeted rate increases to RCCFs.

Historical growth rates: The source of data is 372 waiver reports. The Department reviews data from SFY 2007-08 through SFY 2018-19 but might only include certain SFYs in the development of trends. For example, the Department may look at data from SFY 2007-08 and beyond but apply a trend that only incorporates growth rates from SFY 2016-17 and SFY 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 SFY 2007-08 however the Department focuses on more recent data for trend development.

Graphical trends: In some cases, the Department will plot the data in a graph to try and discern a reliable trend. This could be done for the following forecast elements: number of utilizers or units per utilizer. Graphical trends would not be used for rates.

Movement Therapy, Community Connector, Transition Support Services, and Intensive Support Services services were updated to include telehealth service delivery options, although there may not have been a cost-per-unit differential to the traditional delivery methods.

All services were updated to include the most recent 372 data (SFY 2018-19), which did not include telehealth utilization since telehealth was not established as an option in SFY 2018-19.

Update for WYs 3-5 for Amendment with requested effective date of 01/01/2022:
Factor D was updated to include a 2.5% ATB rate increase approved by the Colorado State Legislature in 2021 for all services, excluding the following services: Habilitation-Residential Child Care Facility Leve 6.

Update for WYs 4-5 for Amendment with requested effective date of 07/01/2022:
The growth in expenditure in SFY 2020-21 is driven by high enrollment in SFY 2019-20 and SFY 2020-21; the addition of new services, including Residential Child Care Facilities' rates effective 1-1-2021; and the long-term effects of targeted rate increases to RCCFs.

Historical growth rates: The source of data is 372 waiver reports. The Department reviews data from SFY 2007-08 through SFY 2019-20 but might only include certain SFYs in the development of trends. For example, the Department may look at data from SFY 2007-08 and beyond but apply a trend that only incorporates growth rates from SFY 2016-17 and SFY 2017-18.

The slight decrease in Factor D for WYs 4 and 5 is due to small changes in utilizer and units per utilizer projections resulting from new data for SFY 2019-20 as reported on the 372. This is primarily the case for services that were implemented in SFY 2019-20, which prior to the SFY 2019-20 372 reports, the State-based utilization projections on the utilization of similar services on different waivers. After receiving the first year of actuals on SFY 2019-20 372 reports, the State is now able to project more accurate figures for the newly added services.

For Foster Home Level 3, Foster Home Level 4, and Foster Home Level 6. The Department's main trend for units per utilizer is the average of the previous two years of actuals, as reported on 372 reports. Utilization reported on the SFY 2019-20 372 report came in lower than expected, resulting in a decrease in utilization for future WYs. Additionally, during the COVID-19 pandemic, utilization trends changed significantly compared to previous year trends.
SFY 2019-20 was the first year that Movement Therapy was offered. The State's projections prior to this amendment were based on the utilization of other services. SFY 2019-20 utilization reported on the 372 report was used to re-evaluate the trend, resulting in a decrease in the projection for future WYs.

SFY 2019-20 was the first year that Respite Individual - In Home Family and Respite Individual - In Residential Settings were offered. The State's projections of utilization for these services prior to this amendment were based on the utilization of other services. SFY 2019-20 utilization reported on the 372 report was used to re-evaluate the trend, resulting in a decrease in the projection for future WYs.

Hippotherapy and Hippotherapy Group: The States' current data utilization and authorization only show two distinct users for this service with 0 units utilized since 2019. CHRP's unduplicated client count is the lowest among IDD waiver programs, and utilization of newly added services is difficult to project. Initial estimates were developed assuming the Hippotherapy service in the CHRP waiver would increase, similar to the CES waiver. The State is not seeing an increase similar to the Hippotherapy service in the CES waiver and thus assumed future utilization for CHRP Hippotherapy and Hippotherapy group will be 5% of the total waiver enrollment.

Additional Information located in Main B. Optional

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

To calculate State Plan services costs associated with CHRP Waiver clients, the Department analyzed historical D' values using the CMS 372 report from FY 2017-18 as the source data. D' has been increasing fairly steadily since FY 2012-13. The Department has chosen half the average cost per client growth rate in forecast years by calculating an average two-year growth (FY 2016-17 and FY 2017-18). The Department believes that there will be small positive growth in the state plan cost per client as the redesigned waiver picks up. The claims information used in the derivation of Factor D' does not contain costs for prescribed drugs for those dually eligible for Medicare and Medicaid as those claims are not tracked in the MMIS system. Therefore, the costs of those drugs are not included in the estimate of Factor D'.

Update for WYs 4-5 for Amendment with a requested effective date of 07/01/2022:

Factor D' value for FY 2018-19 was $70,990.40, which was much higher than in prior years. Factor D' value reported on the FY 2019-20 372 was $38,998.82, which is more consistent with historical values. As such, the State has elected to use FY 2019-20 data as the base value for projections, trending the value by a proportion of historical growth, not including the FY 2018-19 amount.

Update for WY 5 for Amendment with the requested effective date of 7/1/2023:
To calculate State Plan services costs associated with CHRP Waiver clients, the Department analyzed historical D' values from the annual 372 reporting from SFY 2012-13 through SFY 2020-21. D' has been increasing fairly steadily since SFY 2012-13. The Department does not believe the 18.76% increase in cost per client from SFY 2019-20 to SFY 2020-21. The Department has chosen half the average cost per client growth rate in forecast years by calculating the average two-year growth of SFY 2016-17 and SFY 2017-18. The Department believes that there will be small positive growth in state plan cost per client as the redesigned waiver picks up. The claims information used in the derivation of Factor D' does not contain costs for prescribed drugs for those dually eligible for Medicare and Medicaid as those claims are not tracked in the MMIS system. Therefore, the costs of those drugs are not included in the estimate of Factor D'.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

.To calculate ICF/IID costs, the Department examined utilization and average per-user ICF/IID costs. The Department trended expenditure using half the growth of FY 2016-17. The source of the ICF/IDD data used to calculate Factor G is ICF claims data during the ICF span on an individual member basis, included in 372s. It was difficult to discern an appropriate trend given 372 actuals for Factor G as the most recent growth in FY 2016-17 appears to be an outlier. The Department decided to bring down the most recent year's growth by putting weight on the most recent data and putting weight on what has happened historically. The Department decided to use half of the FY 2016-17 growth rate. The Department focused on FY 2015-16 and FY 2016-17 to develop the trend The Department projected the value for Factor G for WY1 by using the FY 2016-17 actual value and trending it forward by 7.94% each following year (half the growth in FY 2016-17).

Update for WY 5 for Amendment with the requested effective date of 7/1/2023:
The Department did not update Factor G figures from the approved waiver.

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 since FY 2015-16 and chose a future trend that is 1/2 of the FY 2016-17 growth rate. The source for the state plan costs for IDF/IDD clients is claims and capitation data during the ICF span on an individual member basis, included in 372s The Department used 372 data to forecast Factor G' using FY 2016-17 (most recent available). It was difficult to discern an appropriate trend given 372 actuals for Factor G' as the most recent growth in FY 2016-17 appears to be an outliner. The Department decided to bring down the most recent year's growth by putting weight on the most recent data and putting weight on what has happened historically. The Department decided to use half of the FY 2016-17 growth rate. The Department focused on FY 2015-16 and FY 2016-17 to develop the trend. The Department projected the value for Factor G' for WY1 by using the FY 2016-17 actual value and trending it forward by 7.94% each following year (half the growth in FY 2016-17).

Update for WY 5 for Amendment with the requested effective date of 7/1/2023:
The Department did not update Factor G' figures from the approved waiver.

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	
Habilitation	
Respite	
Wraparound Services	
Child and Youth Mentorship	
Community Connector	
Hippotherapy	
Massage Therapy	
Movement Therapy	

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*
Habilitation Total:						***2374461.50***
Foster Home Level 1	*Day*	*1*	*28.00*	*56.67*	***1586.76***	
Foster Home Level 2	*Day*				***19774.80***	
				GRAND TOTAL:		***2466797.79***
				Total Estimated Unduplicated Participants:		***81***
				Factor D (Divide total by number of participants):		***30454.29***
				Average Length of Stay on the Waiver:		*195*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		1	216.00	91.55		
Foster Home Level 3	Day	7	307.70	111.86	240935.25	
Foster Home Level 4	Day	5	240.52	136.21	163806.15	
Foster Home Level 5	Day	15	214.08	156.49	502520.69	
Foster Home Level 6	Day	11	312.96	196.70	677151.55	
Group Home Level 1	Day	1	28.00	83.09	2326.52	
Group Home Level 2	Day	1	48.00	109.38	5250.24	
Group Home Level 3	Day	2	270.25	128.86	69648.83	
Group Home Level 4	Day	6	83.50	152.22	76262.22	
Group Home Level 5	Day	10	275.50	168.17	463308.35	
Group Home Level 6	Day	4	191.50	198.29	151890.14	
Residential Child Care Facility Level 1	Day	0	0.00	0.01	0.00	
Residential Child Care Facility Level 2	Day	0	0.00	0.01	0.00	
Residential Child Care Facility Level 3	Day	0	0.00	0.01	0.00	
Residential Child Care Facility Level 4	Day	0	0.00	0.01	0.00	
Residential Child Care Facility Level 5	Day	0	0.00	0.01	0.00	
Residential Child Care Facility Level 6	Day	0	0.00	0.01	0.00	
Foster Home Level 7	Day	0	0.00	0.01	0.00	
Group Home Level 7	Day	0	0.00	0.01	0.00	
Respite Total:						70638.51
Respite - 15 min	15 min	16	728.00	5.55	64646.40	
Respite - Day	Day	3	9.00	221.93	5992.11	
Respite Individual - In Home Family - unskilled	15 min	0	0.00	0.01	0.00	

GRAND TOTAL:	2466797.79
Total Estimated Unduplicated Participants:	81
Factor D (Divide total by number of participants):	30454.29
Average Length of Stay on the Waiver:	195

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Individual Day - In Home Family - unskilled	Day	0	0.00	0.01	0.00	
Respite Individual - In Residential Setting	15 min	0	0.00	0.01	0.00	
Respite Individual Day - In Residential Setting	Day	0	0.00	0.01	0.00	
Respite CNA - In Home Family - 4 hours or less	15 min	0	0.00	0.01	0.00	
Respite CNA - In Home Family - 4 hours or more	Day	0	0.00	0.01	0.00	
Therapeutic Respite - In Home Family 4 hours or less	15 min	0	0.00	0.01	0.00	
Therapeutic Respite - In Home Family - 4 hours or more	Day	0	0.00	0.01	0.00	
Skilled Respite - In Home Family - 4 hours or less	15 min	0	0.00	0.01	0.00	
Skilled Respite - In Home Family - 4 hours or more	Day	0	0.00	0.01	0.00	
Wraparound Services Total:						0.00
Wraparound Plan	15 min	0	0.00	0.01	0.00	
Prevention and Monitoring	15 min	0	0.00	0.01	0.00	
Child and Youth Mentorship Total:						0.00
Child and Youth Mentorship	15 min	0	0.00	0.01	0.00	
Community Connector Total:						3681.50
Supported Community Connections	15 min	1	370.00	9.95	3681.50	
Hippotherapy Total:						5492.60
Hippotherapy - Individual	15 min	4	63.00	21.65	5455.80	
Hippotherapy - Group	15 min	4	1.00	9.20	36.80	
Massage Therapy Total:						4588.80
Massage Therapy	15 min	4	60.00	19.12	4588.80	
Movement Therapy Total:						7934.88
Bachelors					7934.88	

GRAND TOTAL:	2466797.79
Total Estimated Unduplicated Participants:	81
Factor D (Divide total by number of participants):	30454.29
Average Length of Stay on the Waiver:	195

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	15 min	4	122.00	16.26		
Masters	15 min	4	0.00	23.83	0.00	
				GRAND TOTAL:		2466797.79
				Total Estimated Unduplicated Participants:		81
				Factor D (Divide total by number of participants):		30454.29
				Average Length of Stay on the Waiver:		195

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
Habilitation Total:						3147768.32
Foster Home Level 1	Day	1	28.00	56.10	1570.80	
Foster Home Level 2	Day	1	216.00	90.63	19576.08	
Foster Home Level 3	Day	8	307.70	110.74	272597.58	
Foster Home Level 4	Day	6	240.52	134.85	194604.73	
Foster Home Level 5	Day	18	214.08	154.93	597013.46	
Foster Home Level 6	Day	13	312.96	194.73	792255.11	
Group Home Level 1	Day	1	28.00	82.26	2303.28	
Group Home Level 2	Day	1	48.00	108.29	5197.92	
Group Home Level 3	Day	3	270.25	127.57	103427.38	
Group Home Level 4	Day	7	83.50	150.70	88084.15	
Group Home Level 5	Day	12	275.50	166.49	550415.94	
Group Home Level 6					187966.82	
				GRAND TOTAL:		3286336.37
				Total Estimated Unduplicated Participants:		97
				Factor D (Divide total by number of participants):		33879.76
				Average Length of Stay on the Waiver:		259

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Day	5	191.50	196.31		
Residential Child Care Facility Level 1	Day	1	28.00	296.72	8308.16	
Residential Child Care Facility Level 2	Day	1	100.00	320.67	32067.00	
Residential Child Care Facility Level 3	Day	1	263.00	344.41	90579.83	
Residential Child Care Facility Level 4	Day	3	120.00	370.61	133419.60	
Residential Child Care Facility Level 5	Day	3	51.00	394.09	60295.77	
Residential Child Care Facility Level 6	Day	3	6.00	449.15	8084.70	
Foster Home Level 7	Day	0	0.00	0.01	0.00	
Group Home Level 7	Day	0	0.00	0.01	0.00	
Respite Total:						106499.40
Respite - 15 min	15 min	24	780.00	5.35	100152.00	
Respite - Day	Day	3	10.00	211.58	6347.40	
Respite Individual - In Home Family - unskilled	15 min	0	0.00	0.01	0.00	
Respite Individual Day - In Home Family - unskilled	Day	0	0.00	0.01	0.00	
Respite Individual - In Residential Setting	15 min	0	0.00	0.01	0.00	
Respite Individual Day - In Residential Setting	Day	0	0.00	0.01	0.00	
Respite CNA - In Home Family - 4 hours or less	15 min	0	0.00	0.01	0.00	
Respite CNA - In Home Family - 4 hours or more	Day	0	0.00	0.01	0.00	
Therapeutic Respite - In Home Family 4 hours or less	15 min	0	0.00	0.01	0.00	
Therapeutic Respite - In Home Family - 4 hours or more	Day	0	0.00	0.01	0.00	
Skilled Respite - In Home Family - 4 hours or less	15 min	0	0.00	0.01	0.00	
Skilled Respite - In Home Family - 4	Day	0	0.00	0.01	0.00	

GRAND TOTAL:	3286336.37
Total Estimated Unduplicated Participants:	97
Factor D (Divide total by number of participants):	33879.76
Average Length of Stay on the Waiver:	259

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
hours or more						
Wraparound Services Total:						**0.00**
Wraparound Plan	15 min	0	0.00	0.01	**0.00**	
Prevention and Monitoring	15 min	0	0.00	0.01	**0.00**	
Child and Youth Mentorship Total:						**0.00**
Child and Youth Mentorship	15 min	0	0.00	0.01	**0.00**	
Community Connector Total:						**3644.50**
Supported Community Connections	15 min	1	370.00	9.85	**3644.50**	
Hippotherapy Total:						**7117.45**
Hippotherapy - Individual	15 min	5	66.00	21.43	**7071.90**	
Hippotherapy - Group	15 min	5	1.00	9.11	**45.55**	
Massage Therapy Total:						**10884.75**
Massage Therapy	15 min	5	115.00	18.93	**10884.75**	
Movement Therapy Total:						**10421.95**
Bachelors	15 min	5	128.00	16.10	**10304.00**	
Masters	15 min	5	1.00	23.59	**117.95**	
				GRAND TOTAL:		**3286336.37**
				Total Estimated Unduplicated Participants:		**97**
				Factor D (Divide total by number of participants):		**33879.76**
				Average Length of Stay on the Waiver:		259

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
Habilitation Total:						**5856975.30**
Foster Home Level 1	Day	1	28.00	57.50	**1610.00**	
Foster Home Level 2	Day	1	216.00	92.90	**20066.40**	
Foster Home Level 3	Day	14	242.30	113.51	**385048.62**	
Foster Home Level 4	Day	23	228.97	138.22	**727909.37**	
Foster Home Level 5	Day	33	217.66	158.79	**1140553.64**	
Foster Home Level 6	Day	26	301.83	199.60	**1566376.97**	
Group Home Level 1	Day	1	28.00	84.32	**2360.96**	
Group Home Level 2	Day	1	48.00	111.00	**5328.00**	
Group Home Level 3	Day	9	200.50	130.76	**235956.42**	
Group Home Level 4	Day	6	71.00	154.46	**65799.96**	
Group Home Level 5	Day	11	211.25	170.64	**396524.70**	
Group Home Level 6	Day	7	249.33	201.22	**351191.28**	
Residential Child Care Facility Level 1	Day	1	28.00	523.11	**14647.08**	
Residential Child Care Facility Level 2	Day	1	100.00	545.25	**54525.00**	
Residential Child Care Facility Level 3	Day	3	263.00	573.95	**452846.55**	
Residential Child Care Facility Level 4	Day	4	120.00	603.73	**289790.40**	
Residential Child Care Facility Level 5	Day	4	51.00	635.49	**129639.96**	
Residential Child Care Facility Level 6	Day	4	6.00	700.00	**16800.00**	
Foster Home Level 7	Day	0	0.00	0.01	**0.00**	
Group Home Level 7	Day	0	0.00	0.01	**0.00**	
Respite Total:						**210365.90**
Respite - 15 min	15 min	0	0.00	0.01	**0.00**	

GRAND TOTAL:	**6223314.04**
Total Estimated Unduplicated Participants:	**144**
Factor D (Divide total by number of participants):	**43217.46**
Average Length of Stay on the Waiver:	287

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite - Day	Day	0	0.00	0.01	0.00	
Respite Individual - In Home Family - unskilled	15 min	27	832.00	5.48	123102.72	
Respite Individual Day - In Home Family - unskilled	Day	4	11.00	216.87	9542.28	
Respite Individual - In Residential Setting	15 min	16	832.00	5.48	72949.76	
Respite Individual Day - In Residential Setting	Day	2	11.00	216.87	4771.14	
Respite CNA - In Home Family - 4 hours or less	15 min	0	0.00	0.01	0.00	
Respite CNA - In Home Family - 4 hours or more	Day	0	0.00	0.01	0.00	
Therapeutic Respite - In Home Family 4 hours or less	15 min	0	0.00	0.01	0.00	
Therapeutic Respite - In Home Family - 4 hours or more	Day	0	0.00	0.01	0.00	
Skilled Respite - In Home Family - 4 hours or less	15 min	0	0.00	0.01	0.00	
Skilled Respite - In Home Family - 4 hours or more	Day	0	0.00	0.01	0.00	
Wraparound Services Total:						0.00
Wraparound Plan	15 min	0	0.00	0.01	0.00	
Prevention and Monitoring	15 min	0	0.00	0.01	0.00	
Child and Youth Mentorship Total:						0.00
Child and Youth Mentorship	15 min	0	0.00	0.01	0.00	
Community Connector Total:						14948.00
Supported Community Connections	15 min	4	370.00	10.10	14948.00	
Hippotherapy Total:						35420.44
Hippotherapy - Individual	15 min	22	69.00	21.98	33365.64	
Hippotherapy - Group	15 min	22	10.00	9.34	2054.80	
Massage Therapy Total:						51642.80

GRAND TOTAL:	6223314.04
Total Estimated Unduplicated Participants:	144
Factor D (Divide total by number of participants):	43217.46
Average Length of Stay on the Waiver:	287

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Massage Therapy	15 min	22	121.00	19.40	51642.80	
Movement Therapy Total:						53961.60
Bachelors	15 min	22	134.00	16.50	48642.00	
Masters	15 min	22	10.00	24.18	5319.60	
				GRAND TOTAL:		6223314.04
				Total Estimated Unduplicated Participants:		144
				Factor D (Divide total by number of participants):		43217.46
				Average Length of Stay on the Waiver:		287

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
Habilitation Total:						12131120.02
Foster Home Level 1	Day	1	28.00	75.17	2104.76	
Foster Home Level 2	Day	2	237.00	122.11	57880.14	
Foster Home Level 3	Day	25	228.44	150.11	857278.21	
Foster Home Level 4	Day	36	205.06	184.07	1358834.19	
Foster Home Level 5	Day	52	251.85	213.25	2792764.65	
Foster Home Level 6	Day	39	285.18	270.61	3009729.83	
Group Home Level 1	Day	1	28.00	132.28	3703.84	
Group Home Level 2	Day	1	48.00	159.82	7671.36	
Group Home Level 3	Day	12	204.83	181.63	446439.27	
Group Home Level 4					151799.67	
				GRAND TOTAL:		12570794.70
				Total Estimated Unduplicated Participants:		230
				Factor D (Divide total by number of participants):		54655.63
				Average Length of Stay on the Waiver:		286

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Day	9	81.00	208.23		
Group Home Level 5	Day	13	218.00	229.61	650714.74	
Group Home Level 6	Day	12	259.83	268.78	838045.29	
Residential Child Care Facility Level 1	Day	2	28.00	533.57	29879.92	
Residential Child Care Facility Level 2	Day	2	100.00	556.16	111232.00	
Residential Child Care Facility Level 3	Day	6	263.00	585.43	923808.54	
Residential Child Care Facility Level 4	Day	8	120.00	615.80	591168.00	
Residential Child Care Facility Level 5	Day	8	51.00	648.20	264465.60	
Residential Child Care Facility Level 6	Day	8	6.00	700.00	33600.00	
Foster Home Level 7	Day	0	0.00	0.01	0.00	
Group Home Level 7	Day	0	0.00	0.01	0.00	
Respite Total:						203864.94
Respite - 15 min	15 min	0	0.00	0.01	0.00	
Respite - Day	Day	0	0.00	0.01	0.00	
Respite Individual - In Home Family - unskilled	15 min	9	936.00	6.44	54250.56	
Respite Individual Day - In Home Family - unskilled	Day	18	11.00	268.62	53186.76	
Respite Individual - In Residential Setting	15 min	9	936.00	5.90	49701.60	
Respite Individual Day - In Residential Setting	Day	18	11.00	235.99	46726.02	
Respite CNA - In Home Family - 4 hours or less	15 min	0	0.00	0.01	0.00	
Respite CNA - In Home Family - 4 hours or more	Day	0	0.00	0.01	0.00	
Therapeutic Respite - In Home Family 4 hours or less	15 min	0	0.00	0.01	0.00	

GRAND TOTAL:	12570794.70
Total Estimated Unduplicated Participants:	230
Factor D (Divide total by number of participants):	54655.63
Average Length of Stay on the Waiver:	286

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Therapeutic Respite - In Home Family - 4 hours or more	Day	0	0.00	0.01	0.00	
Skilled Respite - In Home Family - 4 hours or less	15 min	0	0.00	0.01	0.00	
Skilled Respite - In Home Family - 4 hours or more	Day	0	0.00	0.01	0.00	
Wraparound Services Total:						0.00
Wraparound Plan	15 min	0	0.00	0.01	0.00	
Prevention and Monitoring	15 min	0	0.00	0.01	0.00	
Child and Youth Mentorship Total:						0.00
Child and Youth Mentorship	15 min	0	0.00	0.01	0.00	
Community Connector Total:						64942.40
Supported Community Connections	15 min	16	370.00	10.97	64942.40	
Hippotherapy Total:						20514.48
Hippotherapy - Individual	15 min	12	72.00	22.42	19370.88	
Hippotherapy - Group	15 min	12	10.00	9.53	1143.60	
Massage Therapy Total:						87966.55
Massage Therapy	15 min	35	127.00	19.79	87966.55	
Movement Therapy Total:						62386.32
Bachelors	15 min	35	45.00	16.83	26507.25	
Masters	15 min	35	41.57	24.66	35879.07	
				GRAND TOTAL:		12570794.70
				Total Estimated Unduplicated Participants:		230
				Factor D (Divide total by number of participants):		54655.63
				Average Length of Stay on the Waiver:		286

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
Habilitation Total:						**17070203.88**
Foster Home Level 1	Day	1	28.00	85.32	**2388.96**	
Foster Home Level 2	Day	3	269.00	142.25	**114795.75**	
Foster Home Level 3	Day	28	228.50	171.99	**1100392.02**	
Foster Home Level 4	Day	40	246.55	211.67	**2087489.54**	
Foster Home Level 5	Day	58	255.52	246.93	**3659542.11**	
Foster Home Level 6	Day	44	285.18	314.80	**3950085.22**	
Group Home Level 1	Day	1	57.00	139.87	**7972.59**	
Group Home Level 2	Day	1	125.00	167.81	**20976.25**	
Group Home Level 3	Day	14	204.83	191.69	**549694.08**	
Group Home Level 4	Day	10	91.00	219.06	**199344.60**	
Group Home Level 5	Day	14	218.00	241.76	**737851.52**	
Group Home Level 6	Day	13	259.83	285.66	**964899.49**	
Residential Child Care Facility Level 1	Day	2	28.00	549.58	**30776.48**	
Residential Child Care Facility Level 2	Day	2	134.00	572.84	**153521.12**	
Residential Child Care Facility Level 3	Day	26	110.44	602.99	**1731449.61**	
Residential Child Care Facility Level 4	Day	8	134.50	634.27	**682474.52**	
Residential Child Care Facility Level 5	Day	8	104.60	667.65	**558689.52**	
Residential Child Care Facility Level 6	Day	8	66.50	700.00	**372400.00**	
Foster Home Level 7	Day	1	242.18	323.11	**78250.78**	
Group Home Level 7	Day	1	136.27	493.21	**67209.73**	
Respite Total:						**518950.56**

GRAND TOTAL:	**19902259.96**
Total Estimated Unduplicated Participants:	**260**
Factor D (Divide total by number of participants):	**76547.15**
Average Length of Stay on the Waiver:	285

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite - 15 min	15 min	0	0.00	0.01	0.00	
Respite - Day	Day	0	0.00	0.01	0.00	
Respite Individual - In Home Family - unskilled	15 min	10	1040.00	6.82	70928.00	
Respite Individual Day - In Home Family - unskilled	Day	31	11.00	292.89	99875.49	
Respite Individual - In Residential Setting	15 min	10	1040.00	6.08	63232.00	
Respite Individual Day - In Residential Setting	Day	21	11.00	243.07	56149.17	
Respite CNA - In Home Family - 4 hours or less	15 min	5	1540.00	7.96	61292.00	
Respite CNA - In Home Family - 4 hours or more	Day	1	1.00	142.20	142.20	
Therapeutic Respite - In Home Family 4 hours or less	15 min	5	1540.00	7.96	61292.00	
Therapeutic Respite - In Home Family - 4 hours or more	Day	1	1.00	142.40	142.40	
Skilled Respite - In Home Family - 4 hours or less	15 min	4	1540.00	17.14	105582.40	
Skilled Respite - In Home Family - 4 hours or more	Day	1	1.00	314.90	314.90	
Wraparound Services Total:						1070353.32
Wraparound Plan	15 min	138	121.97	29.30	493173.50	
Prevention and Monitoring	15 min	127	155.11	29.30	577179.82	
Child and Youth Mentorship Total:						692594.00
Child and Youth Mentorship	15 min	122	700.00	8.11	692594.00	
Community Connector Total:						280830.00
Supported Community Connections	15 min	66	370.00	11.50	280830.00	
Hippotherapy Total:						22334.68
Hippotherapy - Individual	15 min	12	76.00	23.09	21058.08	
Hippotherapy - Group	15 min				1276.60	

GRAND TOTAL:	19902259.96
Total Estimated Unduplicated Participants:	260
Factor D (Divide total by number of participants):	76547.15
Average Length of Stay on the Waiver:	285

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		13	10.00	9.82		
Massage Therapy Total:						**106696.59**
Massage Therapy	15 min	39	133.00	20.57	**106696.59**	
Movement Therapy Total:						**140296.93**
Bachelors	15 min	40	98.00	17.33	**67933.60**	
Masters	15 min	39	73.05	25.40	**72363.33**	

GRAND TOTAL:	**19902259.96**
Total Estimated Unduplicated Participants:	**260**
Factor D (Divide total by number of participants):	**76547.15**
Average Length of Stay on the Waiver:	285