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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

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

B. Program Title:
Children's Home and Community Based Services (CHCBS) waiver

C. Waiver Number:CO.4157
Original Base Waiver Number: CO.4157.

D. Amendment Number:

E. Proposed Effective Date: (mm/dd/yy)
07/01/24
Approved Effective Date of Waiver being Amended: 07/01/23

2. Purpose(s) of Amendment

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

The purpose of this amendment is to:
- Update the Organized Health Care Delivery System provider type due to Case Management Redesign and details outlined in IM 22-042. Waivers are being amended to clarify when the OHCDS can act as a provider for select services.
- Remove Hospice from the list of State Plan services that require Electronic Visit Verification (EVV) in appendix I-2d.
- Update HCPF's Rate Methodology description to include information on the locality, county, metropolitan area, and other types of regional boundaries for minimum wage increases and an allowance for HCPF to update these rates retroactively.
- Remove the reference to the number of Case Management Agencies that are contracted entities. (All waivers)
- Remove language that references "annual on-site monitoring" of the Case Management Agencies in Appendix F-1 and I-1, Participants Rights.
- Update the Cost Neutrality Demonstration in Appendix J with the new 372 data from State Fiscal Year

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

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

☐ **Modify target group(s)**

☐ **Modify Medicaid eligibility**

☐ **Add/delete services**

☐ **Revise service specifications**

☐ **Revise provider qualifications**

☐ **Increase/decrease number of participants**

☐ **Revise cost neutrality demonstration**

☐ **Add participant-direction of services**

☐ **Other**

Specify:

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

1. Request Information (1 of 3)

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

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

Children's Home and Community Based Services (CHCBS) waiver

C. Type of Request: amendment

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: CO.4157
Draft ID: CO.005.07.03

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/23
Approved Effective Date of Waiver being Amended: 07/01/23

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:

The CHCBS Waiver is limited to an acute care 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:

The CHCBS waiver is limited to skilled 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:

The State submitted the 1915(b)(4) waiver titled Colorado Home and Community-Based Services Case Management Waiver (CO.0005.R00.00) on February 27, 2023.

The State will be submitting a 1915(b)(4) waiver titled Colorado HCBS Wellness Education Benefit on September 15, 2023.

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

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

☐ **§1915(b)(2) (central broker)**

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

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

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

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

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

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

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

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

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

2. Brief Waiver Description

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

The Children's Home and Community Based Services (CHCBS) waiver assists children who require long-term supports and services in order for them to remain in their family residence and participate in their community. Eligibility is limited to children, age - birth up to their eighteenth (18th) birthday who require long-term supports at a level typically provided in a Skilled Nursing Facility or Acute Care Hospital, as specified in this application.

The State has defined two (2) community-based services designed to support children to maintain residence in their family home. These services include Case Management Services and Health Maintenance Activities delivered through a participant-directed service delivery option called In-Home Support Services. In addition to these waiver services, the child also has access to all Colorado Medicaid State Plan benefits. The child's parents and/or legal guardian assist the case manager to identify, through a participant-centered service planning process, those services and supports needed to prevent placement in a Nursing Facility or Hospital. A child's parents and/or legal guardian may choose to direct health maintenance activities or choose to have similar services delivered by a home care agency through agency-based care in the long-term home health state plan service.

The Case Management Agencies provide intake and subsequent case management support services for the CHCBS program. These agencies ensure a statewide network of available Case Management Agencies to perform case management functions for individuals enrolled in the CHCBS waiver. Functions of case management include intake/screening/referral, assessment of the child's needs, functional eligibility determination through the Level of Care Screen, Needs Assessment, Person-Centered Support Plan development, ongoing case management, and monitoring to assure participant protection and quality assurance.

3. Components of the Waiver Request

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

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

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

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

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

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

◉ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*

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

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

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

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

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

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

4. Waiver(s) Requested

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

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

○ **Not Applicable**

◉ **No**

○ **Yes**

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

◉ **No**

○ **Yes**

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

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

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

5. Assurances

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

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

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

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

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

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

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

State: **Colorado**

Zip:

Phone: **Ext:** ☐ **TTY**

Fax:

E-mail:

8. Authorizing Signature

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

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name: Flores-Brennan

First Name: Adela

Title: Medicaid Director

Agency: Colorado Department of Health Care Policy & Financing

Address: 303 E 17th Ave

Address 2:

City: Denver

State: **Colorado**

Zip: 80203

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

Fax: (303) 866-2786

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

Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

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

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

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

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

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

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

Completed

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix I: Financial Integrity and Accountability continued

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

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

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

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

Appendix A: Waiver Administration and Operation

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

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

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

   ◉ **The Medical Assistance Unit.**

   Specify the unit name:

   Office of Community Living, Benefits and Services Management Division

   (Do not complete item A-2)

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

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

   (Complete item A-2-a).

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

   Specify the division/unit name:

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

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

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

Appendix A: Waiver Administration and Operation

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

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

The Department currently has provider agreements with Case Management Agencies throughout the state of Colorado that are responsible for providing utilization reviews; developing service plans, and prior authorizations. The number of case management agencies fluctuates dependent on willing, approved, and qualified providers.

In addition to the contracts that delegate administrative functions in other Colorado HCBS waivers, case management agencies providing case management through the HCBS waiver are required to sign and gain approval from the Department of a Standard Provider Application. Within the Standard Provider Application is the Provider Participation Agreement through which the Provider Participation Section, paragraph A requires that the Provider complies with all applicable provisions of the Social Security Act, as amended; federal or state laws, regulations, and guidelines; and Department rules. Additionally, the provider specialty type defines the services that they will provide upon approval of the agreement by the Department's Fiscal Agent. The Department has established regulations at 10 C.C.R. 2505-10 § 8.506 that outline the functions required to be completed in the course of providing case management services in the Children's Home and Community-Based Services (CHCBS) waiver. This section references 10 C.C .R. 2505-10 § 8.487.20 to define the certification standards for Case Management Agencies. The functions included throughout these rules are the administrative functions outlined in Appendix A-7 of this waiver application.

The Department of Health Care Policy and Financing (the Department) maintains an Interagency Agreement with the state Survey Agency, the Department of Public Health and Environment (DPHE), to license, survey, and investigate complaints against IHSS agencies. CDPHE has a purview for health facilities and survey and certification-related activities. The Department monitors the survey schedule activities through monthly reports required through the interagency agreement. Once an IHSS provider has been surveyed and licensed by DPHE, they are referred to the Department to obtain Medicaid Certification. IHSS providers are surveyed at regular intervals for continued licensing or more frequently to investigate complaints or follow up on survey deficiencies in accordance with the CMS state operations manual.

The Department contracts with a Quality Improvement Organization (QIO) to review a portion of the waiver targeting criteria. The QIO reviews family and collateral information and determines if the child meets specific eligibility criteria as set forth in 10 CCR 2505-10 8.506.6.A.

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

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

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

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

The Department contracts with a Wellness Education Benefit (WEB) contractor to help with the development and distribution of the WEB.

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:

☒ **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 has provider agreements with Case Management Agencies located throughout the state of Colorado. Some of the agencies are Local/Regional non-governmental non-state agencies. The number of case management agencies fluctuates dependent on willing, approved, qualified providers.

These agencies are responsible to perform Home and Community-Based waiver operational and administrative services, case management, development of service plans, utilization review, and prior authorization of waiver services. All CHCBS Case Management Agencies are held to the same standards and requirements. All CHCBS case management agencies must complete the state-approved provider agreement (contract) and be approved by the Department.

Appendix A: Waiver Administration and Operation

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

Colorado Department of Health Care Policy and Financing, Office of Community Living, Benefits and Service Management Division.

Appendix A: Waiver Administration and Operation

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

The Department provides ongoing oversight of the Interagency Agreement with the Colorado Department of Public Health and Environment (CDPHE) through monthly meetings and reports. Issues that impact the agreement, problems discovered at specific agencies, or widespread issues and solutions are discussed. In addition, the Department is provided with monthly reports detailing the number of agencies that have been surveyed, the number of agencies that have deficiencies, the number of complaints received complaints investigated, and complaints that have been substantiated. The Interagency Agreement between the Department and CDPHE requires that all complaints be investigated and reported to the Department. By gathering this information the Department is able to develop strategies to resolve issues that have been identified. For the CHCBS waiver, CDPHE is responsible for monitoring In-Home Support Services providers. Further information about the relationship between CDPHE and the Department is provided in Appendix G of the waiver application.

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

The administrative evaluation is used to monitor compliance with agency operations and functions as outlined in waiver and department contract requirements. The Department will evaluate CMAs through the ongoing tracking of administrative contract deliverables on a monthly, quarterly, semi-annually, and yearly frequency basis depending on the contract deliverable. These documents include an 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, provider, and other community service coordination. Should the Department find that a CMA is not in compliance with policy or regulations, the agency is required to take corrective action. In addition, the contract with CMAs allows the Dept. to withhold funding and terminate a contract due to noncompliance. Technical assistance is provided to CMAs via phone, e-mail, and through meetings. The Department conducts follow-up monitoring to assure corrective action implementation and ongoing compliance. If a compliance issue extends to multiple CMAs, the Department provides clarification through formal Policy Memos, formal training, or both. Technical assistance is provided to CMAs via phone and e-mail.

The programmatic evaluation consists of a desk audit in conjunction with the Benefits Utilization System (BUS) to audit client files and assure that all components of the CMA contract have been performed according to necessary waiver requirements. The BUS is an electronic record used by each CMA to maintain client-specific data. Data includes client referrals, screening, Level of Care (LOC) assessments, individualized service plans, case notes, reassessment documentation, and all other case management activities. Additionally, the BUS is used to track and evaluate timelines for assessments, reassessments, and a notice of action requirements to assure that processes are completed according to Department's prescribed schedules. The Department reviews a sample of client files to measure the accuracy of documentation and track the appropriateness of services based on 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 are completed by a quality improvement organization.

The Department has oversight of the fiscal agent, QIO, and Wellness Education Benefit (WEB) contractor through different contractual requirements. Deliverable due dates include monthly, quarterly, and/or annual reports to ensure vendors are completing their respective delegated duties. The Department's Operations Division ensures that deliverables are given to the Department on time and in the correct format. Subject Matter Experts who work with the vendors review deliverables for accuracy.

For any post-payment claims review work completed by the Department’s Recovery Audit Contractor (RAC), all deliverables and work products will be reviewed and approved by the Department as outlined in the Contract. The Department requires the RAC to develop and implement an internal quality control process to ensure that all deliverables and work products—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 the 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 the 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 into 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 which audience the results are being released. All assessments are reviewed by the RAC Manager, the Audit Contract Management and Oversight Unit Supervisor, and the Program Integrity and Contract Oversight Section Manager. Clearance for certain reporting, including legislative requests for information, can also include the Compliance Division Director, the Medicaid Operations Office Director, and other areas of the Department.

Appendix A: Waiver Administration and Operation

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

Function	Medicaid Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	☒	☒	☒
Waiver enrollment managed against approved limits	☒	☐	☐
Waiver expenditures managed against approved levels	☒	☐	☐
Level of care evaluation	☒	☒	☒
Review of Participant service plans	☒	☒	☒
Prior authorization of waiver services	☒	☒	☒
Utilization management	☒	☒	☒
Qualified provider enrollment	☒	☒	☐
Execution of Medicaid provider agreements	☒	☒	☐
Establishment of a statewide rate methodology	☒	☐	☐

Function	Medicaid Agency	Contracted Entity	Local Non-State Entity
Rules, policies, procedures and information development governing the waiver program	☒	☐	☐
Quality assurance and quality improvement activities	☒	☒	☒

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

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

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

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

		Review
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: QIO	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
A.6 Number and Percent of Fiscal Intermediary service level agreements reviewed by the Dept demonstrating financial monitoring of the CHCBS waiver N: Number of Fiscal Intermediary service level agreements reviewed by the Dept demonstrating financial monitoring of the CHCBS 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
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:

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
A.27 # and % of deliverables submitted by the Wellness Education Benefit (WEB) contractor that are reviewed by the Department demonstrating performance of delegated functions N:Number of deliverables submitted by the WEB contractor that are reviewed by the Department demonstrating performance of delegated functions D: Total number of deliverables for WEB contractor mandated by the contract

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

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

Data Aggregation and Analysis:

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

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

The Department maintains oversight of waiver contracts/interagency agreements by tracking contract deliverables on a monthly, quarterly, semi-annually, and yearly basis depending on the requirements of the contract deliverable. The Department 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: the number and types of agencies surveyed, the number of agencies with deficiencies, the types of deficiencies cited, the 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. The department reviews monthly, quarterly, and annual reports to ensure the QIO is performing delegated duties. The Department's Operations and Administration Division ensures that deliverables are provided timely and as specified in the contract. Subject Matter Experts review deliverables for accuracy.

A.6
The fiscal agent is required to submit weekly reports regarding performance standards as established in the contract. The reports include summary data on timely and accurate coding, claims submission, claims reimbursement, time frames for completion of data entry, and processing claims PARs. The 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 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 Department 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.27
WEB contractor oversight is through contractual requirements and deliverables. The Department reviews all reports provided by the WEB contractor to ensure performance of delegated duties. The Department's Operations and Administration Division ensures that deliverables are provided timely and as specified in the contract. Subject Matter Experts review deliverables for accuracy.

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.27
Delegated responsibilities of contracted agencies/vendors are monitored, corrected, and remediated by the Department's Office of Community Living (OCL).

During routine annual evaluations 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.

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

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

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

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☒ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☒	**Medically Fragile**	0	17	☐
	☐	**Technology Dependent**			☐
☐ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐
	☐	**Intellectual Disability**			☐
☐ **Mental Illness**					
	☐	**Mental Illness**			☐
	☐	**Serious Emotional Disturbance**			

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

Individuals must have been determined to have a significant functional impairment as identified by a Level of Care Eligibility Determination Screen (LOC Screen) using the state-prescribed LOC Screen instrument and must require long-term support services at a level comparable to services typically provided in a skilled nursing facility or acute care hospital. A disability determination will be conducted prior to the approval of the CHCBS waiver to assure that the federal SSI definition of disability is met.

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:

When the child enrolled in the CHCBS waiver reaches the age of 17 years, the case manager will start the transition process by informing the child's parents and/or legal guardians of the Adult Home and Community-Based Services waivers for which the child may be eligible for when the child reaches 18.

The case manager, at the six (6) month review, sends a letter to the parents and/or legal guardians informing them of the adult Home and Community-Based Services waivers that are available and the steps that they will need to have a smooth transition. A plan of action will be developed with the parents and/or legal guardians three (3) months before the child's 18th birthday. The child's parents and/or legal guardians will be informed that on the child's 18th birthday, they may be eligible for SSI benefits and can apply for long-term care services and supports.

Appendix B: Participant Access and Eligibility

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

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

○ **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

○ **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

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

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

Specify the percentage:

○ **Other**

Specify:

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

○ **Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

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

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

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Prior to entrance into the CHCBS waiver, the case manager meets with the child's parents and/or legal guardian to develop a Person-Centered Support Plan (PCSP). If the case manager identifies that a child's needs are more extensive than the services offered in the waiver can support, the case manager informs the child's parents and/or legal guardian that their health and safety cannot be assured in the community. The case manager then provides the child's parents and/or legal guardian with appeal rights. Please see Appendix F-1 for more information on the client's appeal rights.

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

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

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

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

Upon a change in the child's condition, the case manager assesses the child to determine if the client's health and welfare can be assured in the community. If the case manager determines the client's health and welfare can be assured, the case manager submits the request to the Department for approval.

☐ **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	3753
Year 2	4250
Year 3	4812
Year 4	5449
Year 5	6169

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

◉ **The state does not limit the number of participants that it serves at any point in time during a waiver year.**

○ **The state limits the number of participants that it serves at any point in time during a waiver year.**

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

Table: B-3-b

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

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

Appendix B: Participant Access and Eligibility

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

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

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

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

Children from birth up to their 18th birthday, whose disability meets the established minimum criteria for a skilled nursing facility or an acute hospital level of care and have been determined to meet the SSI definition of disability but are not otherwise eligible for Medicaid services due to the child's parent's and/or legal guardian's income/resources.

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)**
- [x] **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:

  Not applicable

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

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

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

Select one and complete Appendix B-5.

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

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

Check each that applies:

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

Select one:

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

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

Specify percentage:

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

Specify dollar amount:

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

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

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

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

Select one:

○ **100% of FPL**

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility

for the special home and community-based waiver group under 42 CFR §435.217:

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

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

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

Select one:

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

(*select one*):

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

Specify the percentage:

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

Specify dollar amount:

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

Specify percentage:

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

Specify:

○ **The following dollar amount**

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

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

Specify:

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

○ **Other**

Specify:

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

◉ **Not Applicable**

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

Specify:

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

○ **SSI standard**

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

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

Specify:

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

- (●) **Not Applicable (see instructions)**
- ( ) **AFDC need standard**
- ( ) **Medically needy income standard**
- ( ) **The following dollar amount:**

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

  Specify:
- ( ) **Other**

  Specify:

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

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

Select one:

- (●) **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- ( ) **The state does not establish reasonable limits.**
- ( ) **The state establishes the following reasonable limits**

  Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

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

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

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

  Specify formula:

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

  Specify:

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

Select one:

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

  Explanation of difference:

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

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

Select one:

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near

future (one month or less), but for the availability of home and community-based waiver services.

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

i. Minimum number of services.

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

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

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

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

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

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

Specify the entity:

Case Management Agencies that have provider agreements with the state.

- ( ) **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 are:

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 an 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:

A child is referred to the Case Management Agency (CMA) for a Home and Community-Based Services eligibility determination. The CMA screens the referrals to determine if a LOC Screen is appropriate.

Should the CMA determine that a LOC Screen is not appropriate; the CMA provides information and referral to other agencies as needed. The child's parents or legal guardian are informed of the right to request a LOC Screen if they disagree with the CMA's determination. If the client disagrees with the determination, the CMA will complete the LOC Screen, upon request.

Should the CMA determine that a LOC Screen is appropriate, or the client requests one, the CMA:
- Verifies the applicant's current financial eligibility status,
- Refers the applicant to the county department of social services of the child's county of residence for application, or
- Provides the applicant with the financial eligibility application form(s) for submission with required attachments to the county department of social services for the county in which the child resides, and documents follow-up on the return of forms.

The determination of the applicant's financial eligibility is completed by the county Department of Social Services for the county in which the applicant resides.

Upon verification of the applicant's financial eligibility or verification that an application has been submitted, the CMA completes the assessment within the following periods:
- For a child who is not being discharged from an acute hospital or a skilled nursing facility, the child LOC Screen is completed within ten (10) working days.
- For a child who is being transferred from a skilled nursing facility to an HCBS program, the LOC Screen is completed within five (5) working days.
- For a child who is being transferred from an acute hospital to an HCBS program, the LOC Screen is completed within two (2) working days.

Case managers are required to complete a reevaluation of the child within twelve months of the initial client evaluation or the previous Continued Stay Review (CSR) evaluation. A reevaluation may be completed sooner if the child's condition changes or if required by program criteria, i.e., the child's condition improves and the waiver is no longer needed or the child's condition deteriorates and more services are needed to keep the child in the home. 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 the state and federal government.

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

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

  Specify the other schedule:

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

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

  Specify the qualifications:

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

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

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

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

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

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

Data Source (Select one):
Other

If 'Other' is selected, specify:

State's case management IT system

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

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:
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:

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

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

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

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

B.c.2
LOC 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 in this performance measure.

B.c.3
Compliance with this performance measure requires assurance that each initial LOC Screen has an associated PMIP completed and signed by a licensed medical professional according to Department regulations, (prior to and within six months of the LTC start date). The Department uses the QI Review Tool results and the participant's state's case management IT system record to discover deficiencies in 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 Screens. The Department compiles and analyzes CMA CAPs to determine a statewide root cause for deficiencies. Based on the analysis, the Department identifies the need to provide policy clarifications, and/or technical assistance, design specific training, and determine the need for modifications to current processes to address statewide systemic issues.

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

Responsible Party*(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: As warranted by nature of discovery and/or severity of incidence

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

The child's parents and/or legal guardian or representative are informed of any feasible alternatives under the waiver and given the choice of either institutional or home and community-based services during the LOC Screen and Person-Centered Support Planning process, and at the time of continued stay review (CSR). The LOC Screen determines eligibility for an institutional level of care. If an individual is determined eligible, they are provided a choice between institutional or HCBS waiver services. If waiver services are chosen, the Person-Centered Support Planning process assesses which waiver(s) the client is eligible for based on both the level of care and targeting criteria. The waiver(s) for which the client meets targeting criteria and their associated services are explained to the client and discussed relative to the client's service and support needs. Based on this assessment and discussion, the client and/or their legal representative choose the best waiver and service options for them, and a Person-Centered Support Plan is developed and agreed upon, which includes a section covering the member's right to choice. Case managers complete a PCSP information and summary form that is reviewed with the client. 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. Case managers also provide a choice of providers.

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	**Case Management**		
Other Service	**In Home Support Services**		
Other Service	**Wellness Education Benefit**		

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):

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:

Case management service is assistance provided by a Case Management Agency on behalf of an eligible child, which includes referral of needed Medicaid services and supports, including In-Home Support Services (IHSS), that enable the child to remain in his/her community-based setting.

Additionally, Case Managers employed by a Case Management Agency complete the LOC Screen, reevaluations, and Person-Centered Support Plan.

When activities related to the assessment of level of care and service plan development are furnished as waiver case management activities, payment for such services may not be made until the individual is actually enrolled in the waiver.

The scope of case management services may not include activities/services that constitute the provision of direct services to the participant that normally are covered as distinct services. Case management must comport with conflict of interest requirements at 42 CFR 441.301(1)(vi).

Through the selective contracting process, Case Management Agencies will be determined by defined service areas. Each defined service area will have one case management agency that will provide case management functions.

Members will have the option to choose their case manager at the agency to which they are assigned.

Case managers are responsible for sharing information about self-directed delivery options, referring members to the Training and Operations Vendor for training, developing a person-centered allocation in collaboration with the member, reviewing and approving the Attendant Support Management Plan, and ongoing monitoring of the approved services including review of expenditure statements.

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

Case Management services must be provided at least monthly.

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	Single Entry Point Agency
Agency	Community Centered Board
Agency	Organized Health Care Delivery System (OHCDS)
Agency	Private Case Management Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Agency

Provider Type:

Single Entry Point Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certification standards for the Children's HCBS Waiver Program Case management Agencies shall be the same as those prescribed for provider agencies in accordance with procedures found in the HCBS-EBD, General Certification Process Section 8.487.20.

Qualifications for individuals completing the Level of Care determination for waiver participants are defined in section B-6c of this waiver application.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy and Financing

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Agency

Provider Type:

Community Centered Board

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certification standards for the Children's HCBS Waiver Program Case management Agencies shall be the same as those prescribed for provider agencies in accordance with procedures found in the HCBS-EBD, General Certification Process Section 8.487.20.

Case management agencies operated by Community Centered Boards shall also meet the General Provisions set forth in the Case Management Services Section of the Colorado Code of Regulations (C.C.R.), 8.607.

Case management agencies are required to apply specifically for certification as a Children's HCBS Waiver Program provider and have a Provider Agreement with the State.

Qualifications for individuals completing the Level of Care determination for waiver participants are defined in section B-6c of this waiver application.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy and Financing

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Agency

Provider Type:

Organized Health Care Delivery System (OHCDS)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certification standards for the Children's HCBS Waiver Program Case management Agencies shall be the same as those prescribed for provider agencies in accordance with procedures found in the HCBS-EBD, General Certification Process Section 8.487.20.

Case management agencies operated by Community Centered Boards shall also meet the General Provisions set forth in the Case Management Services Section of the Colorado Code of Regulations (C.C.R.), 8.607.

Case management agencies are required to apply specifically for certification as a Children's HCBS Waiver Program provider and have a Provider Agreement with the State.

Qualifications for individuals completing the Level of Care determination for waiver participants are defined in section B-6c of this waiver application.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy & Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Agency

Provider Type:

Private Case Management Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certification standards for the Children's HCBS Waiver Program Case management Agencies shall be the same as those prescribed for provider agencies in accordance with procedures found in the HCBS-EBD, General Certification Process Section 8.487.20.

Qualifications for individuals completing the Level of Care determination for waiver participants are defined in section B-6c of this waiver application.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy and Financing

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: 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:

In Home Support Services

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:**

In-Home Support Services (IHSS), service is limited in the CHCBS waiver to Health Maintenance Activities. The child's need for this service has been determined to be extraordinary and can be provided in the home or the community.

Health maintenance activities are those routine and repetitive tasks that require skilled assistance for health and normal bodily functioning, and which would be carried out by a child of the same age if he or she were physically/cognitively able.

Extraordinary care is determined by assessing that the activity is one that a parent would not normally provide as part of a normal household routine and that a child's parents and/or legal guardian is not responsible to provide.

An IHSS Plan means a written and signed plan between the child's parent and/or legal guardian and the IHSS agency. The Plan shall include a detailed listing of the amount, scope, and duration of the health maintenance service provided to the child and who will be responsible for providing the service.

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

IHSS services are offered in this waiver and are limited based on the client's assessed need for services and prior authorization by case managers, IHSS will be limited to children who can be determined that they will be served safely in the home.

The child's parent and/or legal guardian must provide a statement from his/her primary physician indicating that:
1. The child's parent and/or legal guardian has sound judgment and the ability to direct their child's care; or
2. The child has an authorized representative who has the judgment and ability to assist in acquiring and using IHSS services; or
3. The child's parent or legal guardian works with an IHSS agency that is able and willing to support the client as necessary to participate in IHSS.

Health Maintenance Activities completed through the IHSS service delivery option cannot be duplicative of any state plan benefits. Case Managers are required, in accordance with 8.552.7.A of the Colorado Code of Regulations, to ensure the cost-effectiveness and non-duplication of services. This includes documentation of the discontinuance of long-term home health services; ensuring all required information is contained in the IHSS Plan, and authorizing cost-effective and non-duplicative services through the prior authorization process.

For a child with an unstable medical condition, the physician's statement shall include a recommendation regarding whether additional in-home monitoring is necessary and if so, the amount and scope of the in-home monitoring and that the child is served safely in their home. IHSS Agencies are required, in accordance with Section 8.522.6 of the Colorado Code of Regulations, to collaborate with the child or the child's parent/guardian to determine the level of monitoring that is required. The IHSS agency is responsible for ensuring that the child's attendant monitors any medical risks for the child, and the level of oversight the attendant receives from a licensed healthcare professional.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency
Agency	Personal Care Agency
Agency	In Home Support Services Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: In Home Support Services

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Class A or B

Certificate *(specify):*

Certification as a Medicaid provider of In Home Support Services. 10 C.C.R. 2505-10 8.487 and 8.552

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Providers are surveyed on a 9 to 36 month risk based survey cycle. Providers that have deficiencies in areas of staff training/ supervision, or client care are surveyed every 9-15 months according to the number and severity of the deficiencies. Providers that have administrative deficiencies due to errors in paperwork are surveyed every 15 to 24 months. Providers that have no deficiencies are surveyed every 24 to 36 months. In addition, if DPHE receives a complaint involving client care, the findings of the investigation may be grounds for DPHE to initiate a full survey of the provider agency regardless of the date of their last survey.

For all In Home Support Services (IHSS) providers: Providers are surveyed every 9-15 months for until a Risk-Based Survey Schedule is developed.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: In Home Support Services

Provider Category:

Agency

Provider Type:

Personal Care Agency

Provider Qualifications

License *(specify):*

Class A or B

Certificate *(specify):*

Certification as a Medicaid provider of In Home Support Services. 10 C.C.R. 2505-10 8.487 and 8.552

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Providers are surveyed on a 9 to 36 month risk based survey cycle. Providers that have deficiencies in areas of staff training/ supervision, or client care are surveyed every 9-15 months according to the number and severity of the deficiencies. Providers that have administrative deficiencies due to errors in paperwork are surveyed every 15 to 24 months. Providers that have no deficiencies are surveyed every 24 to 36 months. In addition, if DPHE receives a complaint involving client care, the findings of the investigation may be grounds for DPHE to initiate a full survey of the provider agency regardless of the date of their last survey.

For all In Home Support Services (IHSS) providers: Providers are surveyed every 9-15 months for until a Risk-Based Survey Schedule is developed.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: In Home Support Services

Provider Category:

Agency

Provider Type:

In Home Support Services Agency

Provider Qualifications

License *(specify):*

Class A or B

Certificate *(specify):*

Certification as a Medicaid provider of In Home Support Services. 10 C.C.R. 2505-10 8.47 and 8.552

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

IHSS providers are surveyed on a 9 to 36-month risk-based survey cycle. Providers that have deficiencies in areas of staff training/ supervision or client care are surveyed every 9-15 months according to the number and severity of the deficiencies. Providers that have administrative deficiencies due to errors in paperwork are surveyed every 15 to 24 months. Providers that have no deficiencies are surveyed every 24 to 36 months. In addition, if CDPHE receives a complaint involving client care, the findings of the investigation may be grounds for CDPHE to initiate a full survey of the provider agency regardless of the date of their last survey.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Wellness Education Benefit

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Wellness Education Benefit (WEB) is individualized educational materials designed to reduce the need for a higher level of care by offering educational materials that provide members and their families with actionable tools that can be used to prevent the progression of a disability, increase community engagement, combat isolation, and improve awareness of Medicaid services. The Wellness Education Benefit helps members and their unpaid caregivers to obtain, process, and understand information that assists with managing health-related issues, promoting community living, and achieving goals identified in their person-centered service plans. For example, the Wellness Education Benefit can provide the information needed to:

- Navigate the Medicaid/medical system to achieve better health outcomes.
- Successfully manage chronic conditions in order to decrease risk of nursing facility placement.
- Effectively communicating health and wellness goals.
- Effectively communicate with medical and social service professionals.
- Provide unpaid caregivers with relevant information regarding best practices around support and care of the member.
- Achieve community living goals identified in the person-centered service plan by providing simple, actionable suggestions to help support the health and welfare of waiver members; including local community resources.
- Prevent and avoid health risks such as pneumonia, influenza, infections, and other illnesses or conditions that can lead to nursing facility placement for medically unstable individuals and older adults;
- Develop support networks that can promote engagement and combat isolation that can lead to increased health and safety risks that can result in institutional placement.

Materials are furnished in the format and/or language preferred by the participant and may be delivered through monthly printed mailings via United States Postal Service.The WEB will be delivered in multiple languages and formats at the request of the beneficiary and their support team, to ensure all members can access these materials. For members who cannot read standard print and would benefit from an alternative format, educational materials will be sent to members in the requested accessible format, which may include larger print or braille. Wellness Education Benefit services include varied topics such as engaging in community activities, nutrition, adaptive exercise, balance training and fall prevention, money management, and developing social networks.

The Wellness Education Benefit (WEB) ensures a continuum of care for members by expanding upon information from providers and case managers, along with the inclusion of additional information that a provider and/or case manager may not have provided during a visit. The WEB does not duplicate services found in EPSDT. The WEB provides actionable, day-to-day tools that differ by the individual's person-centered support plan to prevent the need for additional medical care. Additionally, the WEB will provide educational information that supports members and their families in identifying local community resources that will promote community engagement, develop networks of support, and combat isolation.

The service provider will conduct member outreach to gather information on how the service has helped members thrive in the community and meet the health and wellness goals that are identified in their person centered support plan. The member may work with their case manager to request different subject matter for the educational materials. The case manager can then work with the provider to ensure the educational materials are being targeted to meet any new needs the member may have. The provider will also utilize monthly data on the member’s person-centered support plan and updated health conditions to guide the subject matter of the educational materials. Finally, the WEB materials will include Department contact information for members to ask questions or provide feedback.

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

The Wellness Education Benefit will be delivered once every month equaling 12 units that will initially be included on the PAR. The Case Manager may authorize up to 12 additional units per service plan year for the following:

• The WEB was returned to sender as a non-deliverable, and the address is updated in time for the second round of monthly delivery
• A member has requested reasonable accommodation for an alternative format, such as braille.
• A member requests that their representative receives a copy of the benefit to help them better utilize information provided in the benefit.

The Annual total units that may be authorized shall not exceed 24 units per plan year.

The services under the Children's HCBS waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Wellness Education Benefit Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Wellness Education Benefit

Provider Category:

Agency

Provider Type:

Wellness Education Benefit Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Medicaid provider of benefit - 10 CCR 25.5 § 8.740 eq seq

Other Standard *(specify):*

The provider agency, WEB Vendor, furnishing services to waiver clients shall abide by all general certification standards, conditions, and processes established for the client's respective waiver: Children's Home and Community-Based Services (CHCBS) Waiver.

The provider is selected by the Department in accordance with Colorado Procurement rules and regulations, holds a contract with the state of Colorado to deliver these benefits, including the Departments HIPAA Business Agreement (BA), and meets all other provider qualifications found in the section. Complies with requirements outlined in 10 CCR 25.5 § 8.740 eq seq.

WEB Vendors must also have the ability and resources to:
• Receive and manage client data in compliance with all applicable HIPAA regulations and ensure client confidentiality and privacy.
• Translate materials, as directed by the Department.
• Ability to target materials into the participant's person-centered service plan.

The Department contracts with a single provider under the service approved through the concurrent 1915(b)(4) Colorado HCBS Wellness Education Benefit.

Verification of Provider Qualifications

Entity Responsible for Verification:

Colorado Department of Health Care Policy & Financing

Frequency of Verification:

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

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:

CHCBS Case Management Agencies are providers responsible for case management services. The Department currently has provider agreements with Case Management Agencies throughout the state of Colorado that are responsible for providing utilization reviews; developing service plans and prior authorizations. Case managers are responsible for sharing information about self-directed delivery options, referring members to the Training and Operations Vendor for training, developing a person-centered allocation in collaboration with the member, reviewing and approving the Attendant Support Management Plan, and ongoing monitoring the approved services including review of expenditure statements.

Members on the CHCBS waiver will transition from case management as a service to TCM from July 1, 2023, through June 30, 2024. Case Management will be removed as a service upon the transition completion.

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

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

Appendix C: Participant Services

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

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

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

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

Home Care Agencies (HCAs) certified to provide In-Home Support Services (IHSS) are licensed annually by the Colorado Department of Public Health and Environment (CDPHE). This licensure requires that any individual seeking employment with the agency submit to a Colorado Bureau of Investigation (CBI) criminal history record check. The criminal history record check must be conducted not more than 90 days prior to the employment of the individual. To ensure that the individual does not pose a risk to the health, safety, and welfare of the consumer, HCAs must develop and implement policies and procedures regarding the employment of any individual who is convicted of a felony or misdemeanor.

CDPHE will not issue a license or recommend certification until the agency conforms to all applicable statutes and regulations. Should it be found that an agency has not performed the criminal background investigations as required by licensure or regulatory standards, CDPHE requires the agency to submit a plan of correction within 30 days. CDPHE has the discretion to approve, impose, modify, or reject a plan of correction. Only after the plan of correction has been accepted will a license or recommendation for certification be issued. CDPHE sends the survey and licensing information to the Department for review. Agencies denied licensure or recommendation for certification by DPHE are not approved as Medicaid providers.

State-approved educational programs for Certified Nurse Aides also require Colorado Bureau of Investigation (CBI) criminal history checks upon admission to the education program.

In addition, all prospective attendants for IHSS are subjected to a board of nursing and certified nurse aide background check. Any person who has had his or her license as a nurse or certification as a nurse aid suspended or revoked or his or her application for such license or certification denied shall be denied employment as an attendant.

The Department does not require an abuse registry screening, because the State does not have such a registry.

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

- (◉) **No. The state does not conduct abuse registry screening.**
- (○) **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

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.*

The child's parents and/or legal guardian may be paid to furnish health maintenance activities through In-Home Support Services so long as the care is determined to be extraordinary. Extraordinary care is determined by assessing whether a child 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.

Services provided by a legal guardian are authorized and reviewed quarterly by the case manager based on the client's needs. To receive In-Home Support Services, the client is required to have an authorized representative to direct and manage services in collaboration with the In-Home Support Services provider agency. Services delivered through In-Home Support Service provider agencies are monitored by the case manager and audited by the Colorado Department of Public Health and Environment.

A parent and/or guardian who is the child's authorized representative may not be reimbursed for the provision of IHSS.

HMA is authorized based on the medical and functional conditions of the member. All requests receive a Utilization Review by a Utilization Review Contractor (URC) prior to authorization. HMA services provided by a legally responsible adult cannot exceed 24 hours per day, and may not duplicate other authorized services such as home health or private duty nursing.

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

☒ **Self-directed**

☐ **Agency-operated**

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

○ **The state does not make payment to relatives/legal guardians for furnishing waiver services.**

◉ **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

For the purpose of this section, the family shall be defined as any persons related to the child by virtue of blood, marriage, adoption, or common law.

Family members may be employed by an In-Home Support Services (IHSS) agency to provide Health Maintenance Activities to the child under the CHCBS waiver; however, the family member who is an individual's authorized representative may not be reimbursed for the provision of IHSS.

Services provided by a legal guardian are authorized and reviewed quarterly by the case manager based on the client's needs. To receive In-Home Support Services, the client is required to have an authorized representative to direct and manage services in collaboration with the In-Home Support Services provider agency. Services delivered through In-Home Support Service provider agencies are monitored by the case manager and audited by the Colorado Department of Public Health and Environment.
The Service Plan includes a statement of allowable attendant and personal care service hours and a detailed listing of the amount, scope, and duration of each service to be provided for each day and visit. The Service Plan also includes documentation of the level of oversight by a licensed health care professional determined by the client or the client's authorized representative and the agency, documentation that adequate staffing including backup staff will be available to provide necessary services, a dispute resolution process, and who will be providing each service. The Service Plan is signed by the client or the client's authorized representative to ensure that the services are furnished in the best interest of the individual. The agency also signs the Service Plan.
The CMA reviews the IHSS Prior Authorization Request (PAR) and approves it prior to services being rendered. Reimbursement only occurs upon approval of the Service Plan and after the PAR has been submitted and approval has been received. Payment is only made to services that have been approved in the PAR

○ **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:

An IHSS provider interested in providing services must first complete a survey by the Department of Public Health and Environment(DPHE). After the provider has completed the survey, DPHE will recommend or deny the provider for Medicaid certification. A second certification is then conducted by the Department after reviewing the recommendation by DPHE and either certifying the provider or asking that the provider improve their conformance to rules and/or regulations before certifying the provider.

Once an In-Home Support Services (IHSS) provider has obtained Medicaid certification, the provider is referred to the Colorado Medical Assistance Program fiscal agent to obtain a provider number and a Medicaid provider agreement. Any certified, willing, and interested providers may request an enrollment packet from the Colorado Medical Assistance Program fiscal agent. The fiscal agent enrolls providers in accordance with Medical Assistance Program regulations and the Department's directives. The fiscal agent maintains provider enrollment information in the Medical Assistance Program Management Information System.

The enrollment application is designed to address requirements for providers who render specific types of services. Providers who have questions about how to complete the application may contact the fiscal agent for technical assistance. The fiscal agent processes applications promptly and sends written notification of the action to the provider within ten (10) days of receipt of the application. Providers whose applications are approved will be sent a provider number and information to help the provider to begin to submit claims. Incomplete applications are delayed in processing, but the provider will be sent a letter identifying the missing information or incomplete documents. Providers whose applications are denied will be advised of the reason for denial.

The Department also distributes a Provider Bulletin that contains notification of changes to existing programs or updates about new programs and services. Providers are able to contact the fiscal agent or Department directly to inquire about enrollment or provider qualification requirements.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

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

Performance Measures

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

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

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

waiver providers, by type, surveyed during perfce period

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

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

Data Aggregation and Analysis:

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

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:

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

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

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

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

Data Aggregation and Analysis:

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

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

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

☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: CDPHE	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Data Source (Select one):

Other
If 'Other' is selected, specify:
MMIS provider records

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

Data Aggregation and Analysis:

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

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:
C.c.1 Number and percent of surveyed CHCBS waiver providers who meet Department waiver training requirements in accordance with state requirements and the approved waiver Numerator: Number of surveyed CHCBS 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:	☒ **Annually**	☐ **Stratified** Describe Group:

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

Data Aggregation and Analysis:

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

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

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

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

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

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

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

C.b.1
The Department reviews the waiver provider qualifications. The fiscal agent enrolls providers in accordance with program regulations and maintains provider enrollment information in the MMIS. All provider qualifications are verified by the fiscal agent upon initial enrollment and in a revalidation cycle; at least every five years. Data reports verifying that non-licensed/non-certified providers continually meet waiver requirements are maintained by the Department's waiver provider enrollment staff.

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

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

C.c.2
Department regulations for provider general certification standards require provider agencies to maintain a personnel record for each employee and supervisor that includes documentation of qualification and required training completed.

b. Methods for Remediation/Fixing Individual Problems

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

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

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

C.a.2
The Department initiates termination of the provider agreement for any provider who is in violation of any applicable certification standard, licensure requirements, or provision of the provider agreement and does not adequately respond to a corrective action plan within the prescribed period of time.

C.a.6
If areas of non-compliance with standards exist, the Department issues a list of deficiencies to the provider. The provider is required to submit an acceptable Plan of Correction (POC) to the Department within a specified timeframe. If areas of non-compliance exist where the health and welfare of participants receiving services are in jeopardy, then the provider is required to correct the problem immediately and provide documentation of corrections to Department. The Department initiates termination of the provider agreement for any provider who is in violation of any applicable certification standard, licensure requirements, or provision of the provider agreement, and does not adequately respond to a POC within the prescribed period of time.

C.b.1
If areas of non-compliance with standards exist, the Department issues a list of deficiencies to the provider. The provider is required to submit an acceptable Plan of Correction to the Department within a specified timeframe. If areas of non-compliance exist where the health and welfare of participants receiving services are in jeopardy, then the provider is required to correct the problem immediately and provide documentation of corrections to Department. Providers that do not remediate deficiencies in accordance with the POC are terminated from the program.

C.c.1
The Department reviews CDPHE provider surveys to ensure plans of correction are followed up on and waiver providers are trained in accordance with Department regulations.

C.c.2
The Department initiates termination of the provider agreement for any provider who is in violation of any applicable certification standard, licensure requirements, training requirements, or provision of the provider agreement and does not adequately respond to a corrective action plan within the prescribed period of time.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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.

The Department limits In Home Support Services (IHSS) to children who are determined that they will be safely served in the home.

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.

Waiver participants reside in the homes of their parents or legally responsible adults. Case Management Agencies include a description of the home's conditions at the time of the initial functional assessment, during periodic monitoring, and/or annual visits for the purposes of documenting the appropriateness of the child to remain in the home. These descriptions are a part of the 100.2 Long-Term Care Assessment.

Services are most often provided in the child's private residence. Services may be provided in the community, such as a community event, a siblings' sporting event, a park, or anywhere else in the community that allows the child to be a part of the community. Clients and families have a choice of where they would like to receive services.

During the transition period, all service settings in this waiver were presumed to meet the HCB Settings requirements in accordance with 42 C.F.R. 441.301(c)(4)-(5). See 10 CCR 2505-10 section 8.484.1.B.1 ("The following settings were presumed compliant during the transition period and remain covered by this presumption until March 17, 2023: . . . Residential settings owned or leased by individuals receiving HCBS or their families (personal homes).").

Measures to ensure ongoing compliance include the following:
-The Department codified the settings criteria in rule (10 CCR 2505-10 section 8.484). Section 8.484.3 of the rule details requirements for all HCBS settings, including personal homes.

The Department developed processes for case managers to confirm with individuals that the settings in which they receive services are compliant. To date, most of these processes and tools are related to ensuring that rights modifications are appropriately developed, documented, and consented to. An additional monitoring tool for case managers cover the settings criteria more broadly. Case managers are directed to use the tool to help monitor settings compliance during quarterly monitoring contacts with members.

-The Department and CDPHE updated their websites and materials sent to providers and prospective providers seeking to add/expand their HCBS offerings, to enhance awareness of settings rule expectations.

-CDPHE updated the tools and processes it uses to conduct routine provider enrollment and quality assurance surveys, with cross-training of survey staff on settings rule criteria.

-Members are informed of their rights under the rule through videos and resource sheets. If they have a question or concern about potential noncompliance, they can escalate it as detailed in the dedicated Ask a Question/Report a Concern section of the Department's settings rule website.

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:
- ☐ **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.

Clients and/or parents, guardians, or legal representatives may choose among qualified providers and services. The case manager will advise the client and/or parents, guardians, or legal representative of the range of services and supports for which the client is eligible in advance of service plan development. The choice of services and providers for the waiver benefit package is ensured by facilitating a person-centered planning process and providing a list of all providers from which to choose. Waiver clients and/or parents, guardians, or legal representatives are informed they have the authority to select and invite individuals of their choice to actively participate in the service planning process.

When scheduling to meet with the client and or child's parents and/or legal guardian the case manager makes reasonable attempts to schedule the meeting at a time and location convenient for all participants. In addition, the child and/or the child's parents and/or legal guardian have the authority to select and invite individuals of their choice to actively participate in the service planning process. Case managers develop emergency backup plans with the client and/or child's parents and/or legal guardian during the service planning process and document the plan on the service plan. The client must be seen at the time of the initial assessment and at the redetermination to ensure that the client is in the home.

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

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

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

To facilitate person-centered practices, CMAs may use phone or other technological contact to engage in the development and monitoring of the PCSP. 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.

All forms completed through the Person-Centered Support Planning process are available for signature through digital or wet signatures based on the member's preference.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

When scheduling to meet with the child's parents and/or legal guardian the case manager makes reasonable attempts to schedule the meeting at a time convenient for the child, the child's parents, and/or legal guardian to complete a Level of Care Eligibility Determination Screen (LOC Screen). 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.

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

The case manager also determines if services provided by a caregiver living in the home are beyond the workload of a normal family/household routine. The case manager works with the child's parents and/or legal guardian to identify risk factors and addresses risk factors with appropriate parties.

Since December 2021, 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.

Once the PCSP is developed, the case manager explains options for services and providers to the child's parent and/or legal guardian. The child's parents and/or legal guardian are required to access services through other sources such as State Plan benefits and EPSDT services when available, before accessing waiver benefits. The case manager arranges and coordinates services documented in the PCSP. Services requiring a skilled assessment, such as skilled nursing or home health aide (Certified Nursing Aide) are determined and referrals are made to the appropriate providers of the child's parents and/or legal guardian choice. The PCSP defines the type of services, frequency, and duration of the services needed. The PCSP documents that the child's parent and/or legal guardian have been informed of the choice of providers and documents that the child's parents and/or legal guardian have chosen to have services provided in the community, in an acute hospital, or in a skilled nursing facility. The PCSP is completed within 15 working days of the child being determined eligible for CHCBS. The child's parents and/or legal guardian sign the PCSP. The services begin when all the criteria are met including program and financial eligibility.

The child's parents and/or legal guardian may contact the case manager for ongoing case management such as assistance in coordinating services, conflict resolution, or crisis intervention, as needed. 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, Assessment, and PCSP with the child's parents and/or legal guardian during the required monitoring contact. This review includes obtaining information concerning the child's parents and/or legal guardian's satisfaction with the services provided, informal assessment of changes in the child's function, service effectiveness, service appropriateness, and service cost-effectiveness. If complaints are raised by the child's parents and/or legal guardian the case manager will document the complaint on the Case Management Agencies complaint log and assist the child's parent and/or guardian to resolve the complaint.

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

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.

If complaints are raised by the client about the Person-Centered Support Planning process, case manager, or other case management agency (CMA) functions, case managers are required to document the complaint on the CMA complaint log and assist the client to resolve the complaint.

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

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

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Risks are assessed as part of the Person-Centered Support Planning and are documented on the PCSP. Case managers are required to provide the child's parents/or legal guardian with all of the choices available to the client for long-term care. These choices include continuing to live in the child's parents' and/or legal guardian's home or choosing to live in a Skilled Nursing Facility or an acute hospital. The case manager discusses the possible risks associated with the child's parents and/or legal guardian's choice of living arrangement with the child's parents and/or legal guardian. The case manager, the child's parents, and/or legal guardian then develop strategies for reducing these risks. Strategies for reducing these risks include developing backup plans. Back-up plans are designed to be child-centered and often include relying on the child's parents and/or legal guardian choice of family, friends, or neighbors to care for the child if a provider is unable to do so, or for life or limb emergencies, child's parents and/or legal guardian are instructed to call his/her emergency number (i.e. 911).

The service provider is informed of the potential risks of providing services to the child prior to services beginning 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.

During the Person-Centered Support Planning process, the case manager discusses the waiver service options with the child's parents and/or legal guardian and provides them with a list of qualified providers for all services included on the PCSP. A client may select providers of his/her choice from the list. The child's parents and/or legal guardian who choose In-Home Support Services will have the flexibility of hiring his/her own attendants.

The Department has developed an informational tool that is available to the child's parents and/or legal guardian to assist them in selecting a service agency. This informational tool is available from the case manager or by visiting the Department of Public Health and Environment (DPHE) 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):

Case Management Agencies (CMAs) are required to prepare PCSP according to the Department and CMS waiver requirements. The Department monitors each CMA annually for compliance. A sample of documentation including individual PCSP is reviewed for accuracy, appropriateness, and compliance with regulations at 10 C.C.R. 2505-10, Section 8.390.

The PCSP must include the client’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 authorizations are compared with the documented level of care for appropriateness and adequacy. A targeted review of PCSP documentation and authorization review is part of the overall administrative and programmatic evaluation by the Department.

Appendix D: Participant-Centered Planning and Service Delivery

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

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**

☐ **Operating agency**

☒ **Case manager**

☒ **Other**

Specify:

The PCSP is also available electronically on the State's case management IT system and can be viewed by the child's Case Management Agency and the Department.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

Case Management Agencies are responsible for PCSP development, implementation, and monitoring. Case managers are required to meet the child's parents and/or legal guardian (and anyone else the child's parents and/or legal guardian chooses) annually for PCSP development. Once the PCSP is implemented case managers are required to conduct monitoring with the child's parents and/or legal guardian to ensure the PCSP continues to meet the child's needs. Case managers are also required to contact the child's parents and/or legal guardians when significant changes occur in the child's physical or mental condition. To facilitate person-centered practices, CMAs may use phone or other technological contact to engage in the development and monitoring of PCSP.

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

Upon Department approval in advance, contact may be completed by the case manager at an alternate location, via the telephone, or using 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 waiver participants. 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. Within the CHCBS waiver, this monitoring often is required to occur at a higher frequency to meet the needs of the child's family. The monitoring includes verifying that services are furnished in accordance with the PCSP. The case management system for PAR development and submission allows case managers to see the unit decrement on the PAR. Additionally, case managers verify with individuals and provider agencies to ensure services are delivered in accordance with the PCSP. The monitoring requires that case managers monitor the access to services, if services are meeting the individual's needs, the use of the contingency plan, health and safety including follow-up to any critical incident reports, and the use of non-waiver services.

Participant's exercise of free choice of providers:
Each case management agency is obligated to provide the child's parents and/or legal guardian with the free choice of qualified providers, the Department has added a signature section to the PCSP that indicates whether they have been offered the 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.

The child's parents and/or legal guardian are provided with this information during the initial and annual Person-Centered Support Planning process using the Client Roles and Responsibilities and the Case Manager's Roles and Responsibilities form. The form provides information to the child's parents and/or legal guardian 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 the child's parents and/or legal guardian are responsible for notifying their case manager of any changes in the child'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 child's parents and/or legal guardian. 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.

In addition, the Department audits each CMA for administrative functions including qualifications of the individuals performing the LOC Screen and Person-Centered Support Planning, the process regarding the evaluation of need, PCSP development, 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 through various sources such as the Department staff, CDPHE, and the child's parents and/or legal guardian complaints. The policies and procedures Program Integrity employs in this review are available from the Department.

Cost is also monitored by the Department staff reviewing the 372 reports and 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 collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval =

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

Data Aggregation and Analysis:

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

Performance Measure:

D.a.3 Number and percent of waiver participants whose PCSPs address identified health and safety risks through a contingency plan Numerator: Number of waiver participants whose PCSPs address identified health and safety risks through a contingency plan Denominator: Total number of waiver participants reviewed

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

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

Data Aggregation and Analysis:

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

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):
Record reviews, on-site
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	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

(check each that applies):		
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level 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.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:

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 the 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 SP sub-assurances and performance measures.

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

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

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

D.c.1
If a PCSP revision need is indicated, the revision must be: included in the participant's record; supported by documentation in the applicable areas of the LOC Screen, Log notes, or CIRS, and address all service changes in accordance with Department policy, delivered to the participant or the participant's representative; and, signed by the participant or the legal guardian, as appropriate. All forms completed through the Person-Centered Care Planning process are available for signature through digital or wet signatures based on the member's preference. The reviewers use the State's case management IT system and/or Bridge to discover deficiencies for this performance measure and report in the QI Review Tool.

D.c.2
The PCSP start date must be within one year of the prior PCSP start date, for existing, non-new waiver participants in the sample. Discovery data for this performance measure is pulled directly from the State's case management IT system.

D.d.2, D.d.4-5
The Department compares data collected from MMIS claims and the participant's PCSP to discover deficiencies in this performance measure. Case managers are required to perform follow-up activities with participants and providers to ensure the PCSP reflects the appropriate services authorized in the amount necessary to meet the participant's identified needs.

D.e.1
PCSP Service and Provider Choice page must indicate that the participant has been provided a choice between/among HCBS waiver services and qualified waiver service providers. Discovery data for this performance measure is pulled directly from the State's case management IT system.

b. Methods for Remediation/Fixing Individual Problems

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

the methods used by the state to document these items.

D.a.1, D.a.2, D.a.3, D.c.1, D.c.2, D.d.2, D.d.4-5, 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 PCSPs. The remediation process includes a standardized template for individual CMA Corrective Action Plans (CAPs) to ensure all of the essential elements, including root-cause analysis, are addressed in the CAP. Time-limited CAPs are required for each performance measure when the threshold of compliance is at or below 85%. The CAPS must also include a detailed account of actions to be taken, staff responsible for implementing the actions, timeframes, and a date for completion. The Department reviews the CAPs, and either accepts or requires additional remedial action. The Department follows up with each individual CMA quarterly to monitor the progress of the action items outlined in their CAP.

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

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

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

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

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

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

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

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

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

The CHCBS waiver currently offers In-Home Support Services (IHSS) as a participant-directed service delivery option. The case manager provides an informational packet including service description, eligibility criteria, and required paperwork to new and current CHCBS clients.

The child's parents and/or legal guardian who is interested in IHSS are required to complete a Physician Attestation of Consumer Capacity and Authorized Representative forms. IHSS agencies who are willing and able to provide the support necessary for clients to participate must document this choice on the Physician Attestation. The case manager completes the PAR and then provides the child's parents and/or legal guardian with a list of certified IHSS agencies.

The child's parents and/or legal guardian who chooses IHSS has the opportunity to hire, train, and schedule an attendant of his/her choice for their child. The attendant is employed by a certified IHSS agency. The child's parents and/or legal guardian develop an IHSS Care Plan with the IHSS agency he/she has chosen. The IHSS care plan must include a statement of allowable attendant service hours, and a detailed listing of the amount, scope, and duration of services to be provided. The IHSS care plan must be signed by the child's parents and/or legal guardian.

The child's parents and/or legal guardian may obtain support from the IHSS agency to hire the attendant(s) of his/her choice. The IHSS agency is required to assure and document that each of a child's parents or legal guardians was offered and either accepted or declined peer counseling, information and referrals, skills training, and individual and systems advocacy. The IHSS agency must also provide a 24-hour backup attendant to the child if the child requires one.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver.

Select one:

- (●) **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ( ) **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ( ) **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- [x] **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- [ ] **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- [ ] **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ( ) **Waiver is designed to support only individuals who want to direct their services.**
- (●) **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ( ) **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

The case manager is responsible to provide a child's parents and/or legal guardian with the service options that are available. These options may include traditional agency services or In-Home Support Services (IHSS). The case manager will inform the child's parents and/or legal guardian about the potential benefits and risks of each service option as well as inform them about the responsibilities that accompany their decision. If the child's parents and/or legal guardian are interested in IHSS the case manager will provide the child's parents and/or legal guardian with the necessary forms needed to participate.

If the child's parents and/or legal guardian are interested in IHSS the child's parents and/or legal guardian are informed about the number of hours of care the participant is eligible for and provides the child's parents and/or legal guardian with a list of IHSS certified agencies. The IHSS agency is responsible to provide the child's parents and/or legal guardian with peer counseling, information, referrals, skills training, and individual and systems advocacy.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one):*

○ **The state does not provide for the direction of waiver services by a representative.**

◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☒ **Waiver services may be directed by a legal representative of the participant.**

☒ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.** Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

The Department allows non-legal representatives to be authorized representatives for CHCBS members utilizing IHSS.

Non-legal representatives are appointed by the member's legal guardian utilizing a shared responsibility form.

In order to ensure the agency actions truly reflect the principles of participant direction, the Department's administrative rules for In-Home Support Services specify the client and/or the Authorized Representatives have the right to:
1. Present a person(s) of their own choosing to the IHSS Agency as a potential Attendant. The client must have adequate Attendants to assure compliance with all tasks in the Care Plan.
2. Train Attendant(s) to meet their needs.
3. Dismiss Attendants who are not meeting their needs.
4. Schedule, manage and supervise Attendants with the support of the IHSS Agency.
5. Determine, in conjunction with the IHSS Agency, the level of in-home supervision as recommended by the client's Licensed Medical Professional.
6. Transition to alternative service delivery options at any time. The Case Manager shall coordinate the transition and referral process.
7. Communicate with the IHSS Agency and Case Manager to ensure safe, accurate, and effective delivery of services.
8. Request a reassessment if the level of care or service needs have changed.

The Department ensures that these policies are enforced through its contract with the Colorado Department of Public Health & Environment (CDPHE). CDPHE manages all aspects of provider surveying and licensure including conducting surveys of agencies to verify that they are complying with IHSS rules before they can be authorized to provide IHSS and then periodically after they are enrolled as providers. Upon completion of each survey of a provider, CDPHE prepares a written statement of deficiencies identifying any standards the provider failed to meet. The written statement of deficiencies is entered into the CMS Automated Survey Processing Environment (ASPEN) system, consistent with CMS guidelines. 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. Additionally, any complaints received by CDPHE are assessed for immediate jeopardy or life-threatening situations and are investigated in accordance with applicable federal requirements and time frames.

The Department not only contracts with CDPHE, but the Department also contracts with Case Management Agencies (CMAs) to ensure the IHSS agency functions in the best interest of the client. Case managers are responsible for assuring the quality of care by monitoring service providers including IHSS agencies. The case manager monitors the appropriateness of services provided, the amount of care, the timeliness of service delivery, client satisfaction, and the safety of the client by taking corrective actions as needed. On an ongoing basis, case managers are required to contact the client concerning the client's satisfaction with the services provided. Lastly, the CMAs are required to contact service providers concerning service coordination, effectiveness, and appropriateness, as well as concerning any complaints raised by the client or others.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
In Home Support Services	☒	☐

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and

integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

○ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☐ **Private entities**

◉ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

Answers provided in Appendix E-1-h indicate that you do not need to complete this section.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☒ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

The Case Management Agency is responsible for providing information on the participant-directed option IHSS to the child's parents and/or legal guardian during the initial Level of Care Eligibility Determination Screen (LOC Screen) and Person-Centered Support Planning process and at the time of the Continued Stay Review (CSR). The case manager will provide an informational packet including service description, eligibility criteria, and required paperwork to the new and current child's parents and/or legal guardian.

When information and assistance supports are furnished as part of TCM services, the supports are detailed by participant direction opportunity. The nature of the supports is consistent with the statutory scope of TCM and the coverage of TCM contained in the state plan.

A child's parent and/or legal guardian interested in participating in In-Home Support Services(IHSS) is required to return the paperwork to the case management agency. The case manager will review the paperwork for proper completion. The case manager will then provide the child's parent and/or legal guardian with a list of certified IHSS agencies from which to choose. The child's parent and/or legal guardian will submit his/her child's IHSS plan to the case manager for approval prior to beginning.

The child's parent and/or legal guardian interested in participating in IHSS must obtain a Physician Attestation from his or her primary care physician indicating that the parent has sound judgment and the ability to direct the child's care or has an authorized representative who is able to direct the child’s care on his or her behalf.

Clients and/or authorized representatives who choose IHSS have the opportunity to hire, train, and schedule an attendant of his/her choice. The attendant is employed by a certified IHSS agency. The client and/or authorized representative develop an IHSS care plan with the IHSS agency of choice. The IHSS care plan must include a statement of allowable attendant care service hours, a dispute resolution process, and a detailed listing of the amount, scope, and duration of services to be provided. The IHSS care plan must be signed by the client and/ or authorized representative and must be reviewed and approved by the case manager.

☒ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Wellness Education Benefit	☐
In Home Support Services	☒
Case Management	☒

☒ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

The child's parents and/or legal guardians who choose IHSS will be referred to certified IHSS agencies. The IHSS agency is responsible for providing the child's parents and/or legal guardian with functional skills training to assist the client the child's parents and/or legal guardian or authorized representative in developing skills and resources to maximize their health care activities.

In the circumstance that the child and their parents/guardian are able to direct some but not all aspects of the child's care, the IHSS agency is able to provide support to the family. Examples of the support allowed to be provided by IHSS agencies include:
- Information and referral services,
- Systems advocacy,
- Independent living skills training,
- Cross-disability peer counseling, and
- 24-hour backup staffing

In-Home Support Service provider agencies receive an initial certification and compliance survey every three years through the Colorado Department of Public Health and Environment to review compliance with In-Home Support Service provider qualifications and rules. Agencies are required to provide assistance to the authorized representative on how to direct and manage services. The provider agency does not receive additional compensation for providing support. The agency is able to bill the waiver service for health maintenance services rendered.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

- (●) **No. Arrangements have not been made for independent advocacy.**
- ( ) **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

Participation in IHSS is voluntary. A child's parents and/or legal guardian may choose to withdraw at any time. If a child's parents and/or legal guardian choose to withdraw, he/she must contact the child's case manager who will assist the child's parents and/or legal guardians in transitioning to equivalent care in the community. Equivalent care is the delivery of similar services through an agency-based model rather than a participant-directed. A child's parents and/or legal guardian may choose to return to the child’s previous Medicaid-funded attendant care program, as long as the child remains eligible for that program or a child's parents and/or legal guardians may choose to withdraw from IHSS.

Prior to the termination of services, the case manager works with the client and their representatives to determine Medicaid and non-Medicaid services in the community to best meet the client's needs. Prior to the termination of services, the case manager arranges alternative services and coordinates a start date to avoid disruption of service delivery.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Circumstances that may result in an involuntary termination of IHSS:
1. The client is no longer eligible for the CHCBS waiver program; or
2. The client's parent or legal guardian fails to comply with IHSS program requirements; or
3. The client's parent or legal guardian demonstrates an inability to manage attendant support; or
4. The client refuses to designate an authorized representative or receive the assistance of an IHSS agency if the client is unable to direct his/her own care as documented by the primary physician; or
5. The client or the client's parent or legal guardian exhibits inappropriate behavior toward the attendant and the Department has determined that the IHSS agency has made adequate attempts to resolve the behavior and resolution has failed. Inappropriate behavior includes but is not limited to, documented verbal, sexual, or physical abuse.
IHSS agencies must assure that equivalent care has been established prior to the discontinuation of services.

Prior to the termination of services, the case manager works with the client and their representatives to determine Medicaid and non-Medicaid services in the community to best meet the client's needs. Prior to the termination of services, the case manager arranges alternative services and coordinates a start date to avoid disruption of service delivery.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1	1536	
Year 2	1740	
Year 3	1970	
Year 4	2231	
Year 5	2526	

Appendix E: Participant Direction of Services

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

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☒ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports

are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

The In-Home Support Services (IHSS) delivery option provides participants an opportunity to direct their services and attendants with the support of a licensed home care agency, which acts as the employer of record. Participants or their Authorized Representatives (ARs) in IHSS receive an orientation to IHSS provided by the agency, as well as a Participant Guide developed by the Department to inform participants and ARs on the principles of self-direction. Members and ARs can also utilize the IHSS Member/AR Training provided by the Training Vendor. Participants or ARs are able to direct and manage their attendants, including recruiting, selecting, interviewing, scheduling, training, supervising, and dismissing attendants. IHSS Agencies are surveyed by the Department of Public Health and Environment to ensure that agencies are compliant with the state's promulgated rules and allow participants or ARs to direct and manage their care.

☐ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☒ **Recruit staff**

☒ **Refer staff to agency for hiring (co-employer)**

☒ **Select staff from worker registry**

☐ **Hire staff common law employer**

☒ **Verify staff qualifications**

☐ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

☐ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☐ **Determine staff wages and benefits subject to state limits**

☒ **Schedule staff**

☒ **Orient and instruct staff in duties**

☒ **Supervise staff**

☐ **Evaluate staff performance**

☒ **Verify time worked by staff and approve time sheets**

☒ **Discharge staff (common law employer)**

☐ **Discharge staff from providing services (co-employer)**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

☐ **Reallocate funds among services included in the budget**

☐ **Determine the amount paid for services within the state's established limits**

☐ **Substitute service providers**

☐ **Schedule the provision of services**

☐ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**

☐ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**

☐ **Identify service providers and refer for provider enrollment**

☐ **Authorize payment for waiver goods and services**

☐ **Review and approve provider invoices for services rendered**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iv. Participant Exercise of Budget Flexibility. *Select one*:

- ○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ○ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

The case management agency notifies the child's parents and/or legal guardian when any of the adverse actions identified at 42 CFR Part 431, Subpart E occurs. These adverse actions include not being given the choice of home and community-based services as an alternative to institutional care, being denied the choice of services or providers, or if services are denied, suspended, reduced, or terminated. Notice of client appeal rights is mailed using the Department-approved Notice of Action form number 803 (LTC 803 Form) and/or prior authorization request (PAR) for services denial letter is generated by the state's case management IT system and includes the appeal rights and instructions on how to file an appeal. The case management agency is required to provide information regarding the right to request a fair hearing to the child's parents and/or legal guardian or authorized representative when they apply for publicly funded programs as set forth in 10 C.C.R. 2505-10, § 2505-10-8.057.7and 8.393.2.B.2.d et seq.

An explanation of appeal rights is made available to all clients when they are approved or denied eligibility for publicly funded programs and when services are denied or reduced. A notice of service status form is mailed to the child's parents and/or legal guardian defining the proposed action and information on appeal rights. The process and procedures for requesting a fair hearing with the State's Office of Administrative Courts (OAC) are listed on the reverse side of the notice. Case managers are required to assist the child's parents and/or legal guardian or authorized representative in developing a written request for an appeal if they are unable to complete one on their own.

Appeal rights are also included on the Long Term Care Plan Information form. The case manager reviews this form with the child's parent and/or legal guardian time of evaluation and reevaluation. A copy of this form is provided to the child's parent and/or legal guardian. During the monitoring of the case management agencies, the Department reviewers survey a random sample of client records. Included in the record review will be an examination of the LTC 803 Notice of Action to ensure that each case management agency is using the approved form to convey information to the child's parents and/or legal guardian or authorized representative on fair hearing rights. Client appeal rights are maintained on an LTC 803 form in the state's case management IT system. Case managers are instructed to send a Notice of Action whenever there is a change or reduction in services or when a client has been denied HCBS services due to functional ineligibility. The 803 forms completed are available for the case manager and case manager's supervisor signature through digital or wet signatures.

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

Clients who are denied CHCBS services due to ineligibility are provided with appeal rights and referred to alternative community resources including home health, and other state plan benefits, if applicable.

Every Medicaid action that is appealed to the OAC is reviewed by the Department. When the child's parents and/or legal guardian appeals a decision, the OAC notifies the Department of the appeal hearing and a case manager participates in the hearing. Following the hearing, the administrative law judge issues an Initial Decision and sends it to the Office of Appeals (OA). The OA distributes the Initial Decision to all parties, including the Department, to review. All parties then have an opportunity to file exceptions to the administrative law judge’s Initial Decision if they disagree with it. The OA is responsible for reviewing all of the documents presented at the hearing, as well as subsequent filings of exceptions to ensure that the Initial Decision complies with the Department's regulations. The OA then issues a Final Agency Decision to affirm, reverse, or remand the administrative law judge’s decision.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ( ) **No. This Appendix does not apply**
- (●) **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

Case managers provide individuals and families with information on how to report a grievance or complaint to multiple individuals. The grievance or complaint may be reported to the case manager, the case manager's supervisor, the case management agency administrator, and/or Department staff. It is not a requirement for complaints to go through the case manager.

Case Management Agencies (CMA) are responsible for operating an internal grievance system, the Department oversees the CMA grievance.

The Department currently has an informal complaint/grievance process that includes direct contact with the child's parents and/or legal guardian, family members, and/or advocates that have concerns or complaints may contact the Department directly. If the Department receives a complaint, the Office of Community Living investigates the complaint and remediates the issue.

A Home Health Hotline is maintained by the Colorado Department of Public Health and Environment, Health Facilities and Emergency Services Division (CDPHE). 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. The hotline system is in addition to the informal process used by CMAs. The home health hotline is used for complaints about individual care providers, fraud, abuse, or the misuse of personal property involving home health agencies. A second critical incident line is used by agencies licensed and/or surveyed by CDPHE to report issues such as unexpected death or disability, abuse, neglect, and misuse of personal property. Both hotlines are maintained by CDPHE.

Case Management Agencies are not licensed or surveyed by CDPHE. CDPHE does not oversee CMA complaints or grievances that might be made to the CDPHE hotline.

If complaints are raised by the child's parents or legal guardian 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. This complaint log comes to the Department on a quarterly basis. The Department is then able to review the log and note trends to discern if a certain case manager or agency is receiving an increase in complaints.

Case managers are required to contact the child's parents and/or legal guardian monthly and inquire about the quality of services clients are receiving. If a CMA identifies ongoing or system-wide issues, the CMA administrator will bring the issue to the Department's attention for resolution. The client may also contact the case manager's supervisor or the Department if they do not feel comfortable contacting the case manager directly. The contact information for the case manager's supervisor, the CMA administrator, and the Department is included on the copy of the support plan that is provided to the client. The client also has the option of lodging an anonymous complaint to the case manager, CMA, or the Department.

Clients are informed that filing a grievance or making a complaint is not a prerequisite for a fair hearing. Instructions for requesting a fair hearing are provided to the client with any notice of adverse action. These instructions do not require that the client file a complaint or grievance.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Colorado Department of Public Health and Environment, Health Facilities and Emergency Services Division (CDPHE) maintains a Home Health 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. 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 the survey. A second critical incident line is maintained by CDPHE for such issues as unexpected death or disability, abuse, neglect, and misuse of personal property for voluntary reporting by licensed agencies. CRS Title 25 Section 25-1-124 and 42 CFR Chapter IV, Section 484.10(f).

In addition, case management agencies maintain a log system for complaints and grievances and either resolve the problem themselves or refer to the appropriate oversight agency. The grievance log must include the date on which the grievance was received and the date on which the Case Management Agency responded. The Department reviews the complaint/grievance process through Case Management Agency contract deliverables 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.

The Department currently has an informal complaint/grievance process that includes direct contact with clients. Clients, family members, and/or advocates that have concerns or complaints may contact the Department directly. If the Department receives a complaint, the program administrator or HCBS provider manager investigates the complaint and remediates the issue within 48 business hours.

State laws, regulations, and policies referenced in the description are available through the Department.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Critical incidents are those incidents that create the risk of serious harm to the health or welfare of the individual receiving services, and they may endanger or negatively impact the mental and/or physical well-being of an individual. Critical Incident categories that must be reported include, but are not limited to Injury/illness; mistreatment/abuse/neglect/exploitation; damage/theft of property; medication mismanagement; lost or missing person; criminal activity; unsafe housing/displacement; or death. Definitions of incidents, as used by the Department are as follows:

Death:
• Unexpected or expected
Mistreatment/Abuse/Neglect/Exploitation:

•Abuse or child abuse or neglect means an act or omission in one of the following categories that threaten the health and welfare of a child:

• Any case in which a child exhibits evidence of skin bruising, bleeding, malnutrition, failure to thrive, burns, fracture of any bone, subdural hematoma, soft tissue swelling, or death and either: Such condition of death is not justifiably explained; the history given concerning such condition is at variance with the degree or type of such condition or death, or the circumstances indicate that such condition may not be the product of an accidental occurrence;

• Any case in which a child is subjected to unlawful sexual behavior as defined in section 16-22-102(9), C.R.S;

• Any case in which a child is a child in need of services because the child's parents, legal guardians, or custodian fails to take the same actions to provide adequate food, clothing, shelter, medical care, or supervision that a prudent parent would take.

• Any case in which a child is subjected to emotional abuse. Emotional abuse means an identifiable and substantial impairment of the child's intellectual or psychological functioning or development or a substantial risk of impairment of the child's intellectual or psychological functioning or development.

• Any act or omission described in section 19-3-102 (1)(a), (1)(b), or (1)(c), C.R.S.

• Any case in which, in the presence of a child, or on the premises where a child is found, or where a child resides, a controlled substance, as defined in section 18-18-102(5), C.R.S, is manufactured or attempted to be manufactured

• Any case in which a child is born affected by alcohol or substance exposure, except when taken as prescribed or recommended and monitored by a licensed health care provider, and the newborn child's health or welfare is threatened by substance use;

• Any case in which a child is subjected to human trafficking of a minor for involuntary servitude, as described in section 18-3-503, or human trafficking of a minor for sexual servitude, as described in section 18-3-504(2)

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

Injury/Illness to Client:
• An injury or illness that requires treatment beyond first aid which includes lacerations requiring stitches or staples, fractures, dislocations, loss of limb, serious burns, skin wounds, etc.
• An injury or illness requiring immediate emergency medical treatment to preserve life or limb.
• An emergency medical treatment that results in admission to the hospital.
• A psychiatric crisis resulting in unplanned hospitalization

Damage to Consumer's Property/Theft:
• Deliberate damage, destruction, theft, or use of a waiver recipient's belongings or money.
• If the incident is mistreatment by a caregiver that results in damage to the consumer's property or theft the incident shall be listed as mistreatment

Medication Management Issues:
• Issues with medication dosage, scheduling, timing, set-up, compliance, and administration or monitoring which results in harm or an adverse effect that necessitates medical care.

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

Criminal Activity:
• A criminal offense that is committed by a person.
• A violation of parole or probation that potentially will result in the revocation of parole/probation.

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

Critical incidents are required to be reported by licensed home health care agencies, personal care agencies and homemaker agencies, Alternative Care Facilities (ACF), Adult Day Centers, and Case Management Agencies. Service providers and agencies are required to report all known incidents to CMAs within 24 hours of the incident. Oversight is provided by the Colorado Department of Health Care Policy and Financing and/or the Departments of Public Health and Environment (CDPHE) and Human Services (CDHS).

Critical incidents that involve alleged child abuse, neglect, or exploitation are to be reported immediately (as soon as an incident is reported or discovered) to the county department of human services, the child protection unit in the child's county of residence, and/or local law enforcement agency as required by 10 CCR 2505-10, Section 8.393.2. Case managers are required to document and report made to a protective services unit in the State's case management IT system log notes within 24 hours of the report and are required to provide and document follow-up within three days. CMAs are required to report to the county departments as soon as an allegation of abuse or neglect is reported or discovered. Case managers report critical incidents to Department staff using the Critical Incident Reporting System (CIRS) accessible through the State's case management IT system.

All county departments of social services are required to use the Colorado Child Protective Services automated system to enter information on referrals, information and referral phone calls, and ongoing cases. CDHS is responsible for the administration and oversight of the Child Protection Program.

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

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

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

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

determined eligible for the waiver pursuant to the eligibility process in the waiver.

The Department identifies incidents that were not reported through the critical incident system by pulling hospital/ER claims to cross-reference data in the critical incident system. The Department uses the cross-referenced information to confirm if the member's file has an incident reported, which case management agency is associated with the member, and additional training needed to case management agencies and providers.

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

The Case Management Agencies (CMAs) are required to share information about mistreatment, abuse, neglect, and exploitation to the participants, guardians, involved family members, and authorized representatives verbally and as a printed information packet at initial enrollment and at least annually thereafter. This packet also includes information on the right to be free from mistreatment, abuse, neglect, and exploitation, and how to recognize signs and report them to the appropriate authorities. This information packet also includes information about the types and definitions of Critical Incidents and how to report a Critical Incident and to whom. A child's parent(s) and/or legal guardian(s) are encouraged to report Critical Incidents to their provider(s), case manager, Child Protective Services, and/or any other client advocate.

The Department uses its case management IT system to track the provision of this information and training. The Critical Incident Mistreatment Reporting Participant Education and Contacts aid and the Critical Incident and Mistreatment Participant Reporting Quick Guide (written and audio) are available on the Department website at https://hcpf.colorado.gov/hcbs-waiver-critical-incident-reporting.

Clients and/or legal representatives are informed by the case manager about the CMA's complaint policy and the availability of the Home Health Hotline, an 800 telephone number maintained by the Colorado Department of Public Health and Environment (CDPHE). Home health agencies are also required to provide all clients with the Home Health Hotline number. Additionally, home health agencies are required to maintain an internal complaint log system under one of the conditions of licensure. CDPHE reviews the complaint log during annual surveys.

Training, orientation, and supervision are provided to In-Home Support Services (IHSS) clients by the certified IHSS provider agency. The IHSS agency is responsible for providing the client and/or authorized representative with peer counseling; information and referral services. An IHSS provider agency must provide information to the client/authorized representative that includes the process for reporting abuse, neglect, and exploitation. Clients can notify the IHSS agency, the case manager, and/or the appropriate authority if the clients have experienced abuse, neglect, or exploitation.

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

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.

Colorado Department of Health Care Policy & Financing is responsible for overseeing the operation of the incident management system.

Review and response to critical incidents are provided by Provider/Service Agencies, the Department, CDPHE, and/or CDHS. The response to a critical incident is unique to the type of incident and the parties involved. However, the contract QIO vendor reviews all critical incidents that have been reported.

10 CCR 2505-10 Section 8.608.8.B requires all Community Centered Boards, Case Management Agencies, program-approved service agencies, and regional centers to have written policies and procedures for handling alleged or suspected abuse, mistreatment, neglect, or exploitation of any member. These policies and procedures must include a mechanism for monitoring to detect instances of abuse, mistreatment, neglect, or exploitation, including a review of incident reports, verbal and written reports of changed behavior, and verbal and written reports from members, advocates, family members, guardians, and friends and procedures for reporting; reviewing and investigating allegations of mistreatment, neglect, or exploitation.

10 CCR 2505-10 8.393.2.G.10 Case Manager shall report critical incidents within 24 hours of notification within the State Approved Incident Management System (IMS). This report must include a. individual name; b. individual's identification number; c. HCBS Program; d. Incident type; e. Date and time of the incident, including the name of the facility, if applicable; g. Individuals involved; and h. Description of Resolution. If any of the previously mentioned criteria is missing, then a follow-up is warranted.

10 CCR 2505-10 8.608.D D. All alleged incidents of abuse, mistreatment, neglect, or exploitation shall be thoroughly investigated in a timely manner using the specified investigation procedures.

An IHSS agency is required to staff a Registered Nurse who is responsible to investigate complaints and critical incidents within ten (10) calendar days.

Providers are required to have policies and procedures pursuant to Section 8.5608.160, which address how to respond to alleged or suspected abuse, mistreatment, neglect, or exploitation, including immediate reporting by employees and contractors to an agency administrator or designee and mandatory reporting according to Sections 19-3-304 and 18-6-108 C.R.S. and to report critical incidents according to Section 8.495.6C, which requires reporting a verbal or written report of a critical Incident to the member's case manager within 24 hours of the discovery of the incident. CHCBS Providers are required per Section 8.506.9.B to respond to and report critical incidents pursuant to Section 19-3-307 C.R.S., which requires known or suspected child abuse or neglect to be reported immediately to the county department, local law enforcement agency, or the child abuse reporting hotline per Section 26-5-111 C.R.S.

Case Managers are required pursuant to 8.393.2.G to monitor member's health, safety, and welfare and to report critical incidents within 24 hours of notification to the Department and subsequent follow-up documentation via the IMS and are required to comply with mandatory reporting statutes (10-6.5-108, Section 10-3-304, Section 26-3.1-102 C.R.S.) Community Centered Boards are required pursuant to Section 608.6A have a written policy and procedure for the timely reporting, recording, and reviewing of incidents, to include compliance with all critical incident reporting requirements outlined in Section 8.519.16, and requirements to review and analyze incident report data to identify trends and problematic practices and to take actions to remediate those practices.

The Department evaluates Community Centered Board and Case Management Agency policies and procedures as part of Performance and Quality Reviews to ensure they meet regulatory and contractual requirements. CDPHE reviews program-approved service agencies' and regional centers' policies and procedures for regulatory compliance.

Section 8.608.8 further requires all Community Centered Boards, Case Management Agencies, program-approved service agencies, and regional centers to follow up actions in response to incidents including, but not limited to, actions to protect the safety of the member pending an investigation, providing victim supports, ensure the member is not retaliated against, and that all incidents of abuse, mistreatment, neglect or exploitation be thoroughly investigated in a timely manner, and appropriate action is taken when allegations against an employee or contractor are substantiated.

Critical incidents involving providers surveyed by CDPHE which meet occurrence reporting criteria must be reported to the Department and CDPHE and are responded to by CDPHE. A Home Health Hotline is maintained by CDPHE, Health Facilities, and Emergency Services Division. This hotline is set up for complaints about the quality of care, fraud, abuse,

and misuse of personal property. CDPHE evaluates the complaint and initiates an investigation. The investigation begins within twenty-four hours or up to three days depending upon the nature of the complaint and the risk to the client's health and welfare. Investigation results of the complaint reported to CDPHE are posted for public view on CDPHE's website at www.colorado.gov/pacific/cdphe/find-and-compare-facilities.

Investigations may lead to targeted surveys or full surveys of the agency involved. Investigation surveys may result in deficient practice citations for those agencies. Deficiencies are categorized as isolated (1-49% of clients surveyed), patterned (50-99% of clients surveyed), widespread (100% of those surveyed), and/or immediate jeopardy/life-threatening. Depending upon the risk to the health and safety of clients, the deficiency will require at a minimum a plan of correction to be submitted to CDPHE within specified timelines. Complainants are provided with an initial summary report of findings at the completion of the investigation; however, official survey reports are available to the public within 30 days of the completed process, including submission of the corrective action plan and appeals hearings, as applicable. If an agency has numerous and severe deficiencies, the provider may lose its Medicaid certification.

A second complaint line is maintained by CDPHE for such issues as unexpected death or disability, abuse, neglect, and misuse of personal property for voluntary reporting by licensed agencies.

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

CMAs must also maintain a log system for complaints and grievances. Issues must be resolved internally or referred to the appropriate oversight agency as required by 42 CFR Chapter IV, Section 484.10(f), 25-1-124, and 26-3.1-102 C.R.S.

Incidents involving providers not surveyed by CDPHE must be reported by providers to the appropriate case manager and responded to by the Department.

All incidents involving abuse, neglect, or exploitation must also be reported to the county departments, Child Protective Services. The Department defines substantiated abuse, neglect, and exploitation as those allegations in which a report is made to law enforcement and/or protective services, an investigation was completed, and that credible evidence of abuse, neglect, or exploitation exists.

All other critical incidents are responded to by the Department.

The Department uses the following criteria to evaluate incident reports in order to determine whether follow-up action is warranted:
1. Has the issue been resolved?
2. Has the health and welfare member seen secured?
3. Have all mandatory reports/referrals been made?
4. Does the member need changes to their services?
If the answer is "no" to any of the questions listed above, the Department will determine that follow-up action is warranted.

State laws, regulations, and policies referenced in the description are available through the Department.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

Colorado Department of Health Care Policy & Financing is responsible for overseeing the operation of the incident management system.

The Department receives monthly complaint reports from CDPHE for licensed and surveyed agencies. The reports provide the Department with information about the type of complaint or occurrence, the source of the complaint or occurrence when the complaint or occurrence was investigated, and the investigation findings. From these reports, Department staff can trend critical incidents and/or request to see a copy of the individual complaints or occurrence reports from CDPHE.

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

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

CIR TRIAGE is the assignment of levels of priority to Critical Incidents Types to determine the most effective order in which to process each report:
1. HIGH PRIORITY: those which need immediate attention and must be addressed when received as no indication of ensuring health and safety are 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 line of sight supports/high care needs has not been found when CIR is submitted.
•Unsafe housing or displacement from a natural disaster, fire, or stemming from caretaker neglect, which leaves the individual without housing and needing immediate attention and housing to ensure health and safety.
•Death under suspicious circumstances that need investigation involves mistreatment, and/or law enforcement, or where the cause of death is unknown and autopsy must be performed by a coroner.
•Injury/Illness in which no treatment has been sought, trends imply mistreatment or those which have no immediate intervention noted to ensure the health and safety of the individual receiving services. DIDD Waivers also include Safety and Emergency Control Procedures resulting in serious injury caused by staff with no least restrictive measures utilized prior to holds/restraints or if mistreatment by staff is suspected.
•Medication Mismanagement in which error leads to an adverse medical crisis (or death) and needs immediate attention to ensure health and safety or mistreatment or theft/mistreatment by staff is a concern.
•Criminal Activity in which individual receiving services is incarcerated for a major serious offense such as homicide and needs immediate follow-up due to the seriousness of the charge and notification to the Department for possible media coverage of the event.
•Damage/Theft of Property to an individual receiving services self or property which results in a need for immediate action to ensure health and safety or must be reported to Law Enforcement.
•Any other CIR in which immediate assurance of health and safety is crucial and has not been addressed by CMA/Agency/staff.
•It should also be noted that Critical Incidents vary and priority levels may be subjective. This is also not an all-inclusive list due to variance in events.
•Any CIR in which there is media coverage or involvement.

2. MEDIUM PRIORITY: those Critical Incidents that may have some immediate follow-up documented, but still need some sort of actions to ensure the health and safety of an individual receiving services or other questions relating to more immediate follow-up. These may be subjective and can vary in the documentation and need for clarification.

3. LOW PRIORITY: those Critical Incidents that have been remediated by CMA/agencies, have addressed immediate and long-term needs, have implemented services or supports to ensure health and safety, and that have protocols in place to prevent a recurrence of a similar CIR. Critical Incidents that would be Low Priority would be
•Death, expected; resulting from long-term illness or natural causes, hospice or palliative care was utilized and documented.

•Missing Person in which the person was immediately found, had no injury, and a plan was implemented to prevent a recurrence.

In instances whereupon review of the complaint or occurrence report the Department identifies individual provider issues, the Department will address these issues directly with the provider and client/guardian. If the Department identifies trends or patterns affecting multiple providers or clients, the Department will communicate a change or clarification of rules to all providers in monthly provider bulletins. If existing rules require an amendment, the Department will develop rules or policies to resolve widespread issues.

In addition, case managers are required to maintain records for all critical incidents that are reported or are known to case managers. During annual CMA monitoring, critical incident and complaint procedures are reviewed as a part of the Administrative evaluation.

The State continues to send reports to CMAs on a monthly basis to include the follow-up timeliness percentages as well as all follow-up reports which remain outstanding. In addition to these reports and the quarterly incentive-based payments, the State began to implement a three-step approach to address all CMAs that do not meet the 90% compliance percentage on a quarterly basis in SFY 2022-23:
1) The State will provide a technical assistance call to any agency that does not meet the 90%.
2) Any agency that does not meet the 90% compliance percentage for a second quarter will be required to have all case managers complete a follow-up specific training module and provide verification to the State that this training was completed.
3) Any agency that does not meet the 90% compliance percentage for a third quarter will be required to complete a Corrective Action Plan and/or be subject to repayment of contract payment to address the failure to meet the required follow-up timeliness metric.

The State utilizes trend analysis of CIRs and the identification of specific issues found to develop targeted critical incident training. The training addresses the identified issues to reduce the recurrence. The specifically identified issues also can trigger policy and contract changes/updates that would mediate and reduce future occurrences.

Oversight activities are conducted on an ongoing monthly, quarterly, and yearly basis.

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 CHCBS waiver does not permit restraints or seclusion. CDPHE surveys for use of restraints in home health agencies. CDPHE conducts this oversight via provider surveys in which adherence to policies and procedures regarding the prohibition of seclusion for all waiver participants is ensured. The State receives monthly, quarterly and annual reporting on provider surveys conducted.

If a Case Management Agency is made aware of it will be reported to the Department program administrator and to the Child's Protection Unit at the county Department of Human Services.

○ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established

concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

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

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

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

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

The CHCBS waiver does not permit the use of restrictive interventions. CDPHE surveys for use of restrictive interventions in home health agencies. CDPHE conducts this oversight via provider surveys in which adherence to policies and procedures regarding the prohibition of seclusion for all waiver participants is ensured. The State receives monthly, quarterly and annual reporting on provider surveys conducted.

If a Case Management Agency is made aware of it will be reported to the Department program administrator and to the Child's Protection Unit at the county Department of Human Services.

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

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

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

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

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

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

The CHCBS waiver does not permit restraints, restrictive interventions, or seclusions. CDPHE is the responsible party for conducting this oversight. CDPHE conducts this oversight via provider surveys in which adherence to policies and procedures regarding the prohibition of seclusion for all waiver participants is ensured. The State receives monthly, quarterly and annual reporting on provider surveys conducted.

If a Case Management Agency is made aware of it will be reported to the Department program administrator and to the Child's Protection Unit at the county Department of Human Services.

○ **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.

Attendants that provide health maintenance activities through In-Home Support Services (IHSS) may administer medications to the client. IHSS are excluded from portions of the nurse practice act, but attendants must be provided training and oversight by the parent, legal guardian, or authorized representative.

When the child is initially and annually assessed for the waiver the case manager is required to review the child's medication regimen and enter the information into the State's case management IT system.

When the case manager visits the child's parents and/or legal guardian in their home, they review medications to identify any harmful practices.

Parents and/or legal guardians choosing IHSS for their child may choose to oversee their child's medication regimens or may choose to have an authorized representative oversee the regimen on their behalf. However, IHSS Agencies must either contract with or have on staff a Health Professional, who shall have monitoring responsibilities, defined as oversight of training of Attendants, verification of adequate skills and competence of Attendants to perform IHSS, and assessment of consumer safety. The Health Professional is responsible for counseling staff on difficult cases, and potentially dangerous situations. He/she must be available to consult with the client and/or the authorized representative or the attendant in the event a medical issue arises and shall investigate complaints and critical incidents.

CDPHE monitors IHSS agencies according to the information provided in Appendix C of the waiver application to ensure IHSS agencies are complying with the above requirements.

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 requires that the attendant providing health maintenance through In-Home Support Services (IHSS), have a licensed medical professional on staff to oversee the training requirements for attendants. The Department of Public Health and Environment (CDPHE) surveys IHSS providers annually to ensure that medications are managed appropriately. If a harmful practice is identified, CDPHE will cite the errors on the survey and require a plan of correction. If the IHSS agency continues to have medication errors CDPHE can refer the compliance issues to the Department to revoke Medicaid certification.

If a case manager identifies a medication error during their monitoring of the client's medication regimen the case manager may report it as either a critical incident (if the error meets the level of a critical incident) or they may note the error and the follow-up in their log notes. All critical incidents are reported to the Department and a sample of all log notes are reviewed by the Department annually. In addition, since the monitoring efforts vary depending upon the services the client is receiving the means by which the Department is informed of the findings also varies. Monitoring efforts of client medication regimens for clients receiving services from an IHSS agency or Home Health agency are reported to the Department by monthly and annual reports of DPHE survey findings.

The Department reviews and tracks ongoing critical incidents to ensure that a resolution is reached and the client's health and safety are maintained. Should a provider demonstrate a pattern of non-compliance or be issued an outcome level deficiency, CDPHE will consider enforcement action in the form of intermediate conditions. Additionally, if information concerning potentially harmful practices is identified by CDPHE, they will conduct either a desk or on-site revisit of the facility to ensure compliance with the POC and/or intermediate condition

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).

Attendants that provide health maintenance activities through In Home Support Services (IHSS) may administer medications to the client. Attendants are excluded from portions of the nurse practice act, but must be provided training and oversight by the authorized representative.

iii. Medication Error Reporting. *Select one of the following:*

◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

Medication errors are currently required to be reported to the Department and to DPHE for clients receiving services from IHSS or Home Health agencies. DPHE compiles the deficiencies and provides the Department with monthly and annual reports of DPHE survey findings.

If a harmful practice is identified, DPHE will cite the errors on the survey and require a plan of correction and it is to be reported to the Department.

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

Incorrect doses and medication given client.
1. wrong client
2. wrong time
3. wrong medication
4. wrong dose
5. wrong route

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

Incorrect doses and medication given client.
1. wrong client
2. wrong time
3. wrong medication
4. wrong dose
5. wrong route

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The Department requires that attendant providing health maintenance through IHSS, have a licensed medical professional on staff to oversee the training requirements for attendants. The Department of Public Health and Environment (DPHE) surveys IHSS providers annually to ensure that medications are managed appropriately. If a harmful practice is, identified (DPHE) will cite the errors on the survey and require a plan of correction. If the IHSS agency continues to have medication errors DPHE can refer the compliance issues to the Department to revoke Medicaid certification.

If a case manager identifies a medication error during their monitoring of the client's medication regimen the case manager may either report it as a critical incident (if the error meets the level of a critical incident) or they may note the error and the follow up in their log notes. All critical incidents are reported to the Department and a sample of all log notes are reviewed by the Department annually. In addition, since the monitoring efforts vary depending upon the services the client is receiving the means by which the Department is informed of the findings also varies. Monitoring efforts of client medication regimens for clients receiving services from an IHSS agency are reported to the Department by monthly and annual reports of DPHE survey findings.

The QIO will support the Department in the analysis of CIR data, understanding the root cause of identified issues, and providing recommendations to changes in CIR and other waiver management protocols aimed at reducing/preventing the occurrence of future critical incidents. The Department reviews and tracks ongoing critical incidents to ensure that a resolution is reached and the client's health and safety is maintained.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
G.a.1 # and % of waiver participants &/or family/guardians who received info/education on how to identify & report abuse, neglect, exploitation (ANE), unexplained death & other critical incidents (CI) N: # of waiver participants &/or family/guardians who rcvd info/ed on how to id & report ANE, unexplained death & other CI D: Total # of waiver participants &/or family/guardians in the sample

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

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

Data Aggregation and Analysis:

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

Performance Measure:
G.a.2 Number and percent of all critical incidents that were reported by the Case Management Agency (CMA) within required timeframe as specified in the approved waiver N: Number of all critical incidents reported by the CMA within the required timeframe as specified in the approved waiver D: Total number of all critical incidents reported by the CMA

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
G.a.6 Number and percent of newly enrolled and revalidated waiver providers trained on how to identify, address, and seek to prevent critical incidents N: # of newly enrolled and revalidated waiver providers trained on how to identify, address, and seek to prevent critical incidents D: Total # of newly enrolled and revalidated waiver providers

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

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

Data Aggregation and Analysis:

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

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.a.3 Number and percent of all critical incidents that were remediated N: Number of all critical incidents that were remediated D: Total number of critical incidents

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
G.a.4 # and % of complaints against licensed waiver providers reported to CDPHE involving allegations of ANE that were resolved according to CDPHE regs N: # of complaints against licensed waiver providers reported to CDPHE involving allegations of ANE resolved according to CDPHE regs D: Total complaints against licensed waiver providers reported to CDPHE involving allegations of ANE

Data Source (Select one):
Other
If 'Other' is selected, specify:
Monthly Complaint Reports Submitted by CDPHE

Responsible Party for data collection/generation	**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: 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:

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

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

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

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

Data Aggregation and Analysis:

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

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

Data Source (Select one):
Other

If 'Other' is selected, specify:

State's case management IT System Data/Critical Incident Reports

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

Data Aggregation and Analysis:

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

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

Performance Measure:
G.b.3 Number and percent of annual reports provided to Case Management Agencies (CMAs) on identified trends in critical incidents N: Number of annual reports provided to the CMAs on identified trends in critical incidents D: Total number of annual reports required to be provided to CMAs

Data Source (Select one):
Other
If 'Other' is selected, specify:
Critical Incident Reports and State's case management IT System Data and/or CDPHE Reports; Record Reviews

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

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

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

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**

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. uses information entered into the State's case management IT system and the Critical Incident Reporting System (CIRS) and/or complaint logs as the primary method for discovery for the Health and Welfare assurance and performance measures.
CMAs must report critical incidents to 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 Department reviews the documentation to determine if the instance was substantiated. If the documentation does not clearly state whether the instance was substantiated, the Department requests follow-up by the CMA to gather the needed information from the parties involved.

G.a.1
An information packet developed by the Dept. must be provided to participants during initial intake and annual CSR. The information includes participant rights, how to file a complaint outside the system, information describing the CIRS and time frames for starting an investigation, the completion of the investigation, or informing the participant/complainant of the results of the investigation. Participants are encouraged to report critical incidents to their provider(s), case manager, protective services, local ombudsman, and/or any other advocate. The information also includes what types of incidents to report and to whom the incident should be reported.
Compliance with this performance measure requires that the signature section in the PCSP indicates that participants (and/or family or guardian) have been provided information regarding rights, and complaint procedures, and have received information/education on how to report abuse, neglect, exploitation (ANE) and other critical incidents.

G.a.2
Critical incidents are reported to the Dept. via the web-based CIRS. CMAs and waiver service providers are required to report critical incidents within specific timeframes. The Department monitors critical incident reporting through the CIRS and/or complaint logs.

G.a.3
All follow-up action steps taken must be documented in the participant’s CIRS record. Documentation must include a description of any mandatory reporting to Adult Protective Services, referral to law enforcement, notification to the ombudsman, or additional follow-up with the participant. The CIR Administrator determines if adequate follow-up was conducted and if all appropriate actions were taken and may require additional follow-up or investigation if needed.

G.a.4
Critical incidents involving providers surveyed by DPHE must be reported to the Dept. and DPHE and are responded to by DPHE. A hotline is set up for complaints about the quality of care, fraud, abuse, and misuse of personal property. DPHE evaluates the complaint and initiates an investigation if warranted. The investigation begins within twenty-four hours or up to three days depending upon the nature of the complaint and risk to the participant’s health and welfare.

G.a.6
CMAs and providers are required to attend preventative strategies training. 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 causes identified/trends reduced as a result of systemic intervention data are tracked and analyzed by the CIR Team on a monthly and quarterly basis.

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

G.d.3
PCSPs must demonstrate that waiver participants identified health needs have been addressed through a waiver service and/or other support, i.e. natural supports, other state programs, and private health insurance. The QIO reviewers use the State's case management IT system and/or Bridge to discover deficiencies for this performance measure and report in the QI Review Tool.

b. Methods for Remediation/Fixing Individual Problems

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

Issues or problems identified during annual program evaluations will be directed to the Case Management Agency (CMA) administrator 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 from Dept. staff. CMAs are required to submit individual remediation action plans for all deficiencies identified within 30 days of notification. Following receipt of the CMA's remediation action plan, the Dept. reviews the plan and confirms the appropriate steps have been taken to correct the deficiencies.
In addition to annual data collection and analysis, Dept. contract managers and program administrators remediate problems as they arise based on the severity of the problem or by nature of the compliance issue. For issues or problems that arise at any other time throughout the year, technical assistance may be provided to the CMA case manager, supervisor, or administrator, and a confidential report will be documented in the waiver recipient care file when appropriate. The Dept. reviews and tracks the ongoing referrals and complaints to ensure that a resolution is reached and that the participant's health and safety have been maintained.

G.a.1
The Dept. provides remediation training CMAs annually to assist with improving compliance with this measure. The remediation process includes a standardized template for individual CMA Corrective Action Plans (CAPs) to ensure all of the essential elements, including root-cause analysis, are addressed in the CAP. Time-limited CAPs are required for each performance measure below the 86% CMS compliance standard. The CAPS must also include a detailed account of actions to be taken, staff responsible for implementing the actions, 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 waiver service providers and/or CMAs when needed for deficient practice in reporting and management of Critical Incidents. This includes a formal request for response, technical assistance, Dept. investigation, 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 from Dept. staff. CMAs are required to submit individual remediation action plans for all deficiencies identified within 30 days of notification. Following receipt of the CMA's remediation action plan, the Dept. reviews the plan and confirms the appropriate steps have been taken to correct the deficiencies.

G.a.4
In instances where upon review of the complaint or occurrence report the Dept. identifies individual provider issues, the Dept. will address these issues directly with the provider and participant/guardian. If the Department identifies trends or patterns affecting multiple providers or participants, the Dept. will communicate a change or clarification of rules to all providers in monthly provider bulletins. If existing rules require an amendment the Dept. will develop rules or policies to resolve widespread issues.
G.a.5

The Department ensures that the appropriate authority is notified of any unexplained deaths that result from substantiated ANE.

G.a.6, G.b.1, G.b.2
The Dept. requires agencies who do not attend preventative strategies training as required to submit a corrective action plan. If remediation does not occur timely or appropriately, the Dept. issues a "Notice to Cure" the deficiency to the CMA/provider. This requires the agency to take specific action within a designated timeframe to achieve compliance.

G.b.3, G.b.4
The Dept. utilizes this information to develop statewide training, and determine the need for an 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 occurrences.

G.b.6
Specific provider trends are relayed to the Benefits division to address and determine what additional remediation/improvement strategies need to be implemented.

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

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

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: As needed by severity of incident or non-compliance.

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

This Quality Improvement Strategy (QIS) encompasses all services provided in the CHCBS 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 the 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. Workgroups 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 the accuracy of QIO reviews.
The Department uses standardized tools for the level of care (LOC) eligibility determinations, person-centered support planning, and critical incident reporting for waiver populations. Through the use of the state's case management system, the data generated from LOC eligibility determinations, Person-Centered Support Plans, 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 provide comparability across CMAs, and waiver programs, and allow ongoing analysis. In addition, the Department is implementing 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 of 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 reviews 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 the 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 the 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 canceled. 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 incident administrators.
Implementation:
Prior to the implementation of a system-level improvement, the Department ensures the following are in place:
- o Process to address the identified need for 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's 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 the 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's 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 §200.22 and 200.23 for all Medicaid administrative payments. To ensure compliance with components detailed in the OMB Uniform Guidance, CMAs contract with external Certified Public Accountant (CPA) firms to conduct an independent audit of their annual financial statements and conduct the Single Audit when applicable (as per Single Audit Act (31 U.S.C 7501-7507) as amended by the Single Audit Act Amendments of 1996 (P.L. 104-105). The Department is responsible for overseeing the performance of the CMAs, reviewing the Single Audits of all CMAs who meet the $750,000 threshold, and issuing management decisions on any relevant audit findings.

(b) & (c) Title XIX of the Social Security Act, federal regulations, the Colorado Medicaid State Plan, state regulations, and contracts establish record maintenance and retention requirements for Medicaid services. A case record/medical record or file must be maintained for each waiver participant. Providers are required to retain records that document the services provided and support the claims submitted for a period of six years. Records may be maintained for a period longer than six years when necessary for the resolution of any pending matters such as an ongoing audit or litigation.

The Department maintains documentation of provider qualifications to furnish specific waiver services submitted during the provider enrollment process and updated according to applicable licensure and survey requirements. This documentation includes copies of the Medicaid Provider Participation Agreement, copies of the Medicaid certification, verification of applicable State licenses, and any other documentation necessary to demonstrate compliance with the established provider qualification standards. All providers are screened monthly against the exclusion lists. Providers are compared against the List of Excluded Individuals and Entities (LEIE), the System for Award Management (SAM), the Medicare Exclusion Database (MED), and the state Medicaid Termination file. Comparing providers against these lists allows the Department to determine if a provider has been excluded by the Office of the Inspector General (OIG), terminated by Medicare, or terminated from another state's Medicaid or Children's Health Insurance Program.

Additionally, the Department monitors the action of licensing boards to ensure Medicaid providers are in good standing.

Claims are submitted to the Department's fiscal agent for reimbursement. Claims data are maintained through the Medicaid Management Information System (MMIS). The MMIS is designed to meet federal certification requirements for claims processing and submitted claims are adjudicated against MMIS edits prior to payment.

Duties of providers include a requirement of documentation of care, in/out times, and confirmation that care was provided per state rules and regulations. Additionally, there must be the completion of appropriate service notes regarding service provision each visit. Documentation shall contain services provided, date and time in and out, and a confirmation that care was provided. Such confirmation shall be according to agency policy. The Department specifies requirements for providers that are then surveyed and certified by CDPHE. 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 the 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 claim 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. All reviews are conducted and desk reviews and they include all service types.

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 a 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 levels 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. waste and abuse.*
- *Reviewing compliance with rules, manuals, and bulletins issued by the Department, the Medical Services 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.

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 survey processes detailed in Appendix D of this application, Department staff review the documentation of rate determination and service authorization activities conducted by case managers. Identification of rate determination practices that are inconsistent with Department policies may result in corrective action and/or recovery of the overpayment.

Additional Information in Main B. Optional

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

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

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

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

		95% confidence level with +/- 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.2 Number and percent of rates adjusted that demonstrate the rate was built in accordance with the approved rate methodology. N: Number of rates adjusted that demonstrate the rate was built in accordance with the approved rate methodology D: Total number of rates adjusted reviewed

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
MMIS Data and Rates Tables

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

☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95% confidence level with +/- 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.1 Number and percent of claims paid where the rate is consistent with the approved rate methodology in the approved waiver N: Number of claims paid where the rate is consistent with the approved rate methodology in the approved waiver D: Total number of paid waiver claims reviewed

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

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95% confidence level with +/- 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 CDPHE upon survey.

All waiver services included in the participant's service plan must be prior authorized by case managers. Approved Prior Authorization Requests (PARs) are electronically uploaded into the MMIS. The MMIS validates the prior authorization of submitted claims. Claims submitted without prior authorization are denied.

When a claim is billed to Medicaid, in addition to the five elements above, the MMIS is configured to check for a Prior Authorization Request (PAR) that matches the procedure code, allowed units, 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 Rates and Fee Schedule section on the external website for providers to access at their convenience. This performance measure allows the Department to identify any system issues or errors resulting in incorrect reimbursement for services rendered.

I.b.2
Benefits and Services Management 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.*

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 the remediation of any deficiencies identified by the annual reporting of performance measures.
In the event an overpayment is discovered, an accounts receivable balance is established with the provider. Overpayments are referred to the PICO Section for investigation as detailed in Appendix I-1 of the waiver application.

I.a.3
In the event an overpayment is discovered, an accounts receivable balance is established with the provider. Overpayments are referred to the PICO Section for investigation as detailed in Appendix I-1 of the waiver application.

I.b.1
Errors identified during claims data analysis as paying in excess of the Department's allowable rate may be attributed to wrong rates in prior authorization forms or additional system safeguards not being in place by the Department. PAR entry errors are addressed with CMAs to prevent future billing errors. The providers receiving overpayments are notified of payment errors and the Department establishes an accounts receivable balance to recover overpayments. The Department reviews errors to determine what additional safeguards are needed to prevent future overpayments.

I.b.2
Benefits and Services Management Division staff coordinate with the Department's Claims Systems and Operations Division staff to initiate any edits necessary to the MMIS for the remediation of deficiencies identified during the performance measure reporting.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☒ ***Other*** *Specify:* *As needed based on severity of occurrence or compliance issue.*

c. Timelines

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

- (●) ***No***
- ( ) ***Yes***

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. *Rate Determination Methods.* *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

The Children's Home and Community Based Service (CHCBS) Waiver utilizes a Fee-for-Service (FFS) rate methodology. Each rate has a unit designation and reimbursement is equal to the rate multiplied by the number of units utilized. Rates are communicated via departmental notices in its monthly Provider Bulletins, and tribal notices, and are posted on the Department's external website (Provider Rates and Fee Schedules landing page) accessible by all stakeholders [including waiver participants] at any time.

The Department's adopted rate methodology (last reviewed and rebased in 2021) incorporates the following factors for all rates:

A. Indirect and Direct Care Requirements:
Salary expectations for direct and indirect care workers are based on the Colorado mean wage for each position, direct and indirect care hours for each position, the full-time equivalency required for the delivery of services to HCBS Medicaid clients, and necessary staffing ratios. Wages are determined by the Bureau of Labor Statistics and are updated by the Bureau every two years. Communication with stakeholders, providers, and clients aids in the determination of direct and indirect care hours required and the full-time equivalency required for the delivery of the services. Finally, collaboration with policy staff ensures the salaried positions, wages, and hours required to conform to the program or service design.

B. Minimum Wage Consideration:
The state will prospectively implement a differential in the rate structure to account for variances in minimum wage requirements as directed by the State Legislation or local ordinances to acknowledge unique geographical considerations impacting access to care. Distinct rates by locality, county, metropolitan area, and other types of regional boundary will be considered and implemented as the Department reviews potential access to care considerations impacting rates. Upon the subsequent waiver amendment or renewal, the Department will update the corresponding rates in accordance with the approved rate methodology. Any changes in the state's rate methodology will be reviewed and amended in accordance with 42 CFR 441.304.

C. Facility Expense Expectations:
Incorporates the facility type using existing facility type property records listing square footage and actual cost. Facility expenses also include estimated repair and maintenance costs, utility expenses, and phone and internet expenses. Repair and maintenance price per square foot is determined by industry standards and varies for facilities that are leased and facilities that are owned. Utility pricing includes gas and electricity which are determined annually through the Public Utility Commission which provides summer and winter rates and therm conversions for appropriate pricing. Finally, internet and phone services are determined through the use of the Build Your Own Bundle tool available through the Comcast Business website.

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

E. Capital Overhead Expense Expectations:
Identifies and incorporates additional capital expenses such as medical equipment, supplies, and IT equipment directly related to providing the service to Medicaid clients.

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

The Department's Waiver Fee Schedule Rates Section is solely responsible for rate determination for all HCBS waivers.

Oversight of the rate determination process is conducted at multiple internal levels within the Finance Office and the Office of Community Living as well as through the stakeholder feedback process during which the Department provides information to stakeholders and providers to solicit feedback about additional considerations for each service.

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

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 state's process for soliciting public comment on rate determination methods involves a standardized and documented process consisting of a 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 Department adjusts rates based on legislative increases and decreases in appropriations for all Colorado HCBS waiver services.

The State will use 9817 ARPA 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.

Update for Amendment with requested effective date of 1/1/2024:
The Wellness Education Benefit (WEB) is a new service being added with this amendment effective 1/1/2024.
The State will use 9817 ARPA funds for the Wellness Education Benefit (WEB).

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

All billing claims flow directly from providers to the MMIS. The MMIS selects a random sample of around 0.2% of the total monthly claims and the Department's fiscal agent mails an EOMB to the clients identified within the sample.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- (●) ***No. state or local government agencies do not certify expenditures for waiver services.***
- ( ) ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

Billing validation is accomplished primarily by the Department's Medicaid Management Information System (MMIS). The MMIS is designed to meet federal certification requirements for claims processing and submitted claims are adjudicated against MMIS edits prior to payment. The Department also validates billings by conducting a post-payment review on a representative sample of claims.

(a) The Colorado Benefits Management System (CBMS) is a unified system for data collection and eligibility. It allows for improved access to public assistance and medical benefits by permitting faster eligibility determinations and allowing for higher accuracy and consistency in eligibility determinations statewide. The electronic files from CBMS are downloaded daily into the MMIS to ensure updated verification of eligibility for dates of service claimed. The first edit in the MMIS when a claim is filed ensures that the waiver client is eligible for Medicaid services. Claims submitted for clients who are not eligible on the date of service are denied.

(b) All waiver services included in the participant's service plan must be prior authorized by case managers. Approved Prior Authorization Requests (PARs) are electronically uploaded into the MMIS. The MMIS validates the prior authorization of submitted claims. Claims submitted without prior authorization are denied.

(c) The Department engages in a post-payment review of claims to ensure the integrity of provider billings. Annually, a statically valid, random sample of claims (95% confidence level +/-5% margin of error) is identified for an audit. These audits include a review of whether required prior authorizations were obtained; support plans included the services; and provider documentation (e.g. timesheets, supervisory visit notes, provider training, and case management notes) supports the service billed. Recovery action is undertaken by the Department for any identified overpayments and the federal share of identified overpayments is returned to the Federal Government.

The Department recoups inappropriate billings in accordance with state rules, specifically 10 CCR 2505-10 8.050.2, by issuing notices of adverse actions. Providers have 30 calendar days to challenge findings or return overpayments back to the Department. Once overpayments are recovered, the Department calculates the federal share for each overpayment based on the FMAP that was originally assigned to the claim at the time of adjudication. Calculated federal share on recovered claims is then reported in the CMS-64.

Case managers monitor service provision to ensure that services are being provided according to the support plan. Should a discrepancy between a provider's claim and what the client reports occur or should the client report that the provider is not providing services according to the support plan, the case manager reports the information to the Department for investigation.

The Department 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 smartphone 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, service provided, location of service, 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 agency. The State's EVV Solution and Data Aggregator for alternate vendor data transfer are available for use.

Services that 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:
In-Home Support Services (IHSS)

The Department also mandates EVV for the following State Plan Services:
Home Health
Occupational Therapy
Pediatric Behavioral Therapies
Pediatric Personal Care
Physical Therapy
Private Duty Nursing
Speech Therapy

On February 1, 2022, the Department activated a pre-payment EVV claim edit. EVV-required services, excluding CDASS, require corresponding EVV records prior to payment. This has resulted in improved provider compliance and better oversight of service provision.

Provider agencies utilizing the State EVV Solution have access to a portal to view and modify visit activity, and in limited circumstances, create EVV records. All information entered via the provider portal is notated as manual entry or edit and is subject to Department audit.

In the event the caregiver is unable to collect EVV data at the time of service delivery, provider agencies will need to enter missing data. Within the State EVV Solution, an agency administrator may complete visit maintenance in the EVV Solution provider portal. The administrator will enter the missing data and select a reason code on why a manual entry was done. Manual entry may be entered on a case-by-case basis. Manual entries are subject to increased scrutiny by the Department and providers must maintain service records for these visits.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

- (●) ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***
- ( ) ***Payments for some, but not all, waiver services are made through an approved MMIS.***

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) ***Payments for waiver services are not made through an approved MMIS.***

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☒ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☐ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***

○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

- ○ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- ◉ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Select County Departments of Public Health provide In Home Health Services(IHSS)for waiver clients. The amount of the payment to public providers does not differ from the amount paid to private providers of the same service.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

- ◉ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- (●) **No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- ( ) **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ( ) **No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- (●) **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

(a) Each Case Management Agency (CMA) is designated as an OHCDS.

(b) Department regulations require that case managers provide participants, guardians, and/or authorized representatives a listing of all qualified providers in the area. The Department's website also contains a statewide list of qualified providers for waiver services.

(c) The Department maintains documentation of qualifications for all providers. This documentation includes copies of the Medicaid Provider Agreement, copies of the Medicaid certification, verification of applicable State licenses, and any other documentation necessary to demonstrate compliance with the established provider qualification standards.

(d) The OHCDS agencies subcontract with providers or independent contractors which have been verified by the OHCDS to have met all applicable licensing and/or established provider qualification standards. The Department assures provider qualifications are met by OHCDS subcontractors through administrative monitoring. Verifying and monitoring the service delivery of enrolled participants receiving a defined service from a qualified provider is the responsibility of the OHCDS. These standards are detailed at 10 CCR 2505-10 8.7202.W.

(e) Financial accountability is assured for services delivered in the OHCDS arrangement through the same methods and processes used for services delivered in a direct service provider arrangement and as described in Appendix I-1 and Appendix I-2.d of this application.

Participants have free choice of all qualified providers, across the state, to include those not affiliated with an OHCDS.

iii. Contracts with MCOs, PIHPs or PAHPs.

- (●) ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ( ) ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ( ) ***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ( ) ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

  In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts

with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☒ ***Appropriation of State Tax Revenues to the State Medicaid agency***

☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable***. *There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***

○ ***The following source(s) are used***

Check each that applies:

☐ ***Health care-related taxes or fees***

☐ ***Provider-related donations***

☐ ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

◉ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***

○ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ○ ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- ◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ ***Nominal deductible***
- ☐ ***Coinsurance***
- ☐ ***Co-Payment***
- ☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- (●) ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ( ) ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: Hospital, Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	43375.34	42069.81	85445.15	84557.31	14925.25	99482.56	14037.41
2	37508.39	47147.00	84655.39	86066.66	15810.32	101876.98	17221.59

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)
3	47567.94	49047.00	96614.94	87602.95	16747.87	104350.82	7735.88
4	47554.00	51023.00	98577.00	89166.66	17741.02	106907.68	8330.68
5	47555.52	53080.00	100635.52	90758.28	18793.06	109551.34	8915.82

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care: Hospital	Level of Care: Nursing Facility
Year 1	3753	415	3338
Year 2	4250	470	3780
Year 3	4812	532	4280
Year 4	5449	603	4846
Year 5	6169	682	5487

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

Update for WYs 1-5 for the Renewal with the requested effective date of 7/1/2023:
The State has used a 0.00% growth rate in the past due to the little variation found in these data. However, to remain consistent with growth rates applied to other areas of the data, the ALOS growth rate has been updated to an average of the trend from SFY 2018-19, SFY 2019-20, and SFY 2020-23 which is 0.8%.

Update for WYs 2-5 for the Amendment with the requested effective date of 7/01/2024:
The Department estimated the average length of stay (ALOS) on the waiver by reviewing historical data included in the annual 372 data report. The trend is an average of the growth rate between FY 2019-20 and FY 2021-22, or 1.24%.

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:*

Update for WYs 1-5 for the renewal with a requested effective date of 7/1/2023:

For each service, the Department considered the number of clients utilizing each service, the number of units per user, the average cost per unit, and the total cost of the service. The Department 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 updated source of data is from the SFY 2020-21 372 waiver reports.

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. Rates included in the Department's Cost Neutrality Demonstration may not match the Department's published rate schedule. 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 12 months.

Number of Users: The source of the data is the 372 waiver reports. The historical growth rates used to calculate the number of users are an average of the growth rates from SFY 2019-20 and SFY 2020-21. The trend in utilizers is applied at a 50% increase for the first year after the most recent actuals (SFY 2020-21). Then, the trend factor is applied normally.

Average Units per User: The source of the data is the 372 waiver reports. The historical growth rates used to calculate the average units per user differ based on the service. For Case Management services, the average units per user are inflated by the growth rate from SFY 2019-20. The units per utilizer for case management services were updated using only SFY 2019-20 growth rate data since the SFY 2020-21 growth rate for these services decreased. For IHSS services, the average number of units per user is inflated by the average growth rate from SFY 2018-19 through SFY 2020-21.

Average Cost Per Unit: The source of the data is the Department's reimbursement rates. No growth rate is applied.

Update for amendment with a 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: Case Management and In-Home Support Services

The base wage increase for services outside Denver County is being implemented for the following services: In-Home Support Services

The Denver County minimum wage increase is being implemented for the following services: In-Home Support Services.

Updated for amendment with a requested effective date of 1/1/2024:
The Department added the Wellness Education Benefit (WEB) to Appendix J. The Department estimated the number of users based on the total number of people expected to be on the waiver. This benefit is a monthly benefit for all members on the waiver. The cost was estimated based on the average cost of providing education materials to members.

The state estimated the number of users trend for the WEB using 372 reports data from SFY 2020-21. The average units per user were determined based on the fact that members will receive 1 unit per month or 12 per year. The state does not forecast increases in rates as rate increases require legislative approval. The state adjusts for rate increases as they are approved through the legislative process.

Update for WYs 2-5 for the Amendment with the requested effective date of 7/01/2024:
For each service, the Department considered the number of clients utilizing each service, the number of units per user, the average cost per unit, and the total cost of the service. The updated source of data is the SFY 2021-22 372 waiver report. With our case management redesign, case management will no longer be offered as an HCBS waiver service but rather CHCBS clients will receive targeted case management through the State Plan beginning January 2025. Case management thus has been phased out in WY 3 from waiver services. The department maintained IHSS -Home Health Maintenance constant for WYs 2-5 at 11,038.53 average units per user, this service will be offered through Community First Choice in the State Plan beginning in 2025.

ii. ***Factor D' Derivation.*** *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Update for WYs 1-5 for Renewal with the requested effective date of 7/01/2023:
To calculate State Plan services costs associated with CHCBS Waiver clients, the Department analyzed historical D' values from CMS-372 reports. Growth in the most recent four fiscal years with actual data (SFY 2017-18 through SFY 2020-21) has averaged around 2.07% therefore the Department is assuming this behavior will continue through all the waiver years. The 2.07% growth rate was calculated as an average of the growth rates in SFY 2017-18 to SFY 2020-21 (-2.15%, -1.25%, and 9.63%).

Update for WYs 2-5 for the Amendment with the requested effective date of 7/01/2024:
To calculate State Plan services costs associated with CHCBS waiver clients, the Department analyzed historical D' values. D' has been increasing steadily. The growth rate was calculated as an average of the growth rates from SFY 2019-20 through 2021-22 (-1.25%, 9.63, and 3.71%). This averages to 4.03% therefore the Department is assuming this behavior will continue through all waiver years.

iii. ***Factor G Derivation.*** *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The magnitude of Factor G has changed significantly since the CHCBS waiver was last renewed. This is a result of the way that nursing facility and hospital levels of care have been defined. Previously, the hospital level of care was defined as any client receiving any home health service. This definition has since been revised to include only clients who receive home health services provided by a registered nurse. As a result, the number of clients at the hospital level of care has dropped significantly which means the average cost per client spread across both levels of care has also dropped as the hospital level of care is significantly more expensive than the nursing facility. The Department adjusted the definition of the hospital level of care to better account for children needing an acute level of services.

To calculate nursing facility and hospital level of care costs, the Department examined historical 372 data reports to determine the utilization and average per-user nursing facility and inpatient hospital costs. Factor G in the CMS 372 reports are previous estimates rather than actuals. Instead of using the Factor G estimate in the CMS 372 report, Department data were used to calculate an actual Factor G amount for SFY 2020-21. The Department data used to calculate the SFY 2020-21 Factor G include yearly average per capita institutional costs per day multiplied by the waiver's average length of stay in SFY 2020-21. Based on this data, the Department calculated a CHCBS SFY 2020-21 Factor G of $80,186.24. The Department used the Factor G per waiver client cost for SFY 2020-21 and grew it by 1.79% which is half of the average deviation of change in the historical per waiver client costs for SFY 2019-20 through SFY 2020-21. Factor G values were trended using one-half average growth in the last two fiscal years.

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:*

The impact of the change in the way hospital level of care in Factor G also impacts Factor G'.

The Department used historical 372 data reports to determine the Factor G' projections. Factor G' in the CMS 372 reports are previous estimates rather than actuals. Instead of using the Factor G' estimate in the CMS 372 report, the Department data are used to calculate an actual Factor G' amount. The Department data used to calculate Factor G' include yearly average per capita non-institutional costs per day multiplied by the waiver's average length of stay in SFY 2020-21 ($12,556.39). An annual growth rate of 5.93% was then applied which was the average growth between SFY 2017-18 and SFY 2019-20.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Case Management	
In Home Support Services	
Wellness Education Benefit	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). *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. If applicable, check the capitation box next to that service. 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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:							7199345.32
Case Management	☐	15 minutes	3302	224.08	9.73	7199345.32	
In Home Support Services Total:							155448292.61
Health Maintenance Activities.	☐	15 minutes	1536	11383.95	8.89	155448292.61	
Wellness Education Benefit Total:							140021.28

GRAND TOTAL:		162787659.20
Total: Services included in capitation:		
Total: Services not included in capitation:		162787659.20
Total Estimated Unduplicated Participants:		3753
Factor D (Divide total by number of participants):		43375.34
Services included in capitation:		
Services not included in capitation:		43375.34
Average Length of Stay on the Waiver:	326	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Wellness Education Benefit	☐	1 unit	3353	6.00	6.96	140021.28	
					GRAND TOTAL:		162787659.20
					Total: Services included in capitation:		
					Total: Services not included in capitation:		162787659.20
					Total Estimated Unduplicated Participants:		3753
					Factor D (Divide total by number of participants):		43375.34
					Services included in capitation:		
					Services not included in capitation:		43375.34
					Average Length of Stay on the Waiver:		326

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *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. If applicable, check the capitation box next to that service. 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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:							6370180.99
Case Management	☐	15 minutes	4146	157.91	9.73	6370180.99	
In Home Support Services Total:							152694219.33
Health Maintenance Activities.	☐	15 minutes	1556	11038.53	8.89	152694219.33	
Wellness Education Benefit Total:							346273.92
Wellness Education Benefit	☐	1 unit	4146	12.00	6.96	346273.92	
					GRAND TOTAL:		159410674.23
					Total: Services included in capitation:		
					Total: Services not included in capitation:		159410674.23
					Total Estimated Unduplicated Participants:		4250
					Factor D (Divide total by number of participants):		37508.39
					Services included in capitation:		
					Services not included in capitation:		37508.39
					Average Length of Stay on the Waiver:		323

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *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. If applicable, check the capitation box next to that service. 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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:							0.00
Case Management	☐	15 minutes	0	0.00	9.73	0.00	
In Home Support Services Total:							228550666.33
Health Maintenance Activities.	☐	15 minutes	2329	11038.53	8.89	228550666.33	
Wellness Education Benefit Total:							346273.92
Wellness Education Benefit	☐	1 unit	4146	12.00	6.96	346273.92	

GRAND TOTAL:	228896940.25
Total: Services included in capitation:	
Total: Services not included in capitation:	228896940.25
Total Estimated Unduplicated Participants:	4812
Factor D (Divide total by number of participants):	47567.94
Services included in capitation:	
Services not included in capitation:	47567.94
Average Length of Stay on the Waiver:	327

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *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. If applicable, check the capitation box next to that service. 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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management							0.00

GRAND TOTAL:	259121760.01
Total: Services included in capitation:	
Total: Services not included in capitation:	259121760.01
Total Estimated Unduplicated Participants:	5449
Factor D (Divide total by number of participants):	47554.00
Services included in capitation:	
Services not included in capitation:	47554.00
Average Length of Stay on the Waiver:	331

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
Case Management	☐	15 minutes	0	0.00	9.73	0.00	
In Home Support Services Total:							258775486.09
Health Maintenance Activities.	☐	15 minutes	2637	11038.53	8.89	258775486.09	
Wellness Education Benefit Total:							346273.92
Wellness Education Benefit	☐	1 unit	4146	12.00	6.96	346273.92	

GRAND TOTAL:	259121760.01
Total: Services included in capitation:	
Total: Services not included in capitation:	259121760.01
Total Estimated Unduplicated Participants:	5449
Factor D (Divide total by number of participants):	47554.00
Services included in capitation:	
Services not included in capitation:	47554.00
Average Length of Stay on the Waiver:	331

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *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. If applicable, check the capitation box next to that service. 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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:							0.00
Case Management	☐	15 minutes	0	0.00	9.73	0.00	
In Home Support Services Total:							293023739.66
Health Maintenance Activities.	☐	15 minutes	2986	11038.53	8.89	293023739.66	

GRAND TOTAL:	293370013.58
Total: Services included in capitation:	
Total: Services not included in capitation:	293370013.58
Total Estimated Unduplicated Participants:	6169
Factor D (Divide total by number of participants):	47555.52
Services included in capitation:	
Services not included in capitation:	47555.52
Average Length of Stay on the Waiver:	335

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Wellness Education Benefit Total:							**346273.92**
Wellness Education Benefit	☐	1 unit	4146	12.00	6.96	**346273.92**	

GRAND TOTAL:	**293370013.58**
Total: Services included in capitation:	
Total: Services not included in capitation:	293370013.58
Total Estimated Unduplicated Participants:	**6169**
Factor D (Divide total by number of participants):	**47555.52**
Services included in capitation:	
Services not included in capitation:	47555.52
Average Length of Stay on the Waiver:	335