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:
Developmental Disabilities (HCBS-DD)

C. Waiver Number:CO.0007
Original Base Waiver Number: CO.0007.

D. Amendment Number:CO.0007.R08.21

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

01/01/23

Approved Effective Date: 01/01/23
Approved Effective Date of Waiver being Amended: 07/01/19

2. Purpose(s) of Amendment

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

The purpose of this amendment is to:

-Expand Home Delivered Meals: The State received authorization through Long Bill HB22-1329 to expand HDM services to waiver participants post-hospitalization. The expansion allows waiver participants to access the HDM benefit for thirty (30) post-discharge from a hospital.

-Add Working Adults with Disabilities for 65+: The State is amending Appendix B in the DD waiver application to reflect SB20-33 which authorizes continued participation in the Medicaid Buy-In Program for w]orking adults with disabilities who are 65 years old and older.

-Add Virtual Case Management: The State is amending the waivers to allow waiver participants to request virtual case management activities except for Level of care assessments that will be done in person unless there is a documented health and safety risk.

-PM Update: The State is removing PM G.c.1 in Appendix G to streamline processes and reporting.

-Removal of Non-integrated Settings Language: The State is updating the services definitions for Specialized Habilitation and Supported Employment to remove the terms which appear to allow for non-integrative settings, such as "non-integrated" and "enclaves" to ensure compliance with the HCBS Settings Final Rule.

-Update to Desk Reviews of Case Files in Case Management Agencies (CMAs): The State is amending language to reflect the change of the responsible party conducting desk reviews. The QIO will no longer be performing the case file desk reviews at CMAs and they will now be conducted by State staff.

-Electronic Visit Verification (EVV) Language Relocation: The State is relocating the EVV language in Appendix I-1 to I-2.d per the Job Aid: Documenting Electronic Visit Verification (EVV) in Appendix I of the 1915(c) Waiver Applications released by CMS in July 2022.

-Across the Board (ATB) Rate Increases: The State is updating Appendix J to reflect the 2% ATB rate increase approved in the budget request for Long Bill HB22-1329 for the following services:
Day Habilitation-Specialized Habilitation Support Levels 1-7
Day Habilitation-Supported Community Connections Support Level 1-7
Prevocational Services Level 1-6
Residential Habilitation-Group Residential Services and Supports Level 1-6
Residential Habilitation-Individual Residential Services and Supports Level 1-6
Residential Habilitation-Individual Residential Services and Supports/Host Home Level 1-6
Supported Employment-Job Coaching-Group Support Level 1-6
Supported Employment-Job Coaching-Individual
Supported Employment-Job Development-Group
Supported Employment-Job Development-Individual
Behavioral Services-Behavioral Line Staff Services
Behavioral Services-Behavioral Consultation
Behavioral Services-Behavioral Counseling-Individual
Behavioral Services-Behavioral Counseling-Group
Behavioral Services-Behavioral Plan Assessment
Home Delivered Meals
Non-Medical Transportation-Mileage Range 0-10
Non-Medical Transportation-Mileage Range 11-20
Non-Medical Transportation-Mileage Range >20
Peer Mentorship
Peer Mentorship-Telehealth
Transition Setup Coordinator

-The State also received approval through the Long Bill to implement a $15 Base Wage Minimum. The following services received the following increases for this implementation:
Day Habilitation-Specialized Habilitation Support Level 1 - 24.164%
Day Habilitation-Specialized Habilitation Support Level 2 - 21.959%
Day Habilitation-Specialized Habilitation Support Level 3 - 19.697%
Day Habilitation-Specialized Habilitation Support Level 4 - 16.754%

Day Habilitation-Specialized Habilitation Support Level 5 - 13.542%
Day Habilitation-Specialized Habilitation Support Level 6 - 9.434%
Day Habilitation-Specialized Habilitation Support Level 7 - 5.985%
Day Habilitation-Supported Community Connections Support Level 1 - 19.817%
Day Habilitation-Supported Community Connections Support Level 2 - 18.156%
Day Habilitation-Supported Community Connections Support Level 3 - 16.049%
Day Habilitation-Supported Community Connections Support Level 4 - 13.978%
Day Habilitation-Supported Community Connections Support Level 5 - 11.607%
Day Habilitation-Supported Community Connections Support Level 6 - 8.832%
Day Habilitation-Supported Community Connections Support Level 7 - 5.985%
Prevocational Services Level 1 - 24.164%
Prevocational Services Level 2 - 21.959%
Prevocational Services Level 3 - 19.697%
Prevocational Services Level 4 - 16.753%
Prevocational Services Level 5 - 13.542%
Prevocational Services Level 6 - 9.434%
Residential Habilitation-Group Residential Services and Supports - Level 1 - Outside Denver - 5.750%
Residential Habilitation-Group Residential Services and Supports - Level 2 - Outside Denver - 6.070%
Residential Habilitation-Group Residential Services and Supports - Level 3 - Outside Denver - 6.511%
Residential Habilitation-Group Residential Services and Supports - Level 4 - Outside Denver - 7.006%
Residential Habilitation-Group Residential Services and Supports - Level 5 - Outside Denver - 7.693%
Residential Habilitation-Group Residential Services and Supports - Level 6 - Outside Denver - 8.499%
Residential Habilitation-Individual Residential Services and Supports - Level 1 - Outside Denver - 7.451%
Residential Habilitation-Individual Residential Services and Supports - Level 2 - Outside Denver - 7.369%
Residential Habilitation-Individual Residential Services and Supports - Level 3 - Outside Denver - 8.008%
Residential Habilitation-Individual Residential Services and Supports - Level 4 - Outside Denver - 8.738%
Residential Habilitation-Individual Residential Services and Supports - Level 5 - Outside Denver - 9.602%
Residential Habilitation-Individual Residential Services and Supports - Level 6 - Outside Denver - 10.612%
Supported Employment-Job Coaching-Group Support - Level 1 - 18.056%
Supported Employment-Job Coaching-Group Support - Level 2 - 16.456%
Supported Employment-Job Coaching-Group Support - Level 3 - 14.773%
Supported Employment-Job Coaching-Group Support - Level 4 - 12.770%
Supported Employment-Job Coaching-Group Support - Level 5 - 10.726%
Supported Employment-Job Coaching-Group Support - Level 6 - 8.207%
-Supported Employment-Job Coaching-Individual - 4.371%
Supported Employment-Job Development-Group-13.713%
Supported Employment-Job Development-Individual - 4.371%

Non-Medical Transportation also received a targeted rate increase (TRI) to reflect 80% of the benchmark.

The State received approval for the rate increases through Appendix K CO.0007.R08.19 effective 7/01/2022 and therefore rates are reflected fully in WYs 4 and 5. The State is updating Appendix J to reflect the Appendix K approval and for permanent ongoing approval in the waiver.

-The State will use 9817 ARP funds for the minimum wage rate increases through April of 2023 and then will utilize state general funds approved by legislation starting in April of 2023.

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	6I

Component of the Approved Waiver	Subsection(s)
☒ Appendix A Waiver Administration and Operation	3(Main B.Optional)
☒ Appendix B Participant Access and Eligibility	4b, 6f
☒ Appendix C Participant Services	1a
☒ Appendix D Participant Centered Service Planning and Delivery	1c, 1d, 2a, QI (a-ii)
☐ Appendix E Participant Direction of Services	
☐ Appendix F Participant Rights	
☒ Appendix G Participant Safeguards	QI (G.c.1)
☐ Appendix H	
☒ Appendix I Financial Accountability	1, 2d
☒ Appendix J Cost-Neutrality Demonstration	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:

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*):

Developmental Disabilities (HCBS-DD)

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.0007
Waiver Number:CO.0007.R08.21
Draft ID: CO.011.08.08

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

Regular Waiver

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

PRA Disclosure Statement

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

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

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

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

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

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

☐ **Nursing Facility**
Select applicable level of care

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

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

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

1. Request Information (3 of 3)

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

◉ **Not applicable**

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

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

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

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

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

☐ **§1915(b)(2) (central broker)**

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

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

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

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

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

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

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

The purpose of the HCBS-DD waiver is to provide services and/or supports to individuals with intellectual and developmental disabilities who are in need of services and supports 24 hours a day that will allow them to live safely and participate in the community.

These services are individually planned and coordinated through the person's uniform Service Plan designed to ensure the health, safety and welfare of the individual, and to assist in the acquisition, retention and/or improvement in skills necessary to support individuals to live and participate successfully in their community. These services may include a combination of life-long or extended duration, supervision, training, and/or support. Services and supports include:

·Residential habilitation
·Supported employment
·Prevocational Services
·Day habilitation (facility based and non-facility based)
·Transportation services to and from day program
·Specialized medical equipment and supplies
·Behavioral services
·Dental services
·Vision services
·Home Delivered Meals
·Peer Mentorship
·Transition Setup

When Residential Habilitation services are provided the responsibility for the living environment rests with the service agency and encompass two types of living environments: Individual Residential Services and Supports (IRSS) in which three or fewer persons receiving services may live in a single residential setting or in a host home. Group Residential Services and Supports (GRSS) in which four to eight persons receiving services may live in a single residential setting which is licensed by the State as a Residential Care Facility/Residential Community Home.

The waiver services are provided through qualified Medicaid providers who have received program approval through the Department of Health Care and Policy Financing (the Department).

The Department contracts with non-state entities called Community Centered Boards (CCBs) who provide a statewide network of case management agencies for individuals enrolled in the HCBS-DD waiver. Case Managers assist the participant in identifying, through a participant-centered service planning process, those services and supports needed to maintain them in their communities.

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 08/11/2022 through 09/09/2022:

The process is summarized as follows: The Department sent, via electronic mail, a summary of all proposed changes to all Office of Community Living (OCL) stakeholders. Stakeholders include clients, contractors, families, providers, advocates, and other interested parties. Non-Web-Based Notice: The Department posted notice in the newspaper of the widest circulation in each city with a population of 50,000 or more on 08/11/2022 and 08/25/2022. The Department employed each separate form of notice as described. The Department understands that, by engaging in both separate forms of notice, it will have met the regulatory requirements, CMS Technical Guidance, as well as the guidance given by the CMS Regional Office. The Department posted on its website the full waiver and a summary of any proposed changes to that waiver at https://hcpf.colorado.gov/hcbs-public-comment. The Department made available paper copies of the summary of proposed changes and paper copies of the full waiver. These paper copies were available at the request of individuals. The Department allowed at least 30 days for public comment. The Department complied with the requirements of Section 1902(a)(73) of the Social Security Act by following the Tribal Consultation Requirements outlined in Section 1.4 of its State Plan on 08/11/2022. The Department had the waiver amendment reviewed by the State Medical Care Advisory Committee (otherwise known as “Night MAC”) in accordance with 42 CFR 431.12 and Section 1.4 of the Department’s State Plan on 08/11/2022. In addition to the specific action steps described above, the Department also ensured that all waiver amendment documentation included instructions about obtaining a paper copy. All documentation contains language stating: “You may obtain a paper copy of the waiver and the proposed changes by calling (303) 866-3684 or by visiting the Department at 1570 Grant Street, Denver, Colorado 80203.”

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

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

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

At the end of the 30-day public comment period the Department received 8 comments. A Summary of the comments is as follows.

Comment (1 total):
Supports the Department allowing for virtual contact for Case Management required activities. As a Case Manager does not support in-home visits at all due to safety issues and personal allergies.

Department Response:
Thank you for your feedback

Comment (3 total):
Requesting that music therapy be considered for inclusion as an available service under the DD, EBD, BI, CHBS, and SCI waivers. Requesting that the profession of music therapy be listed with the descriptor or heading of Music Therapy when included in an HCBS Medicaid Waiver program.

Department Response:
In order for us to expand the waiver benefit to include Music Therapy as a distinct service, the Department would need budget authority to do so. This could either be an appropriation made by the Joint Budget Committee to add this cost to the budget, or legislation that directed the Department to add this distinct service, including an appropriation to cover the costs of this expanded service.

Comment (1 total):
Supports the Department for adding the post-discharge meal benefit to so many waivers. This new meal benefit will help many people throughout Colorado.

Department Response:
The Department appreciates your feedback and support of the expansion of the Home Delivered Meals benefit to members post discharge from a hospital.

Comment (1 total)
Supports the expansion of the Home Delivered Meals benefit. We encourage HCPF to engage with Case Management Agencies and stakeholders, possibly through the ARPA Admission, Discharge, and Transfer pilot funding, to develop tools that update in semi-real time to track when waiver participants are admitted to the hospital and how many times a waiver participant has utilized the benefit within the waiver life cycle.

Department Response:
The Department has established a Home Delivered Meals stakeholder workgroup to finalize and develop the expansion for Home Delivered Meals post-hospital discharge. The workgroup is exploring methods to determine when a participant has been discharged from a hospital and ways to track utilization. The Department agrees that engaging with Case Management Agencies through the ARPA Admission, Discharge, and Transfer Pilot would be beneficial and intends on working with these groups to implement the new expanded benefit. Past meeting notes and additional information on the workgroup is located at https://hcpf.colorado.gov/home-delivered-meals-stakeholder-workgroup. Future discussions will be posted on the OCL Stakeholder Engagement calendar at https://hcpf.colorado.gov/OCL-stakeholder-engagement.

Additional information in Main B. Optional

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 Supervisor

Agency: Colorado Department of Health Care Policy & Financing

Address: 1570 Grant Street

Address 2:

City: Denver

State: **Colorado**

Zip: 80203

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

Fax: (303) 866-2786

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

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Colorado**

Zip:

Phone: **Ext:** ☐ **TTY**

Fax:

E-mail:

8. Authorizing Signature

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

Signature: Julie Masters

State Medicaid Director or Designee

Submission Date: Dec 2, 2022

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

Last Name: Bates

First Name: Cristen

Title: Interim Medicaid Director

Agency: Colorado Department of Health Care Policy & Financing

Address: 1570 Grant Street

Address 2:

City: Denver

State: **Colorado**

Zip: 80203

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

Fax: (303) 866-4411

E-mail: Cristen.Bates@state.co.us

Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

Attachment #2: Home and Community-Based Settings Waiver Transition Plan
Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.
Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.
To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

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

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Main 6I- Public Input:

Comment (1 total):
Supports the option for waiver participants to choose to use phone or telehealth options for developing and monitoring their Person-Center Support Plan (PCSP).
Identified language in D-1d is not consistent between waivers (specifically the DD & EBD waivers) in regard to the development, implementation, and operations of the PCSP.

Department Response:
Thank you for this feedback. The Department will review this section within the waivers for alignment.

Comment (1 total):
Voiced concerns that the language in several waivers pertaining to waiver service definitions and provider qualifications needs to be updated to provide more clarity and specificity in description and requirements. Referenced specifically to the purchasing of technology represented as ‘assistive.' Observed in the community that inappropriate technology was being recommended to individuals who cannot use or access it. That the "assistive technology" was being recommended for a purpose that is not the intended function of the item and stated fear that the individuals’ health and safety were put at risk.
Suggested potential safeguards that could be added to the waiver applications, such as further specifications in the definitions for "assistive technology" and "specialized medical equipment and supplies" to not include devices for the purpose of speech generation; declaring specifically that only licensed professionals can put in place a program for non-skilled care personnel; the service "Behavioral Therapy" needs to be defined in the rule and in waiver service definition; to institute a reporting system for unlicensed service providers, and requested further refinement and specificity in the definition for Transitional Living Program.

Department Response:
We appreciate you taking the time to review the waiver amendments and submitting public comments. While the entire waiver was published for review, the areas provided comment on are not under the scope of the current changes. Your comments regarding assistive technology are very insightful and we appreciate your thoughts and would welcome additional feedback about how we can improve the benefit. We would be happy to connect you with the benefits manager to discuss your concerns and suggestions for improvement.

Information about Appendix A-3 Use of Contracted Entities:

The Dept. contracts with the Dept. of Local Affairs – Division of Housing (DOH) to perform waiver operational and administrative functions on behalf of the Dept. The relationship between the Dept. and DOH is regulated by an Interagency Agreement, which requires the Dept. and DOH to meet no less than quarterly to discuss continued program improvement. DOH’s responsibilities
include inspections of all Host Home locations on a two-year cycle, regular reports to the Department on inspection results, and immediate notification to the Dept. on failed inspections.

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

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

The Department contracts with an Administrative Services Organization (ASO) to administer the waiver dental services in conjunction with the State Plan dental benefit. The ASO completes prior authorization and pre-payment review of waiver dental claims to determine if the service is allowable.

The Department contracts with an Administrative Services Organization (ASO) to provide oversight of the Non-Medical Transportation (NMT) benefit. The ASO is responsible for ensuring all provider agencies, vehicles, and drivers meet the

regulatory and safety requirements set forth by the Department. The ASO will be responsible for coordination with the Regional Transportation District (RTD), verifying eligibility, processing the RTD special discount card, dissemination of transit fares, and production of outlined reports.

The Department contracts with a Quality Improvement Organization (QIO) to consolidate long-term care utilization management functions for waiver programs and Medicaid clients.

The QIO will be responsible for the management of the Critical Incident Reports (CIR) for the HCBS-DD waiver. The QIO is responsible for assessing the appropriateness of both provider and CMA response to critical incidents, for gathering, aggregating, and analyzing CIR data, and ensuring that appropriate follow-up for each incident is completed.

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

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

For out-of-state providers, the Department maintains an Interagency Agreement with the host state's Medicaid Agency/licensing agency to perform quality assurance and quality improvement activities. The Department may contract with out-of-state providers for the in-person monitoring requirements for case management.

I-1 Financial Integrity and Accountability:

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

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

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

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

I-2-a, Rate Determination Methods:

In rare circumstances, due to extreme behavioral or medical support needs, the needs of an individual cannot be completely captured within the 6 standard Support levels. These individuals are categorized into a 7th Support Level for which the Residential Habilitation rate is individually determined based on the specific needs of the individual. Day Habilitation services also include Support Level seven rates to recognize increased direct-service costs for these individuals.

The following rates were determined by the rate-setting model and are reimbursed at a tiered, fee-for-service rate that varies by the participant's Support Level:

Day Habilitation: Specialized Habilitation
Day Habilitation: Supported Community Connections
Prevocational Services
Supported Employment: Job Coaching (Group)
Supported Employment: Job Development (Individual)
Group Residential Services and Supports
Individual Residential Services and Supports
Individual Residential Services and Supports-Host Home

Non-Medical Transportation (To/From Day Program) is reimbursed at a tiered, FFS rate that varies based upon the trip distance.

Residential Habilitation rates for individuals with Support Level 7 are individually determined. Service providers submit information regarding the individual's direct care requirements and associated costs. Dept staff reviews and incorporate these factors into the rate-setting model to determine an individualized rate.

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

The rate methodology has not been changed; however, rates were rebased in 2018 as a part of the waiver renewal using updated wages, direct and indirect care time for each position, the price per square footage information, and updated administrative and capital equipment costs. Also, the methodology is now documented, and calculations were performed primarily by the Dept instead of an independent contractor (Navigant).

The rates for Group Residential Services and Supports – Levels 1 and 2 were reviewed following the 2017 Medicaid Provider Rate Review Analysis Report, which found that they varied between 36.70% and 184.58% of their relevant benchmark comparisons. The Department recommended increasing rates for waiver services as identified through the ongoing rate-setting process, with special attention to services that were identified by stakeholders through the rate review process and those that have the biggest gaps, or budget neutrality factor, between current rates and appropriate rates developed through the Department's rate-setting methodology. Additionally, upon implementation of Peer Mentorship in the waiver, the Department developed a documented rate methodology for Peer Mentorship and the budget neutrality factor was found to be more substantial than expected. The Department is closing the gap or reducing the budget neutrality factor, for these services in the HCBS waivers.

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. The Department updated the waiver application with this information.
The State will use 9817 ARP funds for the minimum wage rate increases through April of 2023 and then will utilize state general funds approved by legislation starting in April of 2023.

I-2-a, Solicitation of stakeholder feedback:
The state's process for soliciting public comment on rate determination methods involves the Presentation of Rate Setting Methodology to stakeholders prior to or during rate-setting and solicitation of feedback on methodology, a 30-day period to receive feedback from providers and community stakeholders, publishing of the rates as determined by the state's methodology in conjunction with a stakeholder presentation reviewing the methodology, providing guidance on documents that would be provided to stakeholders, stakeholder deliverable sent to providers following presentation included all services and the direct/indirect care hours, wage, BLS position, and capital equipment included and offered providers an extended (60 day) period to offer feedback. All feedback is reviewed and feedback that can be validated is incorporated into the rates. All information from the stakeholder process is posted on the Dept external website. Additional information on public input is located in Main 6-

I.

J-2 Derivation of factors continued.
Update for WYs 3-5 for Amendment with requested effective date of 7/01/2021:
For each individual service, the Department considered the number of clients utilizing each service, the number of units per user, the average cost per unit, and the total cost of the service. The Department examined historical growth rates, the fraction of the total population that utilized each service, and graphical trend. Once the historical data was analyzed, the Department selected trend factors to forecast, the number of clients utilizing each service, the number of units per user, and the average cost per unit. Caseload, utilization per client, and cost-per-unit are multiplied together to calculate the total expenditure for each service and added to derive Factor D. For services that have multiple service levels, these service levels are shown separately.

Historical growth rates: The source of data is 372 waiver reports. The Department reviews data from FY 2007-08 through FY 2018-19 but might only include certain FYs in the development of trends. For example, the Department may look at data from FY 2007-08 and beyond but apply a trend that only incorporates growth rates from FY 2017-18 and FY 2018-19.

Fraction of growth rates: The source of data is 372 waiver reports which include the number of utilizers of each service and total waiver clients. The Department divides services utilizers into total waiver enrollments to calculate a fraction of the total population that uses services. Dates of data are all available historical data which for this waiver dates back to FY 2007-08 however the Department focuses on more recent data for trend development.

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

Supported Employment, Behavioral Services, and Peer Mentorship were updated to include telehealth service delivery options, although there may not have been a cost-per-unit differential from the traditional delivery methods.
All services were updated to include the most recent 372 data (SFY 2018-19), which did not include telehealth utilization since telehealth was not established as an option in SFY2018-19.

Update for WYs 3-5 for Amendment with requested effective date of 01/01/2022:

Factor D was updated to include a 2.5% ATB rate increase approved by the Colorado State Legislature in 2021 effective 7/1/2021 for the following services: Behavioral Services, Specialized Habilitation - Tier 2 and Tier 3, Supported Community Connections - Tier 2 and Tier 3, Home-Delivered Meals, Non-Medical Transportation- Mileage Bands 1-3, Peer Mentorship, Prevocational Services, Group Residential Services and Supports (exclude Level 7), Individual Residential Services and Supports(exclude Level 7), Individual Residential Services and Supports/Host Home (exclude Level 7), Supported Employment - Job Coaching and Job Development, and Community Transition Services Coordinator.

Additionally, the unit descriptor for Supported Employment Job Placement - Group and Individual was updated from “Session” to “Item” in Waiver Years 3-5.

Information regarding the consolidation of Supported Employment – Job Development – Individual component service tiers into one component service: The sources and dates of data used to develop the estimates for the number of users, units per user, and cost per unit for Supported Employment - Job Development - Individual have not changed and are the 372 reports. The previous tiers were all reimbursed at the same rate and all components were the same as far as qualifications. Eliminating the tiers will reduce confusion for service providers and waiver members. The state is making this change to better reflect how this service is currently utilized and to limit future confusion.

The Department included the 7.448% increase (from $14.77 to $15.87/hr)associated with the Denver Minimum Wage increases

effective 1/1/2022 for Group and Individual Residential Services and Supports.

Update for WYs 4-5 for Amendment with requested effective date of 7/01/2022:

For each individual service, the Department considered the number of clients utilizing each service, the number of units per user, the average cost per unit, and the total cost of the service. The Department examined historical growth rates, the fraction of the total population that utilized each service, and graphical trends. Once the historical data was analyzed, the Department selected trend factors to forecast, the number of clients utilizing each service, the number of units per user, and the average cost per unit. Caseload, utilization per client, and cost per unit are multiplied together to calculate the total expenditure for each service and added to derive Factor D. For services that have multiple service levels, these service levels are shown separately.

Historical growth rates: The source of data is 372 waiver reports. The Department reviews data from FY 2007-08 through FY 2019-20 but might only include certain SFYs in the development of trends. For example, the Department may look at data from FY 2007-08 and beyond but apply a trend that only incorporates growth rates from SFY 2017-18 and SFY 2019-20.

Fraction of growth rates: The source of data is 372 waiver reports which include the number of utilizers of each service and total waiver clients. The Department divides services utilizers into total waiver enrollments to calculate the fraction of the total population that uses services. Dates of data are all available historical data which for this waiver dates back to FY 2007-08 however the Department focuses on more recent data for trend development.

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

Because of impacts on service utilization resulting from the COVID-19 pandemic, the Department has not changed units per utilizer projections for Non-Medical Transportation, Prevocational Services, Specialized Habilitation, Supported Community Connections, Job Coaching - Group, and Job Coaching - Individual from the currently approved amendment.

The Department's main trend for units per utilizer is the average of the previous two years of actuals as reported on 372 reports. Utilization reported on the SFY 2019-20 372 report came in lower than expected, resulting in a decrease in utilization for future WYs. Additionally, during the COVID-19 pandemic, utilization trends changed significantly compared to the previous year's trends. Impacted waiver services include the following:
Group Residential Services and Supports - Level 1
Group Residential Services and Supports - Level 2
Group Residential Services and Supports - Level 3
Individual Residential Services and Supports - Level 5
Individual Residential Services and Supports/Host Home - Level 3
Individual Residential Services and Supports/Host Home - Level 4

The Department's main trend for utilizers is the average of the previous two years of waiver participation of that service as a percentage of the total unduplicated count as reported on 372 reports. The number of users by service that was reported on the SFY 2019-20 372 report came in lower than expected, resulting in a decrease in utilizers for future WYs. Impacted waiver services include the following:
Specialized Habilitation Support Level 2
Specialized Habilitation Support Level 3
Specialized Habilitation Support Level 5
Specialized Habilitation Support Level 6
Residential Habilitation:
Group Residential Services and Supports - Level 2
Group Residential Services and Supports - Level 3
Group Residential Services and Supports - Level 4
Group Residential Services and Supports - Level 5
Group Residential Services and Supports - Level 6
Group Residential Services and Supports - Level 7
Individual Residential Services and Supports/Host Home - Level 1
Individual Residential Services and Supports/Host Home - Level 2
Individual Residential Services and Supports/Host Home - Level 3
Individual Residential Services and Supports/Host Home - Level 4
Individual Residential Services and Supports/Host Home - Level 5
Individual Residential Services and Supports/Host Home - Level 6
Supported Employment - Job Coaching - Group Support Level 1
Supported Employment - Job Coaching - Group Support Level 2
Supported Employment - Job Coaching - Group Support Level 3
Supported Employment - Job Coaching - Group Support Level 4
Supported Employment - Job Coaching - Group Support Level 5
Supported Employment - Job Coaching - Group Support Level 6
Supported Employment Job Placement – Group
Dental Services:
Major

Preventative-Basic
Vision Services
Behavioral Services - Behavioral Counseling – Individual
Non-Medical Transportation:
Mileage Range 0-10
Mileage Range 11-20
Mileage Ranged >20
Specialized Medical Equipment and Supplies - Equipment

Update for WY 4-5 with Amendment requested effective date of 1/1/2023:
The State is updating Appendix J to reflect the 2% ATB rate increase approved in the budget request for Long Bill HB22-1329 for the following services: Day Habilitation-Specialized Habilitation Support Levels 1-7
Day Habilitation-Supported Community Connections Support Level 1-7
Prevocational Services Level 1-6
Residential Habilitation-Group Residential Services and Supports Level 1-6
Residential Habilitation-Individual Residential Services and Supports Level 1-6
Residential Habilitation-Individual Residential Services and Supports/Host Home Level 1-6
Supported Employment-Job Coaching-Group Support Level 1-6
Supported Employment-Job Coaching-Individual
Supported Employment-Job Development-Group
Supported Employment-Job Development-Individual
Behavioral Services-Behavioral Line Staff Services
Behavioral Services-Behavioral Consultation
Behavioral Services-Behavioral Counseling-Individual
Behavioral Services-Behavioral Counseling-Group
Behavioral Services-Behavioral Plan Assessment
Home Delivered Meals
Non-Medical Transportation-Mileage Range 0-10
Non-Medical Transportation-Mileage Range 11-20
Non-Medical Transportation-Mileage Range >20
Peer Mentorship
Peer Mentorship-Telehealth
Transition Setup Coordinator

-The State also received approval through the Long Bill to implement a $15 Base Wage Minimum. The following services received the following increases for this implementation:
Day Habilitation-Specialized Habilitation Support Level 1 - 24.164%
Day Habilitation-Specialized Habilitation Support Level 2 - 21.959%
Day Habilitation-Specialized Habilitation Support Level 3 - 19.697%
Day Habilitation-Specialized Habilitation Support Level 4 - 16.754%
Day Habilitation-Specialized Habilitation Support Level 5 - 13.542%
Day Habilitation-Specialized Habilitation Support Level 6 - 9.434%
Day Habilitation-Specialized Habilitation Support Level 7 - 5.985%
Day Habilitation-Supported Community Connections Support Level 1 - 19.817%
Day Habilitation-Supported Community Connections Support Level 2 - 18.156%
Day Habilitation-Supported Community Connections Support Level 3 - 16.049%
Day Habilitation-Supported Community Connections Support Level 4 - 13.978%
Day Habilitation-Supported Community Connections Support Level 5 - 11.607%
Day Habilitation-Supported Community Connections Support Level 6 - 8.832%
Day Habilitation-Supported Community Connections Support Level 7 - 5.985%
Prevocational Services Level 1 - 24.164%
Prevocational Services Level 2 - 21.959%
Prevocational Services Level 3 - 19.697%
Prevocational Services Level 4 - 16.753%
Prevocational Services Level 5 - 13.542%
Prevocational Services Level 6 - 9.434%
Residential Habilitation-Group Residential Services and Supports - Level 1 - Outside Denver - 5.750%
Residential Habilitation-Group Residential Services and Supports - Level 2 - Outside Denver - 6.070%
Residential Habilitation-Group Residential Services and Supports - Level 3 - Outside Denver - 6.511%

Residential Habilitation-Group Residential Services and Supports - Level 4 - Outside Denver - 7.006%
Residential Habilitation-Group Residential Services and Supports - Level 5 - Outside Denver - 7.693%
Residential Habilitation-Group Residential Services and Supports - Level 6 - Outside Denver - 8.499%
Residential Habilitation-Individual Residential Services and Supports - Level 1 - Outside Denver - 7.451%
Residential Habilitation-Individual Residential Services and Supports - Level 2 - Outside Denver - 7.369%
Residential Habilitation-Individual Residential Services and Supports - Level 3 - Outside Denver - 8.008%
Residential Habilitation-Individual Residential Services and Supports - Level 4 - Outside Denver - 8.738%
Residential Habilitation-Individual Residential Services and Supports - Level 5 - Outside Denver - 9.602%
Residential Habilitation-Individual Residential Services and Supports - Level 6 - Outside Denver - 10.612%
Supported Employment-Job Coaching-Group Support - Level 1 - 18.056%
Supported Employment-Job Coaching-Group Support - Level 2 - 16.456%
Supported Employment-Job Coaching-Group Support - Level 3 - 14.773%
Supported Employment-Job Coaching-Group Support - Level 4 - 12.770%
Supported Employment-Job Coaching-Group Support - Level 5 - 10.726%
Supported Employment-Job Coaching-Group Support - Level 6 - 8.207%
-Supported Employment-Job Coaching-Individual - 4.371%
Supported Employment-Job Development-Group-13.713%
Supported Employment-Job Development-Individual - 4.371%

Notes:
The State received approval for the rate increases through Appendix K CO.0007.R08.19 effective 7/01/2022, therefore the rates are reflective for the full waiver years 4 and 5.

Non-Medical Transportation rate adjustment for WYs 4 and 5 includes the 2% ATB increase and a targeted rate increase approved by legislation.

The State estimates rates based on a weighting of the location in which services are rendered and the rates in each location. The State received a base wage adjustment for services outside of Denver County and updated the weighted rates for this service based on new utilization trends and the updated rates. Due to this weighting, rate increases may not align with the rate increases that were approved in the long bill for counties outside of Denver.

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

For utilization and units per utilizer projections, the Department utilized data from 372 reports, primarily from the previous two years: SFY 2018-2019 and SFY 2019-2020.

Appendix A: Waiver Administration and Operation

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

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

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

◉ **The Medical Assistance Unit.**

Specify the unit name:

The Office of Community Living, Benefits and Services Management Division

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

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

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

Appendix A: Waiver Administration and Operation

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

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

The Department of Health Care Policy & Financing (the Department) maintains an Interagency Agreement with the Colorado Department of Public Health & Environment (CDPHE) to perform quality assurance and quality improvement activities. This agreement allows CDPHE to survey and investigate complaints against Residential, Day Habilitation, Peer Mentorship, Home Delivered Meals, Transition Setup, Prevocational, Supported Employment, and Non-Medical Transportation HCBS providers. CDPHE conducts the surveys in accordance with and within the scope of the statutory, waiver, and regulatory requirements applicable to the HCBS-DD waiver.

A. CDPHE's certification surveys will be of sufficient scope, duration, and frequency to determine whether HCBS Medicaid providers are in compliance with the HCBS-DD waiver requirements, along with all applicable federal and state requirements, including the health and safety requirements set forth in the 1915(c) HCBS waiver;

B. CDPHE certification surveys will utilize a statistically significant representative sample which is inclusive of the full array of services an HCBS-DD provider is approved to provide.

C. CDPHE's certification surveys must include, but may not be limited to:

1. Ensuring HCBS-DD providers report incidents that include allegations of mistreatment abuse, neglect and/or exploitation to law enforcement, APS, the Community Center Board (CCB), and HCPF pursuant to the 1915(c) HCBS waiver requirements;

2. Ensuring HCBS-DD providers meet the initial and ongoing training required by providers as approved in Appendix C, Provider Qualifications, in the 1915(c) HCBS waiver;

3. Ensuring HCBS-DD providers timely notify waiver participants, designated representatives, and/or guardians of all incidents requiring investigations, including providing information pertaining to the outcome of the investigation, victim supports, and recommendations to prevent recurrence;

4. Ensuring HCBS-DD providers take action to address investigative findings, initiate Human Rights Committee review, provide victim supports, and act on any other recommendations intended to prevent recurrence;

5. Ensuring instances of restraint use are consistent with the 1915(c) HCBS waiver requirements;

6. Ensuring guardians and/or designated representatives receive the required notification of restraint use;

7. Evaluating the actions taken to ensure the health and safety of individuals who are subjected to the use of restraints and/or restrictive interventions to ensure all health and wellness safeguards approved in Appendix G-2 of the approved 1915(c) HCBS waiver are followed as required;

8. Evaluating reports to the Human Rights Committee in cases involving the use of restraints and/or restrictive interventions as an emergency control or safety control procedure to ensure all health and welfare safeguards approved in Appendix G-2 of the approved 1915(c) HCBS waiver are followed as required;

9. Evaluating cases where a waiver participant's suspension of rights is implemented to ensure the suspension of the individual's rights is implemented in accordance with 42 C.F.R. 441.301(c)(2)(xiii)(A) through (H) and all health and wellness safeguards approved in Appendix G-2 of the approved 1915(c) HCBS waiver are followed as required;

10. Evaluating cases where a waiver participant's suspension of rights is implemented to ensure HCBS-DD providers implement the approved process to lift the suspension of rights in accordance with all health and welfare safeguards in Appendix G-2 of the approved waiver;

11. Reviewing consents to ensure that they are person-centered and tailored to the needs of an individual, ensuring participants/guardians are provided with information about how to revoke the consent and evaluating to ensure that any revocation is honored as requested;

12. Reviewing the use of psychotropic medications to ensure all health and welfare processes, procedures and safeguard approved in Appendix G-3 of the approved waiver are followed as required and ensure that psychotropic

medication is not used in place of the provision of supports and services;

13. Reviewing steps taken to reduce the use of psychotropic medications, where appropriate;

14. Reviewing the needs of waiver participants to ensure that staffing patterns are appropriate to meet their needs and these staffing patterns are consistent with the staffing patterns authorized in the person-centered service plans of the participants;

15. Issuing citations of noncompliance when deficient practices are identified as required in the approved 1915(c) waiver. CDPHE will require that a HCBS provider submit a plan of correction in response to deficiency findings. If a HCBS provider fails to remediate a deficiency finding, CDPHE will notify HCPF that the provider has failed to remediate a deficiency and that CDPHE is recommending that the provider's certification as a HCBS provider be terminated and that it will not be re-certified until the deficient practice is remediated and the HCBS provider details how the practice that led to the de-certification will be monitored to ensure on-going compliance.

Additional information pertaining to the Department's use of Contracted Entities is contained in the optional portion of the Main Module of this waiver application.

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

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:

The Department of Health Care Policy & Financing is responsible for assessing the performance of the Community Centered Boards (CCB)in conducting waiver operational and administrative functions.

Appendix A: Waiver Administration and Operation

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

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

The Dept. contracts with the Dept. of Local Affairs – Division of Housing (DOH) to perform waiver operational and administrative functions on behalf of the Dept. The relationship between the Dept. and DOH is regulated by an Interagency Agreement, which requires the Dept. and DOH to meet no less than quarterly to discuss continued program improvement. DOH's responsibilities include inspections of all Host Home locations on a two-year cycle, regular reports to the Department on inspection results, and an immediate notification to the Dept. on failed inspections.

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

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

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

The Department oversees the fiscal agent operating the Medicaid Management Information System (MMIS). The fiscal agent is required to submit weekly reports to the Department on meeting performance standards as established in the contract. The reports include summary data on timely and accurate coding, claims submission, and claims reimbursement, time frames for completion of data entry, processing of claims, and Prior Authorization. The Department monitors the fiscal agent's compliance with Service Level Agreements through reports submitted by the fiscal agent on customer service activities including provider enrollment, provider publication, and provider training. The Department is able to request ad hoc reports as needed to monitor any additional issues or concerns.

The Department maintains oversight of the ASO through several mechanisms. As with all contracted entities, the dental ASO has ongoing performance standards and contractual requirements. The Department receives monthly reports from the ASO on utilization, claims summaries, authorization approvals, authorization denials, member grievance logs,

provider grievance logs, and customer service responses. The Department reviews the monthly reports and uses the results to monitor quality and performance by the ASO. Additionally, to ensure access to benefits, all case managers are required to discuss Dental Benefits during annual and semi-annual plan meetings and ensure services are being delivered in a satisfactory manner.

The Department has oversight of the QIO contractor and the Transportation ASO through different contractual requirements. Deliverable due dates include monthly, quarterly, and annual reports to ensure the vendor is completing their respective delegated duties. The Department's Operations Division ensures that deliverables are given to the Department on time and in the correct format. Subject Matter Experts who work with the vendors review deliverables for accuracy.

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

As part of the payment structure within the Contract, the Department calculates administrative payments to the RAC based on its audit work and 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 an informal reconsideration and formal appeal stages.

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

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

The Department reviews and approves the RAC's internal quality control process at the onset of the Contract and monitors the Contract work product during the term of the Contract. The Department can request changes to this process as it sees fit to improve work performance, which the RAC is required to incorporate in its process.
The Department evaluates, calculates, and approves administrative payments when the RAC invoices the Department work claims reviews completed. The Department reviews each claim associated with the invoice and determines if the Contractor met the administrative payment criteria for each claim. The Department only approves administrative payments for claims that meet the administrative payment criteria.

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

The methods are outlined in more detail in Appendix H of this waiver application.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the

performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

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

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

Data Aggregation and Analysis:

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

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
A.7 # and % of reports submitted by the Dental Administrative Services Organization (ASO) reviewed by the Dept demonstrating performance of all delegated functions N: # of reports submitted by the Dental ASO reviewed by the Dept demonstrating performance of all delegated functions D: Total number of reports required by the Dental ASO as specified in the contract

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
A.18 # and % of data reports submitted by the Transportation ASO that are reviewed by the Dept demonstrating services meet Dept regulation requirements N: # of data reports submitted by the Transportation ASO that are reviewed by the Dept demonstrating services meet Dept regulation requirements D: # of data reports required to be submitted by the Transportation ASO as specified in the contract

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

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: Transportation ASO Contractor	☒ **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.19 Number and percent of deficiencies identified during the state monitoring activities that were appropriately and timely remediated by the contracted entity. N: Number of deficiencies identified during the states monitoring activities that were appropriately and timely remediated by the contracted entity D: Total number of deficiencies identified during the states monitoring activities

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

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

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

Data Aggregation and Analysis:

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

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
A.22 # and % of reports submitted by DOH as required in the Interagency Agreement (IA) that are reviewed by the Dept showing Host Home (HH) inspections are conducted and meet Dept standards N: # of reports submitted by DOH per the IA reviewed by Dept showing HH inspections are conducted and meet Dept standards D: Total # of reports required to be submitted by DOH as required

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

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

Data Aggregation and Analysis:

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

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

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

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

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

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

A.7
The Dept. maintains oversight of the dental ASO through several mechanisms. The ASO has ongoing performance standards and contractual requirements. The Dept. receives monthly reports from the ASO on utilization, claims summaries, authorization approvals, authorization denials, member grievance logs, provider grievance logs, and customer service responses. The Dept. reviews the monthly reports to monitor quality and performance by the ASO.

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

A.20
Monitoring of CMAs is completed through tracking administrative contract deliverables. Regular reporting is required to assure appropriate compliance with Dept. policies, procedures and contractual obligations. The Dept. audits CMAs for administrative functions including qualifications of individuals performing assessments and service planning; process regarding evaluation of need, service planning, participant monitoring, case reviews, complaint procedures, provision of participant choice, waiver expenditures, etc.

A.22
The Dept. reviews DOH reports regarding results of Host Home inspections that ensure adherence to Department standards.

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.7, A.14, A.19, A.20, A.22
Delegated responsibilities of contracted agencies/vendors are monitored, corrected, and remediated by the Dept.'s Office of Community Living (OCL).

During routine annual evaluation or by notice of an occurrence, the Dept. works with sister agencies and/or contracted agencies to provide technical assistance or some other appropriate resolution based on the identified situation.

If remediation does not occur timely or appropriately, the Dept. issues a "Notice to Cure" the deficiency to the contracted agency. This requires the agency to take specific action within a designated timeframe to achieve compliance.

A.20
If problems are identified during a CMA audit, the Dept. communicates findings directly with the CMA administrator, and documents findings in the CMA's annual report of audit findings, and if needed, requires corrective action.

The Dept. conducts follow-up monitoring to assure corrective action implementation and ongoing compliance. In addition, the contract with CMAs allows theDept. to withhold funding and terminate a contract due to noncompliance. If a compliance issue extends to multiple CMAs, the Dept. provides clarification through formal Policy Memos, formal training, or both. Technical assistance is provided to CMAs via phone and e-mail.

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

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

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ Aged or Disabled, or Both - General					
	☐	Aged			☐
	☐	Disabled (Physical)			
	☐	Disabled (Other)			
☐ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☒ Intellectual Disability or Developmental Disability, or Both					
	☐	Autism			☐
	☒	Developmental Disability	18		☒
	☐	Intellectual Disability			☐
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

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

"Intellectual and developmental disability" means a disability that manifests before the person reaches twenty-two years of age, that constitutes a substantial disability to the affected person, and that is attributable to an intellectual and developmental disability or related conditions, including Prader-Willi syndrome, cerebral palsy, epilepsy, autism, or other neurological conditions when the condition or conditions result in impairment of general intellectual functioning or adaptive behavior similar to that of a person with an intellectual and developmental disability. Unless otherwise specifically stated, the federal definition of "developmental disability" found in 42 U.S.C. sec. 15001 et seq., does not apply. (C.R.S. 25.5-10-202 26 (a-c), as amended).

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:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

    Specify the percentage:

  - ( ) **Other**

    Specify:

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

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

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

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	7114
Year 2	7525
Year 3	8422
Year 4	9076
Year 5	9500

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	6891
Year 2	7289
Year 3	8158
Year 4	8791
Year 5	9202

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).**

Purpose(s) the state reserves capacity for:

Purposes
Emergency
18-21 Transition
Deinstitutionalization for Nursing Facility, ICF/IID, and State Mental Health Institutes

Appendix B: Participant Access and Eligibility

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

Purpose *(provide a title or short description to use for lookup):*

Emergency

Purpose *(describe):*

Positions are reserved for individuals whose names are on the waiting list and who meet the individuals experiencing a crises who are in need of immediate assistance in order to ensure their health and safety.

Describe how the amount of reserved capacity was determined:

The amount of reserve capacity is determined by the legislative appropriations. Appropriations take into consideration recent trends (2-5 years) of authorizations within fiscal years.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	285
Year 2	285
Year 3	285
Year 4	285
Year 5	285

Appendix B: Participant Access and Eligibility

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

Purpose *(provide a title or short description to use for lookup):*

18-21 Transition

Purpose *(describe):*

Positions are made available for children who age out of foster care, are adopted through the Colorado Child Welfare system, age out of the HCBS-Children's Extensive Supports Waiver, or age out of the HCBS-Children's Habilitation Residential Program Waiver in order to continue access to services without interruption that will allow them to continue living safely in the community.

Describe how the amount of reserved capacity was determined:

The amount of reserve capacity is determined by the legislative appropriations. Appropriations take into consideration recent trends (2-5 years) of authorizations within fiscal years.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	111
Year 2	111
Year 3	111
Year 4	111
Year 5	111

Appendix B: Participant Access and Eligibility

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

Purpose *(provide a title or short description to use for lookup):*

Deinstitutionalization for Nursing Facility, ICF/IID, and State Mental Health Institutes

Purpose *(describe):*

Deinstitutionalization enrollments are made available for individuals who have requested to transition from an institutional setting to a community setting. Institutions include skilled nursing facilities, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IDD), and state mental health institutions

Describe how the amount of reserved capacity was determined:

The amount of reserve capacity is determined by the legislative appropriations. Appropriations take into consideration recent trends (2-5 years) of authorizations within fiscal years.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	48
Year 2	48
Year 3	48
Year 4	48
Year 5	48

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:

The Department of Health Care Policy & Financing, acting as the Operating Agency for the HCBS-DD waiver, oversees the statewide allocation and management of waiver capacity for the HCBS-DD waiver. Waiting lists are administered in accordance with Health Care & Policy Financing (HCPF) rules set forth at 10 CCR 2505-10 8.500.7.

As vacancies occur in waiver enrollments, the state grants enrollments to the next person on the waiting list based on order of selection date. This method ensures comparable access, as the allocation and management of the enrollment is determined based on the Order of Selection Date and not geographical factors. Once enrolled into the HCBS-DD waiver, an individual can move to any location in the state and maintain waiver enrollment and full choice of available and willing providers.

Exceptions to this process occur for individuals meeting the criteria for reserve capacity. The Department works with CCBs to identify individuals meeting the criteria for reserve capacity and manages the allocation of those enrollments to coincide with the transition for the individual, legislative appropriation, and waiver capacity.

Reserve Capacity:

1.18-21 Transitions
2.Deinstitutionalization
3.Individuals who have emergency needs

Vacancies will be held prospectively, on-going, as they occur for all transition placements. When a sufficient number of vacancies do not occur in the month prior to the month needed for transition placements, a position will be made available at the time needed and the next occurring vacancies will be applied towards those placements.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

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

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

- ( ) **No**
- (●) **Yes**

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

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

- [ ] **Low income families with children as provided in §1931 of the Act**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [x] **Optional state supplement recipients**
- [ ] **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

- ( ) **100% of the Federal poverty level (FPL)**
- ( ) **% of FPL, which is lower than 100% of FPL.**

Specify percentage:

- [x] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [x] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- [ ] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- [ ] **Medically needy in 209(b) States (42 CFR §435.330)**
- [ ] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- [ ] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

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

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

Select one and complete Appendix B-5.

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

Check each that applies:

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

Select one:

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

Specify percentage: [ ]

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

Specify dollar amount: [ ]

- ☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- ☐ **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- ☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- ☐ **Aged and disabled individuals who have income at:**

Select one:

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

Specify percentage amount: [ ]

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

applies only to the 42 CFR §435.217 group.

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

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

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

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

Select one:

○ **SSI standard**

○ **Optional state supplement standard**

○ **Medically needy income standard**

◉ **The special income level for institutionalized persons**

(*select one*):

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

○ **A percentage of the FBR, which is less than 300%**

Specify the percentage:

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

Specify dollar amount:

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

Specify percentage:

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

Specify:

○ **The following dollar amount**

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

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

Specify:

○ **Other**

Specify:

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

◉ **Not Applicable**

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

Specify:

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

○ **SSI standard**

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

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

Specify:

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

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

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

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

Specify:

- ○ **Other**

Specify:

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

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

Select one:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

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

  Specify percentage:

- ○ **The following dollar amount:**

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

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

  Specify formula:

- ○ **Other**

  Specify:

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

Select one:

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

Explanation of difference:

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

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

Select one:

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

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

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

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

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

Specify the entity:

- (●) **Other**

Specify:

Community Centered Boards, which are private, nonprofit corporations.

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

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

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

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

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

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

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

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

The case manager completes 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 state instrument measures six defined Activities of Daily Living (ADL) and the need for supervision for behavioral or cognitive dysfunction. ADLs include bathing, dressing, toileting, mobility, transferring, and eating. To qualify for services, an individual must require an intermediate care facility for individuals with intellectual disabilities (ICF-IID) level of care. 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 level of care.

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

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

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

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

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

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

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

  Specify the other schedule:

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

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

  Specify the qualifications:

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

The CCB is required to track the re-evaluation due dates and complete them on a timely basis for each participant. The Department of Health Care and Policy Financing (the Department) uses two processes to assure timeliness. 1. The Prior Authorization Request (PAR)contains the Long Term Care Certification span. The detailed PAR information, including the certification end date,is uploaded into the Medicaid Management Information System and controls the time period for which claims pay. A new PAR cannot be submitted without the re-evaluation being completed so payment is not made when the re-evaluation is not completed. 2.The Department surveys CCBs for timely completion of annual re-evaluations during on-site reviews and through desk audits of participants' electronic records using the State's case management IT system. The annual program evaluation includes a review of a representative sample of participant records to ensure assessments are being completed correctly and timely.

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

CCBs maintain the evaluation/re-evaluation records in the State's case management IT system. The Department electronically accesses the documentation through the State's case management IT system for the purpose of monitoring.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

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

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or

sub-assurance), complete the following. Where possible, include numerator/denominator.

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

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

Performance Measures

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

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

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

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

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

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

Data Aggregation and Analysis:

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

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

Data Source (Select one):
Other

If 'Other' is selected, specify:
Program Review Tool/Super Aggregate Report

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

Data Aggregation and Analysis:

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

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:

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

The Department utilizes the Super Aggregate Report as the primary data source for monitoring the Level of Care (LOC) assurance and performance measures. The Super Aggregate Report is a custom report consisting of two parts: data pulled directly from the State's case management IT system, the Bridge, and data received from the annual program evaluations document, the QI Review Tool. (Some performance measures use the state's case management IT system only data, some use QI Review Tool only data, and some use a combination of state's case management IT system and/or Bridge, and QI Review Tool data). The Super Aggregate Report provides initial compliance outcomes for performance measures in the LOC sub-assurances and performance measures. To ensure the quality review process is completed accurately, efficiently and in accordance with federal standards, the Department has contracted with an independent QIO to complete the QI Review Tool for the annual CMA program case evaluations.

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

B.a.1
The LOC Screen must be conducted prior to the Long Term Care (LTC) start date; services cannot be received prior to the LTC start date; the assessment must indicate a need for an ICF-IID.

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 provided by the QIO of the QI Review Tool and the participant's case management record to discover deficiencies for this performance measure.

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

b. Methods for Remediation/Fixing Individual Problems

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

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

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

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

The Community Centered Board (CCB) case manager informs the individual, the family, the guardian, and/or authorized representative, of the feasible alternatives available under the waiver and provides the choice of institutional or community-based services. Information is provided during the initial evaluation, the Person-Centered Support Planning process and during the annual re-evaluation on alternatives for service delivery, including choice of types of services available through the waiver and among qualified providers. All forms completed through the LOC Screen and Person-Centered Support Planning processes are available for signature through digital or wet signatures based on the member's preference. The case manager documents that the choice was offered in the Person-Centered Support Plan (PCSP) on the case management IT system.

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

A hard copy of the current Choice Form is maintained in the master record of each individual at the case management agency's office. Freedom of Choice is documented in the State's case management IT system.

Appendix B: Participant Access and Eligibility

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

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

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

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	**Day Habilitation**		
Statutory Service	**Prevocational Services**		
Statutory Service	**Residential Habilitation**		
Statutory Service	**Supported Employment**		

Service Type	Service		
Extended State Plan Service	Dental Services		
Extended State Plan Service	Vision Services		
Other Service	Behavioral Services		
Other Service	Home Delivered Meals		
Other Service	Non Medical Transportation		
Other Service	Peer Mentorship		
Other Service	Specialized Medical Equipment and Supplies		
Other Service	Transition Setup		

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:

Day Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1: 04 Day Services

Sub-Category 1: 04020 day habilitation

Category 2: 04 Day Services

Sub-Category 2: 04070 community integration

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

Day Habilitation includes assistance with acquisition, retention or improvement in self-help, socialization and adaptive skills that takes place in a non-residential setting, separate from the participant's private residence or other residential living arrangement, except for the occasion of extreme medical and/or safety needs. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. These services are individually coordinated through the participant's Service Plan. Day Habilitation Services and Supports encompass two types of habilitative environments: Specialized Habilitation (SH) and Supported Community Connections (SCC). Day Habilitation Services does not include sheltered workshops.

Specialized Habilitation (SH) services focus on enabling the participant to attain his or her maximum functional level or to be supported in such a manner to allow the person to gain an increased level of self-sufficiency. These services include the opportunity to select from age-appropriate activities both within and outside of the setting. Such services include assistance with self-feeding, toileting, self-care, sensory stimulation and integration, self-sufficiency, maintenance skills, and supervision. Specialized habilitation services may serve to reinforce skills or lessons taught in school, therapy or other settings and, where appropriate, are coordinated with any physical, occupational, or speech therapies listed in the Service Plan.

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

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

The number of units available for Day Habilitation in combination with Prevocational Services is 4800 units. When used in combination with Supported Employment Services, the total number of units available for Day Habilitation Services in combination with Prevocational Services will remain at 4800 units and the cumulative total, including Supported Employment Services, may not exceed 7112 units.
In the event the Day Habilitation Services and Supports (DHSS) and Prevocational Services limit of 4800 units per Service Plan year is insufficient to meet a participant's needs, the safety net of Residential Habilitation Services and Supports (RHSS) is available to participants 24-hours a day, seven days a week.

Day Habilitation services provided in an out-of-state setting is only allowed when there is not a service provider within Colorado that is able to meet the waiver participant's needs due to specific, individualized health and safety concerns. The need for out-of-state services and out-of-state providers must be approved by HCPF. When services are provided out-of-state, the standard waiver requirements will continue to be met per the Olmstead Letter #3 State Medicaid Directors on July 25, 2000. These requirements include:

- There must be a written plan of care with the services. The plan of care must identify the services to be provided, the amount and type of each service, and the type of provider.
- Services must be furnished by a qualified provider. The provider must meet the standards for service provision that are set forth by the state where services are being provided. The host state in which services are received must have an equivalent licensure or certification as a Colorado provider Day Habilitation services.
- Colorado remains responsible for the assurance of the health and welfare of the waiver member. Oversight is performed directly by the case management agency via telehealth options and by the host state in which services are received.
- The provider of out-of-state Day Habilitation services must be chosen just as freely as the provider of in-state services by the waiver member.
- The out-of-state provider must have a provider agreement with HCPF per section 1902(a)(27) of the Act and payment must be made directly to the provider per section 1902(a)32 of the Act.

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:

Agency

Provider Type:

Program Approved Service Agency Specialized Habilitation

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

Program Approval

Other Standard *(specify):*

Rules: 10 CCR 2505-10 § 8.500.5
Program Management: Baccalaureate or higher degree from an accredited college or university in the area of Education, Social Work, Psychology, or related field, and one year of successful experience in human services; or an Associates degree from an accredited college and two years of successful experience in human services; or four years successful experience in human services.

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

Day Habilitation services provided in an out-of-state setting is only allowed when there is not a service provider within Colorado that is able to meet the waiver participant's needs due to specific, individualized health and safety concerns. The need for out-of-state services and out-of-state providers must be approved by HCPF. When services are provided out-of-state, the standard waiver requirements will continue to be met per the Olmstead Letter #3 State Medicaid Directors on July 25, 2000. These requirements include:

• There must be a written plan of care with the services. The plan of care must identify the services to be provided, the amount and type of each service, and the type of provider.
• Services must be furnished by a qualified provider. The provider must meet the standards for service provision that are set forth by the state where services are being provided. The host state in which services are received must have an equivalent licensure or certification as a Colorado provider Day Habilitation services.
• Colorado remains responsible for the assurance of the health and welfare of the waiver member. Oversight is performed directly by the case management agency via telehealth options and by the host state in which services are received.
• The provider of out-of-state Day Habilitation services must be chosen just as freely as the provider of in-state services by the waiver member.
• The out-of-state provider must have a provider agreement with HCPF per section 1902(a)(27) of the Act and payment must be made directly to the provider per section 1902(a)32 of the Act.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:

Agency

Provider Type:

Program Approved Service Agency Supported Community Connections

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

Program Approval

Other Standard *(specify):*

Rules: 10CCR 2505-10 § 8.500.5
Program Management: Baccalaureate or higher degree from an accredited college or university in the area of Education, Social Work, Psychology, or related field, and one year of successful experience in human services; or an Associates degree from an accredited college and two years of successful experience in human services; or four years successful experience in human services.

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

Day Habilitation services provided in an out-of-state setting is only allowed when there is not a service provider within Colorado that is able to meet the waiver participant's needs due to specific, individualized health and safety concerns. The need for out-of-state services and out-of-state providers must be approved by HCPF. When services are provided out-of-state, the standard waiver requirements will continue to be met per the Olmstead Letter #3 State Medicaid Directors on July 25, 2000. These requirements include:

- There must be a written plan of care with the services. The plan of care must identify the services to be provided, the amount and type of each service, and the type of provider.
- Services must be furnished by a qualified provider. The provider must meet the standards for service provision that are set forth by the state where services are being provided. The host state in which services are received must have an equivalent licensure or certification as a Colorado provider Day Habilitation services.
- Colorado remains responsible for the assurance of the health and welfare of the waiver member. Oversight is performed directly by the case management agency via telehealth options and by the host state in which services are received.
- The provider of out-of-state Day Habilitation services must be chosen just as freely as the provider of in-state services by the waiver member.
- The out-of-state provider must have a provider agreement with HCPF per section 1902(a)(27) of the Act and payment must be made directly to the provider per section 1902(a)32 of the Act.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:

Agency

Provider Type:

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

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

Program Approval

Other Standard *(specify):*

Rules: 10CCR 2505-10 § 8.500.5

Program Management: Baccalaureate or higher Degree from an accredited college or university in the area of Education, Social Work, Psychology, or related field, and one year of successful experience in human services; or an Associates Degree from an accredited college and two years of successful experience in human services; or four years successful experience in human services.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Prevocational Services

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:**

Prevocational Services prepare a participant for paid community employment. Services include teaching such concepts as following directions, attendance, task completion, problem solving, and safety that are associated with performing compensated work. Services are identified in the participant's Service Plan and are directed to be habilitative rather than explicitly for employment objectives. Services are provided in a variety of locations separate from the participant's private residence or other residential living arrangement. Participants are compensated in accordance with applicable federal laws and regulations. Prevocational services can be differentiated from Supported Employment services by using the following criteria:
1) Compensation is paid at less than 50 percent of the minimum wage (agencies that pay less than minimum wage shall ensure compliance with department of labor section 14(c) regulations); and
2) Goals for prevocational services are general in nature and are not primarily directed at teaching job specific skills.

The intended outcome of prevocational services is to obtain paid or unpaid community employment within five years. Prevocational services may continue longer than five years when documentation in the annual service plan demonstrates this need and the need is based on an annual assessment.

Participants who receive prevocational services may also receive Supported Employment and/or Day Habilitation Services. A participant's Service Plan may include two or more types of day services (i.e. Day Habilitation Services and Supports, Supported Employment or Prevocational Services), however different types of day services may not be billed during the same period of the day.
Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C 1401 et seq.).

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

The number of units available for Day Habilitation Services in combination with Prevocational Services is 4800 units. When used in combination with Supported Employment Services, the total number of units available for Day Habilitation Services in combination with Prevocational Services will remain at 4800 units and the cumulative total, including Supported Employment Services, may not exceed 7112.

In the event the Day Habilitation Services and Supports (DHSS) and Prevocational Services limit of 4800 units per Service Plan year is insufficient to meet a participant's needs, the safety net of Residential Habilitation Services and Supports (RHSS) is available to participants 24-hours a day, seven days a week.

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:

Agency

Provider Type:

Program Approved Service Agency

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

Program Approval
Department of Labor 14C Certificate

Other Standard *(specify):*

Rules: 10 CCR 2505-10 § 8.500.5

Program Management: Baccalaureate or higher degree from an accredited college or university in the area of Vocational Rehabilitation, Education, Social Work, Psychology, or related field, and one year of successful experience in human services; or an Associates degree from an accredited college and two years of successful experience in human services; or four years successful experience in human services.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:

Agency

Provider Type:

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

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

Program Approval
Department of Labor Certificate

Other Standard *(specify):*

Rules: 10 CCR 2505-10 § 8.500.5

Program Management: Baccalaureate or higher degree from an accredited college or university in the area of Vocational Rehabilitation, Education, Social Work, Psychology, or related field, and one year of successful experience in human services; or an Associates Degree from an accredited college and two years of successful experience in human services; or four years successful experience in human services.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy & Financing

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Residential Habilitation

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:**

Residential Habilitation Services and Supports (RHSS) are designed to ensure the health, safety and welfare of the participant, and to assist in the acquisition, retention and/or improvement in skills necessary to support the participant to live and participate successfully in their community. These services are individually planned and coordinated through the participant's Service Plan. The frequency, duration, and scope of these services are determined by the participant's needs identified in the Service Plan. These services may include a combination of lifelong - or extended duration - supervision, training, and/or support (i.e. support is any task performed for the participant, where learning is secondary or incidental to the task itself, or an adaptation is provided) which are essential to daily community living, including assessment and evaluation, the cost of training materials, transportation, fees, and supplies. Reimbursement for RHSS does not include the cost of normal facility maintenance, upkeep, and improvement other than such costs for modifications or adaptations to a facility required to assure the health and safety of participants or to meet the requirements of the applicable life safety code. Under Residential Habilitation Services and Supports the responsibility for the living environment rests with the service agency and encompasses two types of living environments:

Individual Residential Services and Supports (IRSS) in which three (3) or fewer participants receiving services may live in a single residential setting or in a host home setting. The living environment does not require state licensure. However, the Department of Health Care Policy & Financing (the Department) must approve the service agencies to provide such services. Monitoring of IRSS services to participants is the responsibility of the Community Centered Board (CCB) case managers and the monitoring of IRSS provider agencies is the responsibility of the Department. Specific requirements for case management monitoring of all providers is located at 10 CCR 2505-10 8.607.6. The Department, Department of Local Affairs- Division of Housing (DOH), and the Department of Public Health and Environment (CDPHE) monitors IRSS providers on an ongoing basis and for the purpose of provider certification.

Group Residential Services and Supports (GRSS) encompass group living environments of four (4) to eight (8) participants receiving services who may live in a single residential setting which is licensed by the State as a Residential Care Facility/Residential Community Home. All IRSS and GRSS settings are required to have staff available to meet the needs of the participant as defined in the Service Plan.

Residential Habilitation Services and Supports (RHSS) may be provided in a family member's home pursuant to C.R.S. 27-10.5-102(15)(a) and (b). Residential Habilitation Services and Supports (RHSS) may be provided by family pursuant to C.R.S. 27-10.5-102(15)(a) and (b). The cost of room and board is not included in the reimbursement for RHSS. When family members are paid to provide RHSS the following conditions apply:

1) The paid family member shall meet the provider qualifications that have been specified for this service;
2) All of the participant's needs identified in the Service Plan to be met by RHSS shall be met either by the paid family member, other paid direct care or management staff of the service provider agency, or by other unpaid family members, friends or community members; and
3) When a family member is to be paid for providing services and supports the Service Plan must document that the IDT has determined that provision of services by a paid family member is in the best interest of the participant and the reasons for that determination.

The following activities are performed by RHSS staff and are designed to assist participants to reside as independently as possible in the community:
1) Self-advocacy training may include training to assist in expressing personal preferences, self-representation, self-protection from and reporting of abuse, neglect and exploitation, individual rights and to make increasingly responsible choices.
2) Independent living training may include personal care, household services, infant and childcare (for parents who have a developmental disability), and communication skills such as using the telephone.
3) Cognitive services may include training involving money management and personal finances, planning and decision making.
4) Implementation of recommended follow-up counseling, behavioral or other therapeutic interventions by residential staff, under the direction of a professional. Services are aimed at increasing the overall effective functioning of the participant.
5) Medical and health care services that are integral to meeting the daily needs of participants (e.g., routine administration of medications or tending to the needs of participants who are ill or require attention to their medical needs on an ongoing basis.
6) Emergency assistance training includes developing responses in case of emergencies, prevention planning, and training in the use of equipment or technologies used to access emergency response systems.

7) Community access services that explore community services available to all people, natural supports available to the participant, and develop methods to access additional services/supports/activities needed by the participant.
8) Travel services may include providing, arranging, transporting, or accompanying the participant to services and supports identified in the Service Plan.
9) Supervision services which ensure the health and welfare of the participant and/or utilizing technology for the same purpose.

All direct care staff not otherwise licensed to administer medications must complete a training class approved by the Colorado Department of Public Health and Environment (CDPHE), pass a written test and a practical/competency test.

The CCB is expected to review the list of qualified provider service agencies in its designated service area to verify that each agency has maintained a current program approval certification issued by the Department, and a current license from the CDPHE if licensed as a community group home for the developmental disabled. The Department and CCBs provide ongoing monitoring of all residential habilitation providers and the Department, through interagency agreement with CDPHE, is responsible for monitoring all individual and group residential service providers for certification purposes every three years. The Colorado CDPHE is responsible to monitor each individually licensed group home every three years. There are no differences with these processes if the provider or group home is operated by the CCB or by a service agency. IRSS-Host Home settings will be inspected every two years by the Colorado Division of Housing to ensure they are meeting environmental standards.

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

RHSS-GRSS provided in an out-of-state setting is only allowed when there is not a service provider within Colorado that is able to meet the waiver participant's needs due to specific, individualized health and safety concerns. The need for out-of-state services and out-of-state providers must be approved by HCPF. When services are provided out-of-state, the standard waiver requirements will continue to be met per the Olmstead Letter #3 State Medicaid Directors on July 25, 2000. These requirements include:

• There must be a written plan of care with the services. The plan of care must identify the services to be provided, the amount and type of each service, and the type of provider.
• Services must be furnished by a qualified provider. The provider must meet the standards for service provision that are set forth by the state where services are being provided. The host state in which services are received must have an equivalent licensure or certification as a Colorado provider for RHSS-GRSS.
• Colorado remains responsible for the assurance of the health and welfare of the waiver member. Oversight is performed directly by the case management agency via telehealth options and by the host state in which services are received.
• The provider of out-of-state RHSS-GRSS must be chosen just as freely as the provider of in-state services by the waiver member.
• The out-of-state provider must have a provider agreement with HCPF per section 1902(a)(27) of the Act and payment must be made directly to the provider per section 1902(a)32 of the Act.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Program Approved Service Agency Group Residential Services and Supports
Agency	Program Approved Service Agency Individual Residential Services and Supports

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:
Agency
Provider Type:

Program Approved Service Agency Group Residential Services and Supports

Provider Qualifications

License *(specify):*

Colorado Department of Public Health & Environment (CDPHE)

Certificate *(specify):*

Program Approval

Other Standard *(specify):*

Rules: 10 CCR 2505-10 § 8.500.5
Program Management: Baccalaureate or higher Degree from an accredited college or university in the area of Education, Social Work, Psychology, or related field, and one year of successful experience in human services; or an Associates Degree from an Accredited college and two years of successful experience in human services; or four years successful experience in human services.

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

RHSS-GRSS provided in an out-of-state setting is only allowed when there is not a service provider within Colorado that is able to meet the waiver participant's needs due to specific, individualized health and safety concerns. The need for out-of-state services and out-of-state providers must be approved by HCPF. When services are provided out-of-state, the standard waiver requirements will continue to be met per the Olmstead Letter #3 State Medicaid Directors on July 25, 2000. These requirements include:

• There must be a written plan of care with the services. The plan of care must identify the services to be provided, the amount and type of each service, and the type of provider.
• Services must be furnished by a qualified provider. The provider must meet the standards for service provision that are set forth by the state where services are being provided. The host state in which services are received must have an equivalent licensure or certification as a Colorado provider for RHSS-GRSS.
• Colorado remains responsible for the assurance of the health and welfare of the waiver member. Oversight is performed directly by the case management agency via telehealth options and by the host state in which services are received.
• The provider of out-of-state RHSS-GRSS must be chosen just as freely as the provider of in-state services by the waiver member.
• The out-of-state provider must have a provider agreement with HCPF per section 1902(a)(27) of the Act and payment must be made directly to the provider per section 1902(a)32 of the Act.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Verification of provider qualification is completed by HCPF upon initial Medicaid enrollment and every five years through provider revalidation. CDPHE conducts verification through surveys initially and every three years.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:

Agency

Provider Type:

Program Approved Service Agency Individual Residential Services and Supports

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

Program Approval

Other Standard *(specify):*

Rules: 10 CCR 2505-10 § 8.500.5

Program Management: Baccalaureate or higher Degree from an accredited college or university in the area of Education, Social Work, Psychology, or related field, and one year of successful experience in human services; or an Associates Degree from an Accredited college and two years of successful experience in human services; or four years successful experience in human services.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Verification of provider qualification is completed upon initial Medicaid enrollment and every five years through provider revalidation, as well as through the DPHE survey process initially and every three years. Host Home providers will be inspected every two years by the Colorado Division of Housing.

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:

Supported Employment

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:**

Supported Employment services consists of intensive, ongoing supports that enable participants, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need supports, to perform in a regular work setting. Supported employment is conducted in a variety of settings in which participants interact regularly with non-disabled individuals (other than those individuals who are providing services to the participant). Participants must be involved in work outside of a base site. Included are participants who work in community jobs and on mobile crews. Group employment (e.g. mobile crews) shall not exceed eight persons.
Job Development services focus on assessment and identification of vocational interests and capabilities in preparation for job development as well as assisting the participant to locate a job or job development on behalf of the participant.
Job Coaching services focus on activities needed to sustain paid work by participants, including supervision and training. When supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required by participants receiving waiver services as a result of their disabilities. This does not include payment for the supervisory activities rendered as a normal part of the business setting.
Job Placement services may be used to purchase items that a participant needs to obtain and/or sustain employment that are not otherwise the responsibility of the employer to provide under the Americans with Disabilities Act of 1990.
Participants are required to apply for services through the Division for Vocational Rehabilitation. Supported employment does not take the place of nor is it duplicative of services received through the Division for Vocational Rehabilitation. Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).
Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program; payments that are passed through to users of supported employment programs; or payments for training that are not directly related to an individual's supported employment program.

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

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

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

The number of units available for Supported Employment is 7,112 units. The unit limit for Day Habilitation Services and Supports and Prevocational Services is 4800. When these services are used in combination with Supported Employment, the cumulative total cannot exceed 7,112 units. This number of units is the equivalent of 1,778 hours of service per year or on average 7 hours a day for 254 service days.

Reimbursement for Telehealth services is limited to enrolled Colorado Medicaid providers.

Supported Employment services provided in an out-of-state setting is only allowed when there is not a service provider within Colorado that is able to meet the waiver participant's needs due to specific, individualized health and safety concerns. The need for out-of-state services and out-of-state providers must be approved by HCPF. When services are provided out-of-state, the standard waiver requirements will continue to be met per the Olmstead Letter #3 State Medicaid Directors on July 25, 2000. These requirements include:

• There must be a written plan of care with the services. The plan of care must identify the services to be provided, the amount and type of each service, and the type of provider.
• Services must be furnished by a qualified provider. The provider must meet the standards for service provision that are set forth by the state where services are being provided. The host state in which services are received must have an equivalent licensure or certification as a Colorado provider for Supported Employment services.
• Colorado remains responsible for the assurance of the health and welfare of the waiver member. Oversight is performed directly by the case management agency via telehealth options and by the host state in which services are received.
• The provider of out-of-state Supported Employment services must be chosen just as freely as the provider of in-state • The out-of-state provider must have a provider agreement with HCPF per section 1902(a)(27) of the Act and payment must be made directly to the provider per section 1902(a)32 of the Act.

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:
Agency
Provider Type:

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

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

Program Approval

Other Standard *(specify):*

Rules: 10 CCR 2505-10 § 8.500.5

Supported Employment Agency Program Management: Baccalaureate or higher degree from an accredited college or university in the area of Vocational Rehabilitation, Education, Social Work, Psychology or related field and one year of successful experience in employment counseling, job placement, job coaching, or vocational rehabilitation; or, an Associates Degree from an accredited college, and four years of successful experience in employment counseling, job placement, job coaching or vocational rehabilitation.

In addition to the requirements listed above, if an agency also provides Individual Job Development and/or Job Coaching, a nationally recognized certification, approved by the Department, must be maintained.

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

Individual Job Developer/Job Coach: In addition to the requirements listed above, a nationally recognized certification, approved by the Department, must be maintained.

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

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

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

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

Telehealth service delivery may not be used for Supported Employment - Group service delivery.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Agency

Provider Type:

Program Approved Service Agency: Supported Employment

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

Program Approval

Other Standard *(specify):*

Rules: 10 CCR 2505-10 § 8.500.5

Supported Employment Agency Program Management: Baccalaureate or higher degree from an accredited college or university in the area of Vocational Rehabilitation, Education, Social Work, Psychology, or related field, and one year of successful experience in employment counseling, job placement, job coaching, or vocational rehabilitation; or, an Associates Degree from an accredited college, and four years of successful experience in employment counseling, job placement, job coaching, or vocational rehabilitation.

In addition to the requirements listed above, if an agency also provides Individual Job Development and/or Job Coaching, a nationally recognized certification, approved by the Department, must be maintained.

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

Individual Job Developer/Job Coach: In addition to the requirements listed above, a nationally recognized certification, approved by the Department, must be maintained.

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

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

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

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

Telehealth service delivery may not be used for Supported Employment - Group service delivery.

Supported Employment services provided in an out-of-state setting is only allowed when there is not a service provider within Colorado that is able to meet the waiver participant's needs due to specific, individualized health and safety concerns. The need for out-of-state services and out-of-state providers must be approved by HCPF. When services are provided out-of-state, the standard waiver requirements will continue to be met per the Olmstead Letter #3 State Medicaid Directors on July 25, 2000. These requirements include:

• There must be a written plan of care with the services. The plan of care must identify the services to be provided, the amount and type of each service, and the type of provider.
• Services must be furnished by a qualified provider. The provider must meet the standards for service provision that are set forth by the state where services are being provided. The host state in which services are received must have an equivalent licensure or certification as a Colorado provider for Supported Employment services.
• Colorado remains responsible for the assurance of the health and welfare of the waiver member. Oversight is performed directly by the case management agency via telehealth options and by the host state in which services are received.
• The provider of out-of-state Supported Employment services must be chosen just as freely as the provider of in-state services by the waiver member.
• The out-of-state provider must have a provider agreement with HCPF per section 1902(a)(27) of the

Act and payment must be made directly to the provider per section 1902(a)32 of the Act.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Dental Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11070 dental services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Dental services through the waiver are available to participants age 21 and over. Covered Dental Services are for diagnostic and preventative care to abate tooth decay, restore dental health, and are medically appropriate. Services include preventative, basic, and major services. DentaQuest completes prior authorization and/or pre-payment review of dental services. If dental service is not managed through DentaQuest it requires prior authorization at the local Community Centered Board (CCB) level pursuant to Prior Authorization Request (PAR) Process

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

Dental services under the waiver are provided only when the services are not available through the Medicaid State Plan or through a third party. Dental Services under the waiver are not available to a client eligible for Early and Periodic Screening Diagnostic and Treatment (EPSDT) services. General limitations to dental services (i.e. frequency) will follow the Department Guidelines using industry standards and are limited to the most cost-effective and efficient means to alleviate or rectify the dental issues associated with the individual. Implants are not a covered service for participants who smoke daily due to a substantiated increased rate of implant failures for chronic smokers. Subsequent implants are not a covered service when prior implants fail. Full mouth implants and/or full mouth crowns are not covered. Services not covered under the waiver Dental Services include, but are not limited to: cosmetic dentistry, orthodontia, emergency extractions, intravenous sedation, general anesthesia, and hospital fees. Cosmetic dentistry is defined as aesthetic treatments designed to improve the appearance of the teeth and/or smile (e.g. whitening, contouring, veneers).

Preventative and Basic services are limited to $2,000 per State fiscal year.
Major services are limited to $10,000 for the five (5) year renewal period of the waiver.

Dental services provided in an out-of-state setting is only allowed when there is not a service provider within Colorado that is able to meet the waiver participant's needs due to specific, individualized health and safety concerns. The need for out-of-state services and out-of-state providers must be approved by HCPF. When services are provided out-of-state, the standard waiver requirements will continue to be met per the Olmstead Letter #3 State Medicaid Directors on July 25, 2000. These requirements include:

• There must be a written plan of care with the services. The plan of care must identify the services to be provided, the amount and type of each service, and the type of provider.
• Services must be furnished by a qualified provider. The provider must meet the standards for service provision that are set forth by the state where services are being provided. The host state in which services are received must have an equivalent licensure or certification as a Colorado provider for Dental services.
• Colorado remains responsible for the assurance of the health and welfare of the waiver member. Oversight is performed directly by the case management agency via telehealth options and by the host state in which services are received.
• The provider of out-of-state Dental services must be chosen just as freely as the provider of in-state services by the waiver member.
• The out-of-state provider must have a provider agreement with HCPF per section 1902(a)(27) of the Act and payment must be made directly to the provider per section 1902(a)32 of the Act.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Dentist
Individual	Dental Hygienist/ Assistant

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Dental Services

Provider Category:

Individual

Provider Type:

Dentist

Provider Qualifications

License *(specify):*

Per State Board of Dental Examiners

Certificate *(specify):*

Other Standard *(specify):*

C.R.S. 12-35-101 et. seq.3 CCR 709.1: Colorado Board of Dental Examiners, Rules and Regulations

Dental services provided in an out-of-state setting is only allowed when there is not a service provider within Colorado that is able to meet the waiver participant's needs due to specific, individualized health and safety concerns. The need for out-of-state services and out-of-state providers must be approved by HCPF. When services are provided out-of-state, the standard waiver requirements will continue to be met per the Olmstead Letter #3 State Medicaid Directors on July 25, 2000. These requirements include:
• There must be a written plan of care with the services. The plan of care must identify the services to be provided, the amount and type of each service, and the type of provider.
• Services must be furnished by a qualified provider. The provider must meet the standards for service provision that are set forth by the state where services are being provided. The host state in which services are received must have an equivalent licensure or certification as a Colorado provider for Dental services.
• Colorado remains responsible for the assurance of the health and welfare of the waiver member. Oversight is performed directly by the case management agency via telehealth options and by the host state in which services are received.
• The provider of out-of-state Dental services must be chosen just as freely as the provider of in-state services by the waiver member.
• The out-of-state provider must have a provider agreement with HCPF per section 1902(a)(27) of the Act and payment must be made directly to the provider per section 1902(a)32 of the Act.

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: Extended State Plan Service
Service Name: Dental Services

Provider Category:

Individual

Provider Type:

Dental Hygienist/ Assistant

Provider Qualifications

License *(specify):*

Per State Board of Dental Examiners

Certificate *(specify):*

Other Standard *(specify):*

C.R.S. 12-35-101 et. esq.3 CCR 709.1: Colorado Board of Dental Examiners, Rules and Regulations

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy & Financing

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Vision 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:**

Vision services are provided only when the services are not available through the Medicaid State Plan or available through a third party resource. Vision services under the waiver are not available to participants eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services. Vision services are provided by a licensed Optometrist or physician and include eye exams and diagnosis, glasses, contacts, and other medically necessary methods used to improve specific dysfunctions of the vision systems. Lasik and other similar types of procedures shall be approved prior to service delivery and are allowable when the procedure is necessary due to documented specific behavioral complexities (i.e. constant destruction of eye glasses) associated with the participant that make other more traditional remedies impractical.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Optometrist
Individual	Opthalmologist

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Vision Services

Provider Category:

Individual

Provider Type:

Optometrist

Provider Qualifications

License *(specify):*

C.R.S. 12-40-101 et. Seq.

Certificate *(specify):*

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: Extended State Plan Service
Service Name: Vision Services

Provider Category:

Individual

Provider Type:

Opthalmologist

Provider Qualifications

License *(specify):*

C.R.S. 12-40-101 et. Seq.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy & Financing

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Behavioral 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:**

Behavioral Services are services related to an individual's intellectual and developmental disability which assist a client to acquire or maintain appropriate interactions with others.

Behavioral Services include:

1) Behavioral Consultation Services include consultations and recommendations for behavioral interventions and development of behavioral support plans that are related to the individual's intellectual and developmental disability and are necessary for the individual to acquire or maintain appropriate adaptive behaviors, interactions with others and behavioral self-management. Intervention modalities shall relate to an identified challenging behavioral need of the individual. Specific goals and procedures for the Behavioral Services must be established. Individuals with co-occurring diagnoses of developmental disabilities and Medicaid covered mental health conditions shall have identified needs met by each of the appropriate systems without duplication but with coordination by the Behavioral Services professional to obtain the best outcome for the individual.

2) Behavioral Plan Assessment Services include observations, interviews of direct staff, functional behavioral analysis and assessment, evaluations, and completion of a written assessment document.

3) Individual/Group Counseling Services include psychotherapeutic or psychoeducational intervention related to the intellectual and developmental disability in order for the individual to acquire or maintain appropriate adaptive behaviors, interactions with others and behavioral self-management, and to positively impact the individual's behavior or functioning. Counseling may be provided in an individual or group setting and may include Cognitive Behavior Therapy, Systematic Desensitization, Anger Management, Biofeedback, and Relaxation Therapy.

4) Behavioral Line Services include direct 1:1 implementation of the behavioral support plan, under the supervision and oversight of a Behavioral Consultant for acute, short term intervention at the time of enrollment from an institutional setting or to address an identified challenging behavior of an individual at risk of institutional placement and that puts the individual's health and safety and/or the safety of others at risk.

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

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

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

Exclusions:

This waiver service is only provided to individuals age 21 and over. All medically necessary Behavioral Services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

Behavioral services must not duplicate or supplant Behavioral Health Organization services offered under the Medicaid State Plan.

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

Services for the sole purpose of training in basic life skills such as activities of daily living, social skills and adaptive responding are excluded and shall not be reimbursed under Behavioral Services.

Behavioral Line Services shall not use Telehealth for the delivery of this service.

Limits:

1) Behavioral Consultation Services are limited to 80 units per Service Plan Year. One unit is equal to 15 minutes of service.

2) Behavioral Plan Assessment Services are limited to 40 units. There is a limit of one Behavioral Assessment per Service Plan year. One unit is equal to 15 minutes of service.

3) Counseling Services are limited to 208 units per Service Plan year. One unit is equal to 15 minutes of service.

4) Behavioral Line Services are limited to 960 units per Service Plan year. One unit is equal to 15 minutes of service. Requests for Behavioral Line Services units must be prior authorized in accordance with the Department's procedures.

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

Behavioral services provided in an out-of-state setting is only allowed when there is not a service provider within Colorado that is able to meet the waiver participant's needs due to specific, individualized health and safety concerns. The need for out-of-state services and out-of-state providers must be approved by HCPF. When services are provided out-of-state, the standard waiver requirements will continue to be met per the Olmstead Letter #3 State Medicaid Directors on July 25, 2000. These requirements include:

- There must be a written plan of care with the services. The plan of care must identify the services to be provided, the amount and type of each service, and the type of provider.
- Services must be furnished by a qualified provider. The provider must meet the standards for service provision that are set forth by the state where services are being provided. The host state in which services are received must have an equivalent licensure or certification as a Colorado provider for Behavioral Services.
- Colorado remains responsible for the assurance of the health and welfare of the waiver member. Oversight is performed directly by the case management agency via telehealth options and by the host state in which services are received.
- The provider of out-of-state Behavioral Services must be chosen just as freely as the provider of in-state services by the waiver member.
- The out-of-state provider must have a provider agreement with HCPF per section 1902(a)(27) of the Act and payment must be made directly to the provider per section 1902(a)32 of the Act.

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

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

☒ **Provider managed**

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Services

Provider Category:

Agency

Provider Type:

Program Approved Service Agency

Provider Qualifications

License *(specify):*

Behavioral Services may be provided by licensed individuals as required, who are in good standing, as described in “other standard” below.

Certificate *(specify):*

Department Program Approval. Behavioral Services may be provided by individuals with appropriate certification as required, as described in “other standard” below.

Other Standard *(specify):*

Behavioral Consultants shall meet one of the following minimum requirements:

1. Shall have a Master's degree or higher in behavioral, social or health sciences or education and be nationally certified as a "Board Certified Behavior Analyst" (BCBA), or certified by a similar nationally recognized organization. Shall have at least 2 years of directly supervised experience developing and implementing behavioral support plans utilizing established approaches including Behavioral Analysis or Positive Behavioral Supports that are consistent with best practice and research on effectiveness for people with intellectual and developmental disabilities; or

2. Shall have a Baccalaureate degree or higher in behavioral, social or health sciences or education and be 1) certified as a "Board Certified Assistant Behavior Analyst" (BCABA) or 2) be enrolled in a BCABA or BCBA certification program or completed a Positive Behavior Supports training program and 3) working under the supervision of a certified or licensed Behavioral Services Provider.

Counselors shall meet one of the following minimum requirements:

1. Shall hold the appropriate license or certification for the provider's discipline according to state law or federal regulations and represent one of the following professional categories: Licensed Clinical Social Worker, Certified Rehabilitation Counselor, Licensed Professional Counselor, Licensed Clinical Psychologist, or BCBA and must demonstrate or document a minimum of two years' experience in providing counseling to individuals with intellectual and developmental disabilities; or

2. Have a Baccalaureate degree or higher in behavioral, social or health science or education and work under the supervision of a licensed or certified professional as set forth above in requirement one (1).

Behavioral Plan Assessor shall meet one of the following minimum qualifications:

1. Shall have a Master's degree or higher in behavioral, social or health science or education and be nationally certified as a BCBA or certified by a similar nationally recognized organization. Shall have at least 2 years of directly supervised experience developing and implementing behavioral support plans utilizing established approaches including Behavioral Analysis or Positive Behavioral Supports that are consistent with best practice and research on effectiveness for people with intellectual and developmental disabilities; or

2. Shall have a Baccalaureate degree or higher in behavioral, social or health science or education and be 1) certified as a "Board Certified Assistant Behavior Analyst" (BCABA) or 2) be enrolled in a BCABA or BCBA certification program or completed a Positive Behavior Supports training program and working under the supervision of a certified or licensed Behavioral Services provider.

Behavioral Line Staff shall meet the following minimum requirements:

Must be at least 18 years of age, graduated from high school or earned a high school equivalency degree and have a minimum of 24 hours training, inclusive of practical experience in the implementation of positive behavioral supports and/or applied behavioral analysis and that is consistent with best practice and research on effectiveness for people with intellectual and developmental disabilities. Works under the direction of a Behavioral Consultant.

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

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

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

Behavioral Services provided in an out-of-state setting is only allowed when there is not a service provider within Colorado that is able to meet the waiver participant's needs due to specific, individualized health and safety concerns. The need for out-of-state services and out-of-state providers must be approved by HCPF. When services are provided out-of-state, the standard waiver requirements will continue to be met per the Olmstead Letter #3 State Medicaid Directors on July 25, 2000. These requirements include:

• There must be a written plan of care with the services. The plan of care must identify the services to be provided, the amount and type of each service, and the type of provider.
• Services must be furnished by a qualified provider. The provider must meet the standards for service provision that are set forth by the state where services are being provided. The host state in which services are received must have an equivalent licensure or certification as a Colorado provider for Behavioral Services.
• Colorado remains responsible for the assurance of the health and welfare of the waiver member. Oversight is performed directly by the case management agency via telehealth options and by the host state in which services are received.
• The provider of out-of-state Behavioral Services must be chosen just as freely as the provider of in-state services by the waiver member.
• The out-of-state provider must have a provider agreement with HCPF per section 1902(a)(27) of the Act and payment must be made directly to the provider per section 1902(a)32 of the Act.

Verification of Provider Qualifications

Entity Responsible for Verification:

Community Centered Board as the Organized Health Care Delivery System, The Department of Health Care Policy & Financing, The Department of Public Health & Environment.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Services

Provider Category:

Agency

Provider Type:

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

Provider Qualifications

License *(specify):*

Behavioral Services may be provided by licensed individuals as required, who are in good standing, as described in “other standard” below.

Certificate *(specify):*

Department Program Approval. Behavioral Services may be provided by individuals with appropriate certification as required, as described in “other standard” below.

Other Standard *(specify):*

Behavioral Consultants shall meet one of the following minimum requirements:

1. Shall have a Master's degree or higher in behavioral, social or health sciences or education and be nationally certified as a "Board Certified Behavior Analyst" (BCBA), or certified by a similar nationally recognized organization. Shall have at least 2 years of directly supervised experience developing and implementing behavioral support plans utilizing established approaches including Behavioral Analysis or Positive Behavioral Supports that are consistent with best practice and research on effectiveness for people with intellectual and developmental disabilities; or

2. Shall have a Baccalaureate degree or higher in behavioral, social or health sciences or education and be 1) certified as a "Board Certified Assistant Behavior Analyst" (BCABA) or 2) be enrolled in a BCABA or BCBA certification program or completed a Positive Behavior Supports training program and 3) working under the supervision of a certified or licensed Behavioral Services Provider.

Counselors shall meet one of the following minimum requirements:

1. Shall hold the appropriate license or certification for the provider's discipline according to state law or federal regulations and represent one of the following professional categories: Licensed Clinical Social Worker, Certified Rehabilitation Counselor, Licensed Professional Counselor, Licensed Clinical Psychologist, or BCBA and must demonstrate or document a minimum of two years' experience in providing counseling to individuals with intellectual and developmental disabilities; or

2. Have a Baccalaureate degree or higher in behavioral, social or health science or education and work under the supervision of a licensed or certified professional as set forth above in requirement one (1).

Behavioral Plan Assessor shall meet one of the following minimum qualifications:

1. Shall have a Master's degree or higher in behavioral, social or health science or education and be nationally certified as a BCBA or certified by a similar nationally recognized organization. Shall have at least 2 years of directly supervised experience developing and implementing behavioral support plans utilizing established approaches including Behavioral Analysis or Positive Behavioral Supports that are consistent with best practice and research on effectiveness for people with intellectual and developmental disabilities; or

2. Shall have a Baccalaureate degree or higher in behavioral, social or health science or education and be 1) certified as a "Board Certified Assistant Behavior Analyst" (BCABA) or 2) be enrolled in a BCABA or BCBA certification program or completed a Positive Behavior Supports training program and working under the supervision of a certified or licensed Behavioral Services provider.

Behavioral Line Staff shall meet the following minimum requirements:

Must be at least 18 years of age, graduated from high school or earned a high school equivalency degree and have a minimum of 24 hours training, inclusive of practical experience in the implementation of positive behavioral supports and/or applied behavioral analysis and that is consistent with best practice and research on effectiveness for people with intellectual and developmental disabilities. Works under the direction of a Behavioral Consultant.

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home Delivered Meals

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:**

Home Delivered Meals services offer nutritional counseling and meal planning, preparation, and delivery to support a client.

Services do not include the provision of items outside of the nutritional meals identified in the meal planning, such as additional food items or cooking appliances.

To access Home Delivered Meals, a client must participate in a needs assessment through which they demonstrate a need for the service based on the following:
• The client demonstrates a need for nutritional counseling, meal planning, and preparation;
• The client shows documented special dietary restrictions or specific nutritional needs;
• The client cannot prepare meals with the type of nutrition vital to meeting their special dietary restrictions or special nutritional needs;
• The client has limited or no outside assistance, services, or resources through which they can access meals with the type of nutrition vital to meeting their special dietary restrictions or special nutritional needs; and
• The client's need demonstrates a risk to health, safety, or institutionalization; and
• The client demonstrates that, within 365 days, they have the ability to acquire skills, other services, or other resources to access meals.

To access Home Delivered Meals for individuals who are discharged from the hospital, a client must meet the following requirements:
• Has been admitted to the hospital or Emergency Department for at least one (1) day;
• Screened by a physician, registered dietician or nutrition professional, or clinical social worker to receive meals through the program.
• Demonstrates a risk to health, safety, institutionalization, or readmission to the hospital;
• Demonstrates a need for nutritional counseling, meal planning, and preparation;
• Has a documented special dietary restrictions or specific nutritional needs;
• Cannot prepare meals with the type of nutrition vital to meeting their special dietary restrictions or special nutritional needs;
• Does not reside in a provider-owned or controlled setting; and
• Has limited or no outside assistance, services, or resources through which they can access meals with the type of nutrition vital to meeting their special dietary restrictions or special nutritional needs.

The assessed need is documented in the Service Plan as part of the client's acquisition process, which includes gradually becoming capable of preparing his/her own meals or establishing the resources to obtain needed meals.

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

Home Delivered Meal services are available over a period of 365 days following the first day the service is provided. The unit designation for Home Delivered Meal services is per meal. Meals are limited to two meals per day or 14 meals delivered one day per week. Home Delivered Meals is not available when the person resides in a provider owned or controlled setting.

Home Delivered Meals are not available for individuals transitioning to Residential Habilitation Services; including Group Residential Services and Supports and Individual Residential Services and Supports-Host Home.

Home Delivered Meals services post hospital discharge are available for 30 calendar days following discharge from a hospital stay up to two (2) times per service plan certification year. Meals are limited to two meals per day or 14 meals delivered one day per week.

Exceptions will be granted based on extraordinary circumstances.

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Delivered Meals Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Home Delivered Meals Provider

Provider Qualifications

License *(specify):*

The provider must be a legally constituted entity or foreign entity (outside of Colorado) registered with the Colorado Secretary of State Colorado with a Certificate of Good Standing to do business in Colorado. Foreign entities must have a physical presence within the state for delivering the items.

The provider shall have all licensures required by the State of Colorado Department of public health and Environment (CDPHE) for the performance of the service or support being provided, including necessary Retail Food License and Food Handling License for Staff.

Certificate *(specify):*

The provider must meet the certification standards in §8.500.9 (10 CCR 2505-10).

The provider must have an on-staff or contracted certified Registered Dietitian (RD) or Registered Dietitian Nutritionist (RDN).

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Initially and at submission of renewed license upon expiration of each required license. 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:

Non Medical Transportation

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:**

Service offered in order to enable waiver participants to gain access to Day Habilitation and Supported Employment services as specified by the Service Plan that are not related to medical interventions as covered in the State Plan. Transportation to and from work is a benefit in conjunction with Supported Employment service except when the Supported Employment service occurs at a frequency less than the number of days worked. In that case, transportation to and from the place of employment is a benefit when the participant does not have resources available, including personal funds, natural supports, and/or third party resources. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State plan, defined at 42 CFR §440.170(a) (if applicable), and does not replace them. Transportation services under the waiver are offered in accordance with the participant's Service Plan. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge are utilized.

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

Transportation to and from day program shall be reimbursed based on the applicable transportation band. The number of units available for Transportation Services is 508 units per Service Plan year or approximately 42 trips per month. A unit is a per-trip charge for to and from Day Habilitation and Supported Employment programs.

NMT services provided in an out-of-state setting is only allowed when there is not a service provider within Colorado that is able to meet the waiver participant's needs due to specific, individualized health and safety concerns. The need for out-of-state services and out-of-state providers must be approved by HCPF. When services are provided out-of-state, the standard waiver requirements will continue to be met per the Olmstead Letter #3 State Medicaid Directors on July 25, 2000. These requirements include:

• There must be a written plan of care with the services. The plan of care must identify the services to be provided, the amount and type of each service, and the type of provider.
• Services must be furnished by a qualified provider. The provider must meet the standards for service provision that are set forth by the state where services are being provided. The host state in which services are received must have an equivalent licensure or certification as a Colorado provider for NMT services.
• Colorado remains responsible for the assurance of the health and welfare of the waiver member. Oversight is performed directly by the case management agency via telehealth options and by the host state in which services are received.
• The provider of out-of-state NMT services must be chosen just as freely as the provider of in-state services by the waiver member.
• The out-of-state provider must have a provider agreement with HCPF per section 1902(a)(27) of the Act and payment must be made directly to the provider per section 1902(a)32 of the Act.

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Non Medical Transportation

Provider Category:
Agency
Provider Type:

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

Provider Qualifications
License *(specify):*

Colorado Drivers License or Commercial Drivers License, or C.R.S. 40-10-101 et.seq.

Certificate *(specify):*

Other Standard *(specify):*

Rules: 10 CCR 2505-10 § 8.611 Transportation.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy & Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Non Medical Transportation

Provider Category:

Agency

Provider Type:

Program Approved Service Agency

Provider Qualifications

License *(specify):*

Colorado Drivers License, or Commercial Drivers License, or C.R.S. 40-10-101 et.seq.

Certificate *(specify):*

None

Other Standard *(specify):*

Rules:10 CCR 2505-10 § 8.611 Transportation.

NMT services provided in an out-of-state setting is only allowed when there is not a service provider within Colorado that is able to meet the waiver participant's needs due to specific, individualized health and safety concerns. The need for out-of-state services and out-of-state providers must be approved by HCPF. When services are provided out-of-state, the standard waiver requirements will continue to be met per the Olmstead Letter #3 State Medicaid Directors on July 25, 2000. These requirements include:

• There must be a written plan of care with the services. The plan of care must identify the services to be provided, the amount and type of each service, and the type of provider.
• Services must be furnished by a qualified provider. The provider must meet the standards for service provision that are set forth by the state where services are being provided. The host state in which services are received must have an equivalent licensure or certification as a Colorado provider for NMT services.
• Colorado remains responsible for the assurance of the health and welfare of the waiver member. Oversight is performed directly by the case management agency via telehealth options and by the host state in which services are received.
• The provider of out-of-state NMT services must be chosen just as freely as the provider of in-state services by the waiver member.
• The out-of-state provider must have a provider agreement with HCPF per section 1902(a)(27) of the Act and payment must be made directly to the provider per section 1902(a)32 of the Act.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy & Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Non Medical Transportation

Provider Category:

Agency

Provider Type:

Public Transportation Agency

Provider Qualifications

License *(specify):*

As required by state law.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health Care Policy & Financing

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: 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:

Peer Mentorship

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:**

Peer Mentorship is provided by a peer who draws from common experience to support a client with acclimating to community living. The peer supports a client with advice, guidance, and encouragement on matters of community living, including through describing real-world experiences, encouraging the client's self-advocacy and independent living goals, and modeling strategies, skills, and problem-solving.

To access Peer Mentorship, a client must participate in a needs assessment through which they demonstrate a need for the service based on the following:

- The client demonstrates a need for a peer to mentor the client in acclimating to community living;

- The client's need demonstrates health, safety, or institutional risk; and
- There are no other services or resources available to meet the need; and
- The client demonstrates that, within 365 days, they have ability to acquire these skills or establish other services or resources necessary to their need.

Peer Mentorship does not include services or activities that are solely diversional or recreational in nature.

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

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

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

Clients may utilize Peer Mentorship services over a period of 365 days following the first day the service is provided.

Peer Mentorship is billed in 15-minute units. Clients may utilize Peer Mentorship up to 24 units (six hours) a day, and up to 365 days upon initial service provision.
Exceptions will be granted based on extraordinary circumstances.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Peer Mentorship Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Peer Mentorship

Provider Category:

Agency

Provider Type:

Peer Mentorship Provider

Provider Qualifications

License *(specify):*

The provider agency must be licensed under a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all applicable local, state, and federal requirements, laws, and regulations.

Certificate *(specify):*

The provider agency must be a legally constituted entity or foreign entity (outside of Colorado) registered with the Colorado Secretary of State Colorado with a Certificate of Good Standing to do business in Colorado.

The provider must meet the standards for a Certified Medicaid provider under 10 C.C.R. 2505-10 Section 8.500.9.

Other Standard *(specify):*

The provider must ensure services are delivered by a peer mentor staff who:

- Has lived experience transferable to support a client in acclimating to community living through providing them client advice, guidance, and encouragement on matters of community living, including through describing real-world experiences, encouraging the client's self-advocacy and independent living goals, and modeling strategies, skills, and problem-solving;
- Is qualified in the customized needs of the client as described in the Service Plan.
- Has completed the provider agency's peer mentor training, which is to be consistent with core competencies and training standards presented to agencies by the Department's Peer Mentorship provider agency training.

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

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health Care Policy & Financing and the ColoradoDepartment of Public Health & Environment.

Frequency of Verification:

Verification of provider qualification by HCPF is completed upon initial Medicaid enrollment and every five years through provider revalidation. The CDPHE survey process occurs at the time of initial enrollment and every three years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Specialized Medical Equipment and Supplies

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

Specialized Medical Equipment and supplies include:

1. Devices, controls, or appliances that enable participants to increase their ability to perform activities of daily living;

2. Devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live;

3. Items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items;

4. Such other durable and non-durable medical equipment not available under the State plan that is necessary to address participant functional limitations; and,

5. Necessary medical supplies in excess of state plan limitation or not available under the State plan.

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Pharmacy

Provider Category	Provider Type Title
Agency	Medical Supply Company
Agency	Community Centered Board (CCB)/Organized Health Care Delivery System (OHCDS)

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:

Pharmacy
Provider Qualifications
License *(specify):*

Pharmacy License
Certificate *(specify):*

Program Approval
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:

The Department of Health Care Policy & Financing
Frequency of Verification:

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

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:

Medical Supply Company
Provider Qualifications
License *(specify):*

Business License
Certificate *(specify):*

Program Approval

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy & Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

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

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Program Approval

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health Care Policy & Financing

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Transition Setup

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:**

Transition Setup includes coordination and purchase of one-time, non-recurring expenses necessary for a client to establish a basic household upon transitioning from an institutional setting to a community living arrangement.

Allowable setup expenses include:

1. Security deposits that are required to obtain a lease on an apartment or home.
2. Setup fees or deposits to access basic utilities or services (telephone, electricity, heat, and water).
3. Services necessary for the individual's health and safety such as pest eradication or one-time cleaning prior to occupancy.
4. Essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, or bed or bath linens.
5. Expenses incurred directly from the moving, transport, provision, or assembly of household furnishings to the residence.
6. Fees associated with obtaining legal and/or identification documents necessary for a housing application such as a birth certificate, state issued ID, or criminal background check.

Setup expenses do not include rental or mortgage expenses, ongoing food costs, regular utility charges, or items that are intended for purely diversional, recreational, or entertainment purposes. Setup expenses do not include the furnishing of living arrangements that are owned or leased by a waiver provider where the provision of these items and services are inherent to the service they are already providing. Setup expenses do not include payment for room and board.

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

Transition Setup coordination is billed in 15 minute unit increments. The coordination must not exceed 40 units per eligible client. Transition Setup is not available when the person resides in a provider owned or controlled setting.

Transition Setup expenses must not exceed a total of $1,500 per eligible client, unless otherwise authorized by the Department. The Department may authorize additional funds above the $1,500 unit limit, not to exceed a total value of $2,000, when it is demonstrated as a necessary expense to ensure the health, safety, and welfare of the client.

To access Transition Setup, a client must be transitioning from an institutional to a community living arrangement and participate in a needs assessment through which they demonstrate a need for the service based on the following:

- The client demonstrates a need for the coordination and purchase of one-time, non-recurring expenses necessary for a client to establish a basic household in the community;
- The need demonstrates health, safety, or institutional risk; and
- Other services/resources to meet the need are not available.

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	Transition Setup Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transition Setup

Provider Category:

Agency

Provider Type:

Transition Setup Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

The provider must be a legally constituted entity or foreign entity (outside of Colorado) registered with the Colorado Secretary of State Colorado with a Certificate of Good Standing to do business in Colorado.

The provider must meet the standards for a Certified Medicaid provider under 10 C.C.R. 2505-10 Section 8.500.9.

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Verification of provider qualification by HCPF is completed upon initial Medicaid enrollment and every five years through provider revalidation. The CDPHE survey process occurs at the time of initial enrollment and every three years.

Appendix C: Participant Services

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

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

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

◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*

☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*

☒ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*

☐ **As an administrative activity.** *Complete item C-1-c.*

☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

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

Community Centered Boards provide Targeted Case Management services.

Appendix C: Participant Services

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

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

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

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

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be

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

Administration and compliance with this requirement is reviewed at the time of survey of on-site surveys of Program Approved Service Agencies (PASA) and Case Management Agencies (CMA).

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

CDPHE is delegated the authority to conduct on-site quality surveys. During those surveys, CDPHE verifies that the mandatory checks/investigations have occurred. The waiver application has been updated with this information.

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):

Statute 26-3.1-111(6)(a)(I) and State regulation, 12 CCR 2518-1 30.960 state that employees providing direct care to at-risk adults must submit to a Colorado Adult Protective Services (CAPS) check. The Colorado Department of Human Services is the operating agency, ensuring screening takes place and processing the CAPS checks. Employers are required to complete a Colorado Adult Protective Services (CAPS) check prior to hiring a new employee who will provide direct care to an at-risk adult. Employers must register prior to requesting a CAPS check to allow for verification of the employer's legal authority to request the check. The Employer then obtains written authorization and any required identifying information from the new employee prior to requesting the CAPS check and submits the request using an online or hard copy to the Department of Human Services (DHS). DHS completes the CAPS check and will respond to the request as soon as possible, but no later than 5 business days from the receipt of the request. The CAPS check will include: Whether or not there is a substantiated finding for the new employee, the purpose for which the information in CAPS may be made available, consequences for improper release of information in CAPS, and for CAPS checks in which there is a substantiated finding, the CAPS check results will include the date(s) of the report, county department(s) that completed the investigation(s) and the type(s) of severity level(s) of the mistreatment.

Out-of-state providers must meet comparable requirements for abuse registry screening in their state.

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: Facility Specifications

Facility Type:

Community Residential Homes for Persons With Developmental Disabilities

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Vision Services	☐
Specialized Medical Equipment and Supplies	☐
Transition Setup	☐
Dental Services	☐
Home Delivered Meals	☐
Peer Mentorship	☐
Day Habilitation	☐
Supported Employment	☐
Prevocational Services	☐
Residential Habilitation	☒
Non Medical Transportation	☐
Behavioral Services	☐

Facility Capacity Limit:

4 to 8 Beds

Scope of Facility Sandards. For this facility type, please specify whether the state's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☒
Physical environment	☒
Sanitation	☒
Safety	☒
Staff : resident ratios	☒
Staff training and qualifications	☒
Staff supervision	☒
Resident rights	☒
Medication administration	☒
Use of restrictive interventions	☒
Incident reporting	☒

Standard	Topic Addressed
Provision of or arrangement for necessary health services	☒

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

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

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

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

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

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

☐ **Self-directed**

☐ **Agency-operated**

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

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

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

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

Payment may be made to family members who meet provider qualifications for the following services in the HCBS-DD waiver: Residential Habilitation Services and Supports, Day Habilitation Services and Supports, Supported Employment, Non-Medical Transportation, Home Delivered Meals, Transition Set Up, and Peer Mentorship. For the purpose of this section family shall be defined as all persons related to the participant by virtue of blood, marriage, adoption, or common law, and legal guardians as court appointed. For the purpose of this section Prevocational services may be provided by relatives/family, with the exception of legal guardians.

The family member providing services shall meet requirements set forth by the qualified program approved service agency (PASA) through which the family member provides services. The family member must be at least 18 years of age, trained to perform appropriate tasks to meet the participant's needs, and demonstrate the ability to provide support to the participant as defined in the participant's Service Plan and Hiring Agreement.

Participants and/or legal guardians, who choose to hire a family member must document their choice on the Service Plan. The Service Plan is developed under the coordination and direction of the community centered board Interdisciplinary Team (IDT) who provide oversight regarding the appropriateness of the family member providing services. The Service Plan identifies the needs of the person and reflects discussion on how to best meet those needs. The waiver services identified in the Service Plan are submitted for approval using a Prior Authorization Request (PAR.) When the PAR is approved those services are uploaded into the Medicaid Management Information System (MMIS). Only those approved services may be reimbursed. Family members other than spouses may be employed to provide services except a family member who is an individual's authorized representative may not be reimbursed for the provision of services.

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

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

○ **Other policy.**

Specify:

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

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

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**
☐ **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:

Performance Measure:
C.a.3 Number and percent of OHCDS providers during the performance period that have the required license/certification N: Number of OHCDS providers during the

performance period that have the required license/certification D: Total number of OHCDS providers during performance period

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
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**	☒ **Annually**	☐ **Stratified**

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

Data Aggregation and Analysis:

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

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

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

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the

method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

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

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

Performance Measure:
C.c.1 Number and percent of surveyed DD waiver providers who meet Department waiver training requirements in accordance with state requirements and the approved waiver Numerator: Number of surveyed DD waiver providers who meet Department waiver training requirements in accordance with state requirements and the approved waiver Denominator: Total number of surveyed waiver providers

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

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

	Ongoing	Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

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

Data Aggregation and Analysis:

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

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

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

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

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

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

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

C.a.2
Licensed/certified providers must be in good standing with their specific specialty practice act and with current state licensure regulations. Following Medicaid provider certification, all providers are referred to the Department's fiscal agent to obtain a provider number and a Medicaid provider agreement. The fiscal agent enrolls providers in accordance with Medical Assistance Program regulations and the Department's directives and maintains provider enrollment information in the MMIS. All provider qualifications and required 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.3
CCBs are certified as Organized Health Care Delivery Systems (OHCDS) by the Department. A Program Approved Service Agency (PASA) is an agency that has been approved by the OHCDS to provide direct community-based services to individuals with intellectual or developmental disabilities. PASAs provide services to waiver participants with Intellectual/Developmentally Disabilities (IDD)enrolled in Colorado's HCBS waivers through contracts with direct support professionals.

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

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

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

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

C.c.2
Dept. regulations for provider general certification standards require provider agencies to maintain a personnel record for each employee and supervisor that includes documentation of qualification and required training completed. The Department reviews personnel records as part of their provider certification/revalidation activities.

b. Methods for Remediation/Fixing Individual Problems

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

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

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

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

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

C.a.1, C.a.2, C.a.3, C.a.6
The Department initiates termination of the provider agreement for any provider who is in violation of any applicable certification standard, licensure requirements, or provision of the provider agreement and does not adequately respond to a corrective action plan within the prescribed period of time.

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

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

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

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

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **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: Colorado Department of Public Health and Environment	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

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

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

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is

authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

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

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

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

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

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

Please see information on the Department's Statewide Transition Plan in the Main section of the waiver, Attachment #2.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Person-Centered Support Plan (PCSP)

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

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

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

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

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

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

The minimum qualifications for HCBS Case Managers that conduct the person-centered service plan is:
1. A bachelor's degree; or
2. Five (5) years of experience in the field of LTSS, which includes Developmental Disabilities; or
3. Some combination of education and relevant experience appropriate to the requirements of the position.
4. Relevant experience is defined as:
a. Experience in one of the following areas: long-term care services and supports, gerontology, physical rehabilitation, disability services, children with special health care needs, behavioral science, special education, public health or non-profit administration, or health/medical services, including working directly with persons with physical, intellectual or developmental disabilities, mental illness, or other vulnerable populations as appropriate to the position being filled; and
b. Completed coursework and/or experience related to the type of administrative duties performed by case managers may qualify for up to two (2) years of required relevant experience.
Safeguards to assure the health and welfare of waiver participants, including response to critical events or incidents, remain unchanged.

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

☐ **Social Worker**
Specify qualifications:

☐ **Other**
Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

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

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

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

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

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

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

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

Case Managers can assist the individual in directing the PCSP development process if the individual chooses. In addition, there are several advocacy organizations in Colorado that the case manager can contact if the individual wishes. To facilitate person centered practices, CMAs may use phone or other technological contact to engage in the development and monitoring of the PCSP. Each certification period one in person monitoring will be required with up to three additional monitoring contacts either in person, on the phone, or through other technological contact based on the member preference of engagement.

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Case Managers are qualified willing providers. Case management functions include the responsibility to document, monitor, and oversee the implementation of the PCSP [10 C.C.R. 2505-10, Section 8.607]. The case manager meets face-to-face with the client and/or legal guardian to complete a LOC Screen, making reasonable attempts to schedule the meeting at a time and location convenient for all participants. The Colorado Code of Regulations (10 CCR 2505-10 8.607.4 B.) specifies that: Every effort shall be made to convene the meeting at a time and place convenient to the person receiving services, their legal guardian, authorized representative, and parent(s) of a minor. 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). There are quarterly case manager monitoring contacts: one will occur in person with up to three additional monitoring contacts either in person, on the phone, or through other technological contact based on the member preference of engagement.

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

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

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

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

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

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

The case manager reviews the LOC Screen and PCSP with the client every six months. At this time the case manager may meet the client at the residence, monitoring service delivery, health, and welfare. The review is conducted over the telephone, at the client's place of residence, place of service, or other appropriate settings as determined by the client's needs. This review includes the evaluation and assessment strategies for meeting the needs, preferences, and goals of the client. It also includes evaluating and obtaining information concerning the client's satisfaction with the services, effectiveness of services being provided, an informal assessment of changes in the client's function, service appropriateness, and service cost-effectiveness.

If complaints are raised by the client about the Person-Centered Support Planning process, case manager, or other CMA functions, case managers are required to document the complaint on the CMA complaint log and assist the client to resolve the complaint. Complaints that are raised by the client about the Person-Centered Support Planning process, case manager, or other CMA functions, are required to be documented on the CMA complaint log. The case manager and/or case manager's supervisor are also required to assist in the resolution of the complaint.
This complaint log is reviewed by the Department on a quarterly basis. Department staff is able to identify trends or discern if a particular case manager or CMA is receiving an unusual number or increase in complaints and remediate accordingly.
The client may also contact the case manager's supervisor or the Department if they do not feel comfortable contacting the case manager directly. The contact information for the case manager, the case manager's supervisor, the CMA administrator, and the Department is included in the copy of the PCSP that is provided to the client. The client also has the option of lodging an anonymous complaint to the case manager, CMA, or the Department.

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

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

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

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

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

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

The new LTSS LOC Screen, Assessment, and PCSP will begin to be used statewide by December 2021. The time between the end of the pilot and the start of implementation will be used to develop a Resource Allocation methodology

using the new Assessment, as well as developing training for all case management-related functions in the Department's case management software.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Risk Assessment and Mitigation- The initial step of risk assessment includes completion of the Supports Intensity Scale (SIS), completion of other required assessments/exams by service providers (e.g., physical exam, psychiatric assessments, behavioral assessments, etc.) to identify conditions or circumstances that present a risk of adverse outcome for the participant. Concerns identified by the case manager in completing the LOC Screen (e.g., abuse, neglect, exploitation, mistreatment, behavior supports, eating, medical supports, etc.) are identified in the Service Plan. All case managers are provided with training and written instructions on completing the Service Plan.

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

The Department of Health Care Policy & Financing (the Department) staff monitor Case Management Agency (CMA) performance in completing the risk assessment and risk planning activities/documentation. This monitoring occurs at the time of On-site Program Quality Surveys of Community Centered Board (CCB) Administration and Case Management and as part of the Global Quality Improvement Strategy (QIS) when completing desk reviews of PCSP maintained on the State's case management IT system. For more information on these processes please see Appendix H.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the

service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The Department of Health Care Policy & Financing (the Department) developed a web-based system that contains the LOC Screening instrument the PCSP, and the monthly case management log notes. The case manager is required to enter the P into the state's case management IT system in order to receive prior authorization of services. Community Centered Board (CCB) agencies are required to prepare PCSP according to their contract with the Department and the Centers for Medicare and Medicaid Services (CMS) waiver requirements. The Department monitors the CCB agency annually for compliance. A sample of documentation including individual PCSP is reviewed for accuracy, appropriateness, and compliance with regulations.

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Specify the other schedule:

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

- ☒ **Medicaid agency**
- ☐ **Operating agency**
- ☒ **Case manager**
- ☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the

implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

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

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

Participant's exercise of free choice of providers:

Each Case Management Agency (CMA) is required to provide clients with a free choice of willing and qualified providers. CMAs have developed individual methods for providing choice to their clients. In order to ensure that clients continue to exercise a free choice of providers, the Department has added a signature section to the PCSP that allows clients to indicate whether they have been provided with a free choice of providers. All forms completed through the Person-Centered Support Planning process are available for signature through digital or wet signatures based on the member's preference.

Participant access to non-waiver services in the PCSP, including health services:
In 2007, the Department implemented a new PCSP which includes a section for health services and other non-waiver services. At the same time, the Department added acute care benefits and Behavioral Health Organizations breakout sessions to the annual case managers training conference to ensure case managers have a greater understanding of the additional health services available to long-term care clients.

Methods for prompt follow-up and remediation of identified problems:
Clients are provided with this information during the initial and annual support planning process using the Client Roles and Responsibilities and the Case Managers Roles and Responsibilities form. The form provides information to the client about the following, but not limited to, case management responsibilities:
* Assists with the coordination of needed services.
* Communicate with the service providers regarding service delivery and concerns
* Review and revise services, as necessary
* Notifying clients regarding a change in services

The form also states that clients are responsible for notifying their case manager of any changes in the client's care needs and/or problems with services. If a case manager is notified about an issue that requires prompt follow-up and/or remediation the case manager is required to assist the client. Case managers document the issue and the follow-up in the state's case management IT system.

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

Methods for systematic collection of information about monitoring results that are compiled, including how problems

identified during monitoring are reported to the state:

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

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

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

b. Monitoring Safeguards. *Select one:*

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

◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

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

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

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

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

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

Standardized Service Plan Documents- CCBs are required to complete each participant's service plan on the Benefits Utilization System (BUS) and in the Bridge. The Service Plan also includes a mandatory data field to include documentation that the client has been informed of potential conflicts of interest, the option to choose another provider, or whether the participant needs/requests information on a potential new service provider.

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

All CCBs and case managers have received specific instructions from the Department regarding processes to be implemented to assist participants with selecting a service provider. This process requires completion of the Service Provider Selection form at the time of initial enrollment in the waiver when a change in provider is requested when the participant or guardian expresses dissatisfaction with the participant's current waiver provider or when a provider terminates services. All participants are provided choice from among qualified providers at the time of service plan development. Documentation of the confirmation is maintained on the BUS. Lastly, all case managers have been directed by the Department to monitor participants' satisfaction with choices in service providers at the time of service plan development and every quarter as required in quarterly monitoring. Such monitoring must be documented in the service plan and in case manager contact notes maintained on the BUS. The Department's On-site Program Quality Surveys: Every three years, the Department staff complete surveys of CCBs and review, specifically, the separation of case management from service delivery, the Service Plan development process,

provider selection processes, and monitoring of participant satisfaction with services and provider choice. The on-site survey process also includes interviews with participants and guardians regarding Service Plan development and choice from among qualified providers. More information on this process is included Appendix H.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
D.a.1 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: QIO	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
D.a.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: QIO	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
D.a.3 Number and percent of waiver participants 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: 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:

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

Data Aggregation and Analysis:

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

Performance Measure:

D.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

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

Data Aggregation and Analysis:

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

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

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

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

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

Data Aggregation and Analysis:

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

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or

sub-assurance), complete the following. Where possible, include numerator/denominator.

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
NCI Survey 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: NCI Survey Team	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
D.d.2 Number and percent of waiver participants whose scope and type of services are delivered as specified in the PCSP N: # of waiver participants whose scope and type of services are delivered as specified in the PCSP D: Total # of waiver participants in the sample

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

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

Performance Measure:
D.d.4 Number and percent of waiver participants whose amount of services are delivered as specified in the PCSP Numerator: Number of waiver participants whose amount of services is delivered as specified in the PCSP Denominator: Total number of waiver participants in the sample

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

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

	Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
D.d.5 Number and percent of waiver participants whose frequency and duration of services are delivered as specified in the PCSP Numerator: # of waiver participants whose frequency and duration of services are delivered as specified in the PCSP Denominator: Total # of waiver participants in the sample

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

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

Performance Measure:

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

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

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

Data Aggregation and Analysis:

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

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

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

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

D.a.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 participant's record. The QIO reviewers use the State's case management IT system and/or Bridge to discover deficiencies for this performance measure and report in the QI Review Tool.

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

D.c.1
If SP revision need is indicated, the revision must be: included in the participant's record; supported by documentation in the applicable areas of the ULTC assessment, 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. The QIO reviewers use the State's case management IT system and/or Bridge to discover deficiencies for this performance measure and report in the QI Review Tool.

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

D.c.3, D.d.1, D.e.2
Colorado participates in the National Core Indicators (NCI) study that assesses performance and outcome indicators for state developmental disabilities service systems. This study allows the Department to compare its performance to service systems in other states and within our state from year to year.
Performance and outcome indicators to be assessed covering the following domains:
• Consumer Outcomes
• System Performance
• Health, Welfare, & Rights
• Service Delivery System Strength & Stability

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

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

D.e.1
SP 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, D.d.5, D.e.1
The Department provides comprehensive remediation training CMAs annually to assist with improving compliance with PCSP performance measures and in developing future individual PCSP. The remediation process includes a standardized template for individual CMA Corrective Action Plans (CAPs) to ensure all of the essential elements, including a 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, and 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 trainings need to be developed. The Department will analyze future QIS results to determine the effectiveness of the trainings delivered. Additional training, technical assistance, or systems changes will be implemented based on those results.

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

ii. Remediation Data Aggregation

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

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

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

○ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

◉ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

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

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

○ **Yes. The state requests that this waiver be considered for Independence Plus designation.**

○ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

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

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

Notification- Participants are notified of adverse action through the issuance of a written form entitled the Long Term Care Waiver Program Notice of Action (LTC 803 Form). The LTC 803 form informs the participant that waiver services will not be discontinued during the appeal process if the participant files an appeal on or prior to the effective date of the action. The Community-Centered Board (CCB) is required to generate the LTC 803 Form utilizing the Benefits Utilization System (BUS) and mail it to the participant at least ten days before the date of the intended action. The Department of Health Care Policy & Financing (the Department) rules and regulations regarding notification are located at 10 CCR 2505-10 8.057.2.

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

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

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

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

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

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates an additional dispute resolution process**

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

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

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

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

Meeting With an Impartial Decision Maker- The agency and participant shall be provided at least a 10-day notice of a meeting with the impartial decision maker. The impartial decision maker may be the director of the agency taking the action or their designee. Per 10 CCR 2505-10 § 8.605.2(H)(1) the impartial decision maker cannot have been directly involved in the specific decision at issue. The participant may bring a representative to the meeting and shall be provided with the opportunity to respond to or question the opposing position. A decision by the impartial decision maker shall be provided to both parties within 15 days of the meeting and shall include the reasons/rationale for the decision. If the complaint is not resolved, either party may object to the decision and request a review of the decision by the Department within 15 days of the postmark of the written decision.

If a waiver participant has a complaint against a CMA, they may contact the Department per 10 CCR 2505-8.605.2 and the Department will take action to resolve the dispute, which may include the selection of a new CMA if requested by the individual.

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

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

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

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

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

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

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

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

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

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

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that

the state uses to elicit information on the health and welfare of individuals served through the program.

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

Reporting to Law Enforcement and Adult Protection- All Program Approved Service Agencies (PASA), Community Centered Boards (CCB), and Case Management Agencies (CMA) are required to report any incident in which a crime may have been committed to local law enforcement pursuant to Title 18-8-115, C.R.S. (Colorado Criminal Code -Duty To Report A Crime). The PASA, CCB, and CMA also shall report any suspected incidents of mistreatment, abuse, neglect, or self-neglect to law enforcement and county departments of social services adult protection units pursuant to Title 26-3.1-101, C.R.S. (At-Risk Adult Statute. Requirements for such reporting are included in Rules located at 10 CCR 2505-10 § 8.608.8(B)(10).

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

Critical Incident Types:

Death
-Unexpected or expected

Mistreatment/Abuse/Neglect/Exploitation

Mistreatment means:
• Abuse
• Caretaker neglect
• Exploitation
• A Harmful act

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

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

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

Harmful Act means –
○ An act committed against the participant by a person with a relationship to the participant when such act is not defined as abuse, caretaker neglect, or exploitation but causes harm to the health, safety, or welfare of the participant.

Injury/Illness to Client means:

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

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

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

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

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

Unsafe Housing/Displacement means:
-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

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

CMA Reporting- The Department requires all CMAs to report all Critical Incidents, a specific class of incidents, termed critical incidents, to the Department within 24 hours (1 business day). Critical Incidents are reported to the Department via the web-based Critical Incident Reporting System (CIRS) operated by the Department through a secure portal

Licensed Community Group Home Reporting- All PASAs operating group homes licensed by the Colorado Department of Public Health and Environment (CDPHE) are required to report a specific class of incidents through the CDPHE Occurrence Reporting Program no later than the end of the next business day after discovery. A list and definition of critical incidents that must be reported to DPHE through the Occurrence Reporting Program are included in the Occurrence Reporting Manual and include the following types of incidents: Physical abuse, sexual abuse, verbal abuse, neglect, brain injuries, burns, death, diverted drugs, life-threatening complications due to anesthesia, transfusions, malfunction or misuse of medical equipment, misappropriation of resident property, missing persons and spinal cord injuries.

The Department's oversight for monitoring safeguards and standards is with the use of critical incident reports (CIRs) or complaint logs. The Department and the contract QIO review and track critical incident reports to ensure that a resolution is reached and the client's health and safety have been maintained.

Out-of-State providers must comply with comparable requirements in that state's waiver for reporting to law enforcement and Adult Protective Services.

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

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

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

CDPHE occurrences are a licensing mechanism that CDPHE implemented separate and apart from our oversight and quality measures. CDPHE evaluates the complaint and initiates an investigation if appropriate. The investigation begins within twenty-four hours or up to three days depending upon the nature of the complaint and risk to the client’s health and welfare.”

CDPHE submits monthly complaint reports to the Department. The reports provide the Department with information about the facility type, type of complaint, the source of the complaint, when the complaint will be investigated, and the investigation findings.

Additionally, the Department receives a weekly list of any Occurrences filed that week for licensed group homes with CDPHE involving licensed Group Residential Services and Supports facilities (group homes). HCPF uses that weekly report to cross-check for required critical incident reporting.

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

The Community Centered Board (CCB) and Case Management Agency (CMA) provide information about mistreatment, abuse, neglect, and exploitation to the participants, guardians, involved family members, and authorized representatives at initial enrollment and annually thereafter. This includes information on the right to be free from mistreatment, abuse, neglect, and exploitation, how to recognize signs of mistreatment, abuse, neglect, and exploitation, and how to report mistreatment, abuse, neglect, and exploitation to the appropriate authorities. The information is provided to participants, guardians, involved family members, and authorized representatives in the form of a packet. The packet is provided by the CM and explained verbally at initial enrollment and annually thereafter. This information packet also includes information about the types and definitions of Critical Incident Reports and how to report a Critical Incident Report.

Additionally, the information will include the requirements of service provider agencies and CMAs for detecting and follow-up to suspicions and allegations of mistreatment, abuse, neglect, and exploitation.

The Department has developed Policies and Procedures for the Critical Incident Reporting System (CIRS). Similar resources are also available to clients and case managers about emergency backup and safety and prevention strategies.

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

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

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

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

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

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

Alleged incidents of Mistreatment, Abuse, Neglect, and Exploitation are deemed substantiated using the burden of proof standard preponderance of the evidence: the probability that the incident occurred as a result of the alleged/suspected abuse/neglect and/or exploitation is more than 50%.

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

Response to Critical Incidents by CCBs-CCBs are required to investigate all allegations of mistreatment, abuse, neglect, and exploitation pursuant to the Department Rule 10 CCR 2505-10 8.608.8. All investigations completed by CCBs are to comply with the recommended standards of practice specified in the Conducting Serious Incident Investigations manual developed by Labor Relations Alternatives, Inc. The local Human Rights Committee (HRC) reviews all written investigation reports and, where appropriate, issues recommendations for follow-up actions by the provider agency and or the CCB and or the CMA.

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

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

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

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

Additionally, The Department conducts or closely monitors those investigations in which there may be a direct conflict of interest when the investigating party is or is part of the investigated party. The Department reviews all complete, written critical incident and follow-up investigation reports, in the event of mistreatment, abuse, neglect, or exploitation. This is to ensure the investigation is thorough, conclusions are based upon evidence, and that all investigative questions are addressed.

Timelines for completion of follow-up and/or investigation of critical incidents depend upon the severity and complexity of the incident but are generally resolved within 30 days of the critical incident unless a good cause for a delay exists (e.g., awaiting investigation by law enforcement, lack of access to witnesses or the victim for interviews, etc.). Investigations completed by the Department are conducted in accordance with the recommended standards of practice specified in the Conducting Serious Incident Investigations manual developed by Labor Relations Alternatives, Inc.

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

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

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

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

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

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

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

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

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

• Mistreatment (abuse, neglect, exploitation) in which immediate action must be taken to ensure an individual's health and safety, or if law enforcement has not been notified per Mandatory Reporting Requirements.

• Missing Person in which an individual with a line of sight supports/high care needs has not been found when CIR is submitted.

• Unsafe housing or displacement from a natural disaster, fire, or stemming from caretaker neglect, which leaves the individual without housing and needs immediate attention and housing to ensure health and safety.

• Death under suspicious circumstances that needs investigation, involves mistreatment, law enforcement, or where the cause of death is unknown and autopsy must be performed by a coroner.

• Injury/Illness in which no treatment has been sought, trends imply mistreatment, or those which have no immediate intervention noted to ensure the health and safety of an individual receiving services. DIDD Waivers also include Safety and Emergency Control Procedures resulting in serious injury caused by staff with no least restrictive measures utilized prior to holds/restraints or if mistreatment by staff is suspected.

• Medication Mismanagement in which error leads to an adverse medical crisis (or death) and needs immediate attention to ensure health and safety or mistreatment or theft/mistreatment by staff is a concern.

• Criminal Activity in which individual receiving services is incarcerated for a major serious offense such as homicide and needs immediate follow-up due to seriousness of charge and notification to the Department for possible media coverage of the event.

• Damage/Theft of Property to an individual receiving services self or property which results in a need for immediate action to ensure health and safety or must be reported to Law Enforcement

• Any other CIR in which immediate assurance of health and safety is crucial and has not been addressed by CMA/Agency/staff.

• Any CIR in which there is media involvement or coverage

• It should also be noted that Critical Incidents vary greatly, and the priority level may be subjective. This is also not an all-inclusive list due to variance in events.

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

o LOW PRIORITY: those Critical Incidents that have been remediated by CMA/agencies, have addressed immediate and long-term needs, have implemented services or supports to ensure health and safety, and those that have protocols in place to prevent a recurrence of a similar CIR. Critical Incidents that would be Low Priority would be:

• Death, expected. Resulting from long term illness or natural causes, hospice or palliative care was utilized and documented.

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

The Department takes remedial action to address with service providers and/or CMAs when needed for deficient practice in reporting and management of Critical Incidents to ensure the health, safety, and/or welfare of waiver participants. This

includes a formal request for response, technical assistance, Department investigation, the imposition of corrective action, termination of CMA contract, and termination of a service provider's Colorado Provider Participation Agreement/Program Approval for the HCBS-DD waiver.

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

The Department maintains an Interagency Agreement (IA) Colorado Department of Public Health and Environment (CDPHE) to conduct on-site licensure and re-certification and complaint surveys for HCBS-DD providers. CDPHE submits a report monthly to HCPF on the number and type of providers surveyed and the findings. If a deficient practice is detected with critical incident reporting, the agency must correct the practice in order to obtain licensure or recertification.

In addition, case managers are required to maintain records for all critical incidents that are reported or are known to case managers. The Department performs CMA monitoring through a review of critical incident and complaint reporting. All case managers must complete training on Critical Incident Reporting requirements within 120 days of the hire date per contract requirements.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

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

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

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

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

Restraints- The use of physical, mechanical, and chemical restraints is not prohibited in state statutes or policies. However, § 25.5-10-221 C.R.S prohibits the use of certain mechanical devices (e.g., posey vests, straitjackets, wrist and ankle restraints) and places specific restrictions on the use of physical and mechanical restraints. § 26-20-103 C.R.S. provides additional prohibitions and restrictions on the use of restraints.

Restraints may be used only in an emergency after alternative procedures have been attempted and failed, and to protect the participant and others from injury. An "emergency" is defined as a serious, probable, imminent threat of bodily harm to self or others where there is the present ability to affect such bodily harm. Only trained Program Approved Service Agency (PASA) direct care service providers may use mechanical or physical restraints. PASAs are to use alternative methods of positive behavior support (e.g., de-escalation techniques, positive reinforcement, verbal counseling, etc.) and/or the least restrictive alternative to bring the participant's behavior into control prior to the use of mechanical or physical restraints. PASAs and Case Management Agencies (CMAs) must ensure that all direct care service providers are trained in the use of restraints prior to the use of restraint utilizing an approved technique. Approved techniques involve the use of positive behavioral interventions (e.g., de-escalation, redirection, and blocking techniques) and/or the least restrictive alternative to bring the participant's behavior into control prior to the use of mechanical or physical restraints.

Direct care service providers must be trained in general positive behavioral supports and in service and supports specific to individuals for whom services are provided (e.g., Individual Service and Support Plans to address behavior and individual's Safety Control Procedure). In addition, the PASA and CMA must have policies and procedures specific to the use of emergency control procedures (i.e., unanticipated use of restraint) and should include positive behavioral interventions in such procedures.

Requirements and safeguards for the use of mechanical and physical restraints are specified in Rules located at 10 CCR 2505-10 § 8.608.3 et seq. and 8.608.4 et seq., which also require the following:

-The participant shall be released from physical or mechanical restraint as soon as the emergency condition no longer exists.

-Physical or mechanical restraint cannot be a part of an Individual Service and Support Plan, as a substitute for behavior programming, and only can be used in accordance with rules and regulations.

-No physical or mechanical restraint of a participant shall place excess pressure on the chest or back of that person or inhibit or impede the person's ability to breathe.

-During physical restraint, the participant's breathing and circulation must be monitored to ensure that these are not compromised.

Each CMA and PASA must have written policies and procedures on the use of physical restraint exceeding 15 minutes. Such policies and procedures must allow for physical restraint exceeding 15 minutes only when absolutely necessary for safety reasons and provide for backup by appropriate professional and/or direct care service providers.

Relief periods of, at a minimum, 10 minutes every hour must be provided to a participant in mechanical restraint, except when the person is sleeping. A written record of relief periods must be maintained.

A participant placed in a mechanical restraint must be monitored at least every 15 minutes by direct care service providers trained in the use of mechanical restraint to ensure that the person's physical needs are met and the person's circulation is not restricted or airway obstructed. A written record of such monitoring must be maintained.

The use of restraints in a prone position is prohibited.

Mechanical restraints used for medical purposes following a medical procedure or injury must be authorized by a physician's order that must be renewed every 24 hours. Other requirements applicable to mechanical restraint also apply.

Mechanical or physical restraints used for diagnostic or other medical procedures conducted under the control of the agency (e.g., drawing blood by an agency nurse) must be dually authorized by a licensed medical professional and agency administrator, and its use documented in the participant's record.

Monitoring- CMA and PASA staff and direct care service providers are responsible for monitoring incident reports to identify when restraints are not used in accordance with statutory and regulatory requirements. Use of restraints not conforming to those requirements meets the definition of abuse (unreasonable restraint), is required to be reported as an allegation of abuse, and is subject to the investigation of abuse requirements specified in 10 CCR 2505-10 § 8.608.6 (A)(8), (9), and (10). The use of physical, mechanical, and chemical restraints is reviewed by a local Human Rights Committee, pursuant to 10 CCR 2505-10 § 8.608.5(I)(3), either prior to the planned use of restraints or after each incident in which restraint was used.

Emergency Control Procedures- Emergency Control Procedures are defined as the unanticipated use of a restrictive procedure or restraint in order to keep the participant and others safe. Each PASA is required to have written policies on the use of Emergency Control Procedures, the types of procedures that may be used, and requirements for direct care staff training. Behaviors requiring Emergency Control Procedures are those that are infrequent and unpredictable. Emergency Control Procedures may not be employed as punishment, for the convenience of direct care service providers, or as a substitute for services, supports, or instruction.

Within 24 hours after the use of an Emergency Control Procedure, the responsible direct support service provider must file a written incident report. The incident report must include the following information:

1) A description of the Emergency Control Procedure employed, including beginning and ending times;
2) An explanation of why the procedure was judged necessary; and,
3) An assessment of the likelihood that the behavior that prompted the use of the Emergency Control Procedure will recur.

Within three days after the use of an Emergency Control Procedure, the CMA/case manager, guardian, and authorized representative if within the scope of his or her duties, must be notified of the use of the mechanical or physical restraint.

Safety Control Procedure- Safety Control Procedure is defined as a written plan describing what procedures will be used to address emergencies that are anticipated and stating that physical or mechanical restraints are to be used to ensure the safety of the participant or others when previously exhibited behavior is likely to occur again. The use of Safety Control Procedures must comply with the following:

Each CMA and PASA must have written policies on the use of Safety Control Procedures, the types of procedures that may be used, and requirements for staff training. When a Safety Control Procedure is used, the PASA must file an incident report within three days with the CMA/case manager for each use of a Safety Control Procedure. If the Safety Control Procedure is used more than three times within the previous 30 days, the participant's interdisciplinary team must meet to review the situation and to endorse the current plans or to prepare other strategies.

In conformance with the requirements of § 26-20-104 C.S.R., chemical restraints may be used only in an emergency and cannot be ordered or used on a PRN basis. Only a licensed physician that has directly observed the emergency can prescribe chemical restraints or he/she may order the use of the medication for an emergency via telephone if a licensed registered nurse has directly observed the participant and determined that an emergency exists. The licensed registered nurse must transcribe and sign the order at the time the order is received.

Subsequent to the administration of the chemical restraint, the physician or licensed registered nurse must observe the effects of the chemical restraint and record the effects in the record of the participant.

Within 24 hours, the responsible PASA direct care service provider must file a written incident report documenting the use of the chemical restraint with the CMA/case manager.

Training Requirements- All direct care service providers must receive training on the use of restraints, Emergency Control Procedures, and Safety Control Procedures prior to having unsupervised contact with waiver participants. Additionally, direct care service providers responsible for the use of restraints must receive specific training on the emergency procedures to be used with participants under their care.

The Department ensures that requirements and safeguards for the use of mechanical and physical restraints specified in Rules located at 10 CCR 2505-10 § 8.608.3 et seq. and 8.608.4 et seq. are met through on-site certification and recertification surveys. Surveys are conducted by the Colorado Department of Public Health and Environment (CDPHE) on behalf of the Department through interagency agreement.

Out-of-State providers must comply with comparable requirements in that state's waiver for the use of restraints.

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

State oversight of the use of restraints is the responsibility of the Department of Health Care Policy & Financing (the Department). Such oversight is accomplished through the operation of the Critical Incident Reporting System (CIRS), review of Case Management Agency (CMA) incident data and Program Quality surveys of Case Management Agencies (CMA) and Program Approved Service Agencies (PASA).

Critical Incident Reporting System (CIRS) Monitoring- The web-based CIRS system operated by the Department includes a specific data field for recording if any critical incident involved the use of restraints. Therefore, any use of restraint in an allegation of serious abuse, medical crisis (i.e. needing emergency medical treatment), a crime against a person, or death is reported immediately to the Department. Such incidents receive additional scrutiny by the Department staff that includes a review of the original written incident report to ensure restraint was used in compliance with statutory and regulatory requirements. The CIRS monitoring operates on a daily/continuous basis.

The Critical Incident Reporting Team monitors data on a monthly and quarterly basis. Provider trends are relayed to the Department's Benefits Division to address and determine appropriate actions as needed.

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

Program Quality Surveys- The Department conducts regulatory surveys of CMAs that include a review of the agency's incident management practices, compliance with standards for incident reporting and review, and data analysis practices. Such surveys include a specific review of written incident reports documenting the use of restraints to ensure such reports contain the information required by 10 CCR 2505-10 § 8.608.4(A)(4) and 8.608.4(B) and that restraints are used only within the requirements specified in 10 CCR 2505-10 § 8.608.3 et seq. and 8.608.4 et seq. The Department delegates authority to CDPHE to conduct an on-site regulatory survey of PASAs.

The Department maintains an Interagency Agreement with the Colorado Department of Public Health and Environment (CDPHE) to monitor the use of restraints by HCBS-DD waiver service providers. CDPHE conducts on-site recertification surveys of service agencies that include a review of the agency’s incident management practices, compliance with standards for incident reporting, and review and data analysis practices. Such surveys include a specific review of written incident reports documenting the use of restraints to ensure such reports contain the information required by the Department. When non-compliant use of restraints or any use of seclusion is detected, deficiencies are cited, and the responsible agency is required to submit a plan of correction. Program Quality on-site surveys are completed at least every three years. CDPHE submits a report monthly to HCPF on the number and type of providers surveyed and the findings.

Additionally, surveys of CMAs include a specific review of the local HRC review activities, the composition of the participant's interdisciplinary team, and an investigation of allegations of abuse related to unreasonable restraint. When non-compliant use of restrictive procedures, restraints, or any use of seclusion is detected, deficiencies are cited and the responsible agency is required to submit a plan of correction.

Seclusion- As noted above, the use of seclusion is specifically prohibited by state § 25.5-10-221 C.R.S. The oversight mechanisms described above in G.1.c. are employed when an incident involving seclusion is detected.

The Department has waiver-specific performance measures included in the Quality Improvement Strategy (QIS) regarding the use of restraints. Please see the Performance Measure section of this application for additional information. Please note that the review of these waiver specific performance measures will be subject to the same remediation, data aggregation, review, and quality improvement processes specified in the Global QIS.

The Department maintains an Interagency Agreement with the Colorado Department of Public Health and Environment (CDPHE) to monitor the use of restraints by HCBS-DD waiver service providers. CDPHE conducts on-site recertification surveys of service agencies that include a review of the agency’s incident management practices, compliance with standards for incident reporting, and review and data analysis

practices. Such surveys include a specific review of written incident reports documenting the use of restraints to ensure such reports contain the information required by the Department. When non-compliant use of restraints or any use of seclusion is detected, deficiencies are cited, and the responsible agency is required to submit a plan of correction. Program Quality on-site surveys are completed at least every three years. CDPHE submits a report monthly to HCPF on the number and type of providers surveyed and the findings.

Appendix G: Participant Safeguards

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

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

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

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

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

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

The Department's Critical Incident Reporting system detects the use of unauthorized restrictive interventions through the receipt and follow-up on Critical Incident Reports submitted by Case Management Agencies. The Department monitors these reports to ensure they follow the below policies and procedures related to restrictive interventions.

The use of aversive or noxious stimuli is specifically prohibited by § 25.5-10-221 C.R.S. Restrictive procedures may be used only when alternative non-restrictive behavior programs have been proven to be ineffective in changing the behavior. The service provider shall work in conjunction with the client's interdisciplinary team to develop an Individual Service and Support Plan that explains the use of any restrictive procedures. Restraints may not be used as part of a behavior plan and can only be used as part of an Emergency or Safety Control Procedure, as described in G.2.a.i.

10 CCR 2505-10 § 8.600.4 defines a Restrictive Procedures as "any of the following when the intent or plan is to bring the person's behavior into compliance: A. Limitations of an individual's movement or activity against his or her wishes; or, B. Interference with an individual's ability to acquire and/or retain rewarding items or engage in valued experiences". Additionally, this rule defines Challenging Behavior as "Behavior that puts the person at risk of exclusion from typical community settings, community services and supports, or presents a risk to the health and safety of the person or others or a significant risk to property".

10 CCR 2505-10 § 8.608.2 et seq. provides specific requirements anytime a Restrictive Procedure is to be used as part of an Individual Service and Support Plan (ISSP).

The rights of participants may be removed or suspended only in accordance with § 25.5-10-118 C.R.S. and 10 CCR 2505-10 § 8.604.3. A suspension of rights is authorized under the two following processes:

-Imposition of Legal Disability: Pursuant to § 25.5-10-116 C.R.S. any individual, including a case manager for a waiver participant, may petition the district court to issue an imposition of legal disability to remove a participant's legal right. Statute provides specific requirements for when such an imposition may be granted and within six months after a legal disability has been imposed a review must occur. All actions to remove a legal right require a court order.

-Suspension of rights: Under the Statewide Transition Plan (STP), providers and case management agencies are moving toward compliance with the requirements of the HCBS Settings Final Rule, including that any rights suspension or restrictive procedure must comply with the HCBS Settings Final Rule requirements, pursuant to 79 Fed. Reg. 2948 and 42 C.F.R. § 441.301, § 25.5-10-118 C.R.S., and 10 CCR 2505-10 § 8.604.3. As of January 1, 2021, case managers were required to enter information about new and up-for-renewal rights modifications in the State's case management IT system. The Department is working with stakeholders to codify the federal settings criteria within state regulations, with the expectation that this codification will be effective by roughly Summer 2021. Under this codification, all rights suspensions and restrictive procedures will be treated as a rights modification under the Federal Rule, and thus require informed consent. In order to implement a rights modification, the following criteria must be met:

A. Rights modifications are based on the specific assessed needs of the individual, not the convenience of the provider.
B. May only be imposed if the individual poses a danger to themselves or the community.
C. The case manager is responsible to obtain informed and other documentation related to rights modifications/limitations and maintain these materials in their file as a part of the Person-Centered Planning process.
D. Any rights modification must be supported by a specific assessed need and justified in the PCSP. The following requirements must be documented in the PCSP:
1. Identify a specific and individualized need.
2. Document the positive interventions and supports used prior to any modifications to the PCSP.
3. Document less intrusive methods of meeting the need that have been tried but did not work.
4. Include a clear description of the condition that is directly proportionate to the specific assessed need.
5. Include regular collection and review of data to measure the ongoing effectiveness of the modification.

6. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
7. Include the informed consent of the individual.
8. Include an assurance that interventions and supports will cause no harm to the individual.

State regulations and safeguards in place to protect participant's rights are included in 10 CCR 2505-10 § 8.604.1 et seq, 8.604.2 et seq. and 8.604.3 et seq. and includes the following:

All participants, guardians, and authorized representatives must be provided a written and verbal explanation of the participant's rights at the time the person is determined eligible to receive developmental disability services, at the time of enrollment, and when substantive changes to services and supports are considered through the PCSP development process. The information must be provided in an easy to understand format and in the participant's native language, or through other modes of communication as may be necessary to enhance understanding. Community Centered Board (CCB) and Program Approved Service Agencies (PASA) are required to provide assistance and ongoing instruction to participants in exercising their rights. No participant, his/her family members, guardian, or authorized representatives, may be retaliated against in their receipt of services or supports or otherwise as a result of attempts to advocate on their own behalf. Direct care service providers are required to successfully complete training on and be knowledgeable of participant's rights and the procedural safeguards for protecting those rights.

When a suspension of a participant's rights is under consideration, the rights must be specifically explained to the individual, with written notice of the proposed suspension given to the participant, and when appropriate his/her guardian.

At the time a right is suspended, such action shall be referred to the local HRC for review and recommendation. This review must include an opportunity for the participant, guardian, or authorized representative to present relevant information to the local HRC. If suspended, the suspension is documented in the participant's PCSP. The participant's PCSP must specify the services and supports required in order to assist the person to the point that suspension of rights is no longer needed.

When a right has been suspended, the continuing need for such suspension must be reviewed by the participant's Interdisciplinary Team (IDT) at a frequency decided by the team, but not less than every six months. The review must include the original reason for suspension, the participant's current circumstances, the success or failure of programmatic intervention, and the need for continued suspension or modification. Affected rights must be restored as soon as circumstances justify. Case managers are responsible for monitoring that restrictive procedures and a suspension of rights are used only in compliance with these requirements. Additionally, local HRCs are responsible to ensure restrictive procedures and procedures to suspend rights are used only in compliance with the requirements of state law and Department regulations.

When a PASA and IDT recommend or plan to use a restrictive procedure to change a participant's challenging behavior the provider agency and IDT must: a) complete a comprehensive review of the participant's life situation, b) complete functional analysis of the participant's challenging behavior, c) prepare a written ISSP with specific information defined in rule 10 CCR 2505-10 § 8.608.2 3, and d) obtain the informed consent of the participant, his/her guardian for the use of the restrictive procedure.

Documentation Requirements- The use of restrictive procedures must be included in the participant's PCSP or PCSP addendum. Copies of the comprehensive life review, functional analysis assessment, written ISSP, and data documenting the use of the restrictive procedures must be maintained in the participant's records. Additionally, the CCB is responsible for providing the local HRC with copies of all pertinent documents and data for the HRC to complete its review and must maintain documentation of the HRC's review and recommendations.

Direct Care Service Provider Requirements- Direct care service providers are required to be trained specifically on the implementation of the ISSP with a restrictive procedure prior to its use. Documentation of training and a signed assurance that the direct care service provider has demonstrated competence in the implementation of the ISSP with a restrictive procedure must be included on the written ISSP. (Direct care service providers responsible for supervising an ISSP with restrictive procedures and for implementing a

suspension of rights must meet the qualifications of a Developmental Disabilities Professional, defined at 10 CCR 2505-10 § 8.600.4 as a person who has, at least, a Bachelors Degree and a minimum of two years experience in the field of developmental disabilities or a person with at least five years of experience in the field of developmental disabilities with competency in the following areas: a) Understanding of civil, legal and human rights; b) Understanding of the theory and practice of positive and non-aversive behavioral intervention strategies; c) Understanding of the theory and practice of non-violent crisis and behavioral intervention strategies.

Out-of-State providers must comply with comparable requirements in that state's waiver for the use of restrictive procedures.

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

The Department of Health Care Policy and Financing (the Department) is responsible for oversight as the single state Medicaid agency. State oversight of the use of restrictive interventions is the responsibility of the Department. The Department conducts oversight through the following methods to detect unauthorized use or inappropriate/ineffective restrictive interventions.

The Department maintains an Interagency Agreement with the Colorado Department of Public Health and Environment (CDPHE) to monitor the use of restrictive interventions for HCBS-DD service providers not licensed by CDHS. CDPHE conducts on-site recertification surveys of service agencies that include a review of the agency's incident management practices, compliance with standards for incident reporting, and review and data analysis practices. Such surveys include a specific review of written incident reports documenting the use of interventions to ensure such reports contain the information required by the Department. When non-compliant use of interventions is detected, deficiencies are cited, and the responsible agency is required to submit a plan of correction. Program Quality on-site surveys are completed at least every three years. CDPHE submits a report monthly to HCPF on the number and type of providers surveyed and the findings.

Critical Incident Reporting System (CIRS) Monitoring- The web-based CIRS system operated by the Department includes a specific data field for recording if any critical incident involved the use of restrictive interventions. Therefore, any use of a restrictive intervention in an allegation of serious abuse, medical crisis (i.e. needing emergency medical treatment), a crime against a person, or death is reported immediately to the Department. Such incidents receive additional scrutiny by the Department staff that includes a review of the original written incident report to ensure restrictive interventions were used in compliance with statutory and regulatory requirements. The CIRS monitoring operates on a daily/continuous basis.

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

Program Quality Surveys- The Department conducts regulatory surveys of CMAs that include a review of the agency's incident management practices, compliance with standards for incident reporting and review, and data analysis practices. Such surveys include a specific review of written incident reports documenting the use of restrictive interventions to ensure such reports contain the information required by 10 CCR 2505-10 § 8.608.4(A)(4) and 8.608.4(B) and that restrictive interventions are used only within the requirements specified in 10 CCR 2505-10 § 8.608.3 et seq. and 8.608.4 et seq. Additionally, on-site surveys of CMAs include a specific review of the local HRC review activities, the composition of the participant's interdisciplinary team, and an investigation of allegations of abuse related to unreasonable restrictive interventions. When non-compliant use of restrictive procedures, restraints, or any use of seclusion is detected, deficiencies are cited and the responsible agency is required to submit a plan of correction.

The Critical Incident Reporting Team monitors data on a monthly and quarterly basis. Provider trends are relayed to the Department's Benefits Division to address and determine appropriate actions as needed.

CIRs data is tracked, trended, and analyzed by the Critical Incident Reporting Team on a monthly and quarterly basis. Specific provider trends are relayed to the Benefits division to address and determine what improvement strategies need to be implemented.

Appendix G: Participant Safeguards

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

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

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

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this

oversight is conducted and its frequency:

Seclusion- § 25.5-10-221 C.R.S. prohibits the use of seclusion. Monitoring by case managers, investigation of complaints made to Case Management Agencies (CMA) and the Department of Health Care Policy & Financing (the Department), and program quality surveys conducted by the Department are used to detect the illegal use of seclusion and to prevent any future use of seclusion by a provider agency.

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

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

○ **No. This Appendix is not applicable** *(do not complete the remaining items)*

◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

In order to detect potentially harmful practices, and follow up to address such practices, the following entities are responsible for monitoring medication administration:

HCBS-DD waiver service providers must complete on-site monitoring of the administration of medications to waiver participants including inspecting medications for labeling, safe storage, completing pill counts, and reviewing and reconciling the medication administration records, and interviews with staff and participants.

As part of the health inspection and survey process, CDPHE reviews medication administration procedures, storage of all medication, including controlled substances, medication audit and disposal practices, and reporting required for drug reactions and medication errors. If deficiencies are cited in any of these areas, CDPHE will follow-up with the provider to ensure compliance with the regulations.

Medication Management and Administration is a responsibility of the PASA and is monitored through CDPHE. The Department requires all PASA's to submit incidents of medication errors which result in a risk to the health of safety of an individual and meet Critical Incident reporting guidelines within 24 hours. The Department completes reviews of CIRs submitted to ensure compliance with requirements and completes follow up with PASA's for remediation/mitigation when necessary.

In addition, the Department monitors Critical Incident Reports submitted by providers for instances of a critical incident resulting from a medication management issue.

Out-of-State providers must comply with comparable requirements in that state's wavier for medication administration.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

The Department of Health Care Policy and Financing (the Department) is responsible for oversight as the single state Medicaid agency. The Department provides oversight through the following methods:

The Department maintains an Interagency Agreement with the Colorado Department of Public Health and Environment (CDPHE) to monitor medication administration for HCBS-DD service providers. CDPHE conducts on-site recertification surveys of service agencies. When any deficient practices detected, deficiencies are cited, and the responsible agency is required to submit a plan of correction. Program Quality on-site surveys are completed at least every three years. CDPHE submits a report monthly to HCPF on the number and type of providers surveyed and the findings.

In addition, the Department monitors Critical Incident Reports submitted by providers for instances of a critical incident resulting from a medication management issue.

Information obtained by the Department through these methods is used to identify and address potentially harmful practices. This information is additionally used to provide training and/or awareness to Case Managers and service providers.

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

○ **Not applicable.** *(do not complete the remaining items)*

◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of**

medications. *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Medications may be administered by Program Approved Service Agency (PASA) direct care service providers when done in conformance with the requirements of 10 CCR 2505-10 § 8.609.6.D and 6 CCR 1011-1 Chapter 24. The following requirements must be met when medications are administered by direct care service providers:

Assessment- PASAs are required to assess each participant's need for support in medication management and administration. PASAs are required to provide sufficient support to the participant to ensure his/her safe use of medications.

Staff Administration- Unless the assessment indicates that the participant is independent in administering his/her medications, the administration of medication must comply with 6 CCR 1011-1 Chapter 24 and prescribed by a physician or dentist. When medications are administered to a participant,the PASA must ensure that a written record of medication administration is maintained, including time and amount of medication taken by the person receiving services.

Overseeing Self-Administration- When assessment results indicate that the participant is capable of safely self-administering his/her medications and does not require monitoring each time medication is taken, the PASA must provide sufficient, at minimum quarterly, monitoring or review of medications to determine that medications are taken correctly.

Out-of-State providers must comply with comparable requirements in that state's waiver for medication administration.

iii. Medication Error Reporting. *Select one of the following:*

◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

Medication errors meeting the criteria of a critical incident are reported to the Department of Health Care Policy & Financing (the Department) through the Critical Incident Reporting System (CIRS). The criteria for a medication error to reported as a CIR is defined in Appendix G-1-b as: Issues with medication dosage, scheduling, timing, set-up, compliance and administration or monitoring which results in harm or an adverse effect which necessitates medical care.

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

Medication errors must be recorded anytime an error was made in the dose, route, time, medication provided, or missed medication. Additionally, direct support service providers are required to complete a written incident report of any medication errors (including those not meeting the critical incident criteria), which must be reviewed by the Program Approved Service Agency and the participant's case manager.

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

Medication errors reported in the Critical Incident Reporting System (CIRS) are those resulting in an 1) Adverse health outcome, a medical crisis; 2) Death; 3) An allegation of neglect or abuse that results in an adverse medical/health outcome; or, 4) A pattern or trend of medication errors that indicate possible abuse or neglect.

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The Department of Health Care Policy & Financing (the Department) is responsible for ongoing monitoring of the performance of providers that administer medications. To identify problems in provider performance, to support remediation, and to support quality improvement activities, the Department employs the following monitoring methods:

Monitoring Through the Critical Incident Reporting System (CIRS)- As identified in Appendix G.3.iii, specific types of medication errors are required to be reported as a critical incident in the web-based CIRS. Such reports are reviewed by the Department staff as soon as possible upon receipt but always before the end of the next business day and as part of monthly IRT meetings. The CIRS allows the Department staff to issue specific directives to the Case Management Agencies (CMAs) to ensure remediation of identified problems. Specific provider trends identified immediately or through monthly and quarterly reports, are relayed to the Department's Benefits staff to address and determine if further improvement strategies are needed.

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

Program Quality On-site Surveys- CDPHE, on behalf of the Department conducts on-site regulatory surveys of providers and includes a review of the agency's medication administration practices. These surveys evaluate the practices of the agency to ensure a) unlicensed direct support service providers have met state requirements for training and certification; b physician's orders for all medications; c) safe storage of medications; d) appropriate documentation of medication administration, refusals and errors; and e) that participants have a sufficient supply of medications. CDPHE submits a report monthly to HCPF on the number and type of providers surveyed and the findings.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to***

prevent instancesof abuse, neglect, exploitation and unexplained death. *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
G.a.1 # and % of waiver participants &/or family/guardians who received info/education on how to identify & report abuse, neglect, exploitation (ANE), unexplained death & other critical incidents (CI) N: # of waiver participants &/or family/guardians who rcvd info/ed on how to id & report ANE, unexplained death & other CI D: Total # of waiver participants &/or family/guardians in the sample

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

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

	Ongoing	Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
G.a.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	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

(check each that applies):		
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
G.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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
G.a.6 Number and percent of newly enrolled and revalidated waiver providers trained on how to identify, address, and seek to prevent critical incidents N: # of newly enrolled and revalidated waiver providers trained on how to identify, address, and seek to prevent critical incidents D: Total # of newly enrolled and revalidated waiver providers

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
G.b.3 Number and percent of annual reports provided to Case Management Agencies (CMAs) on identified trends in critical incidents N: Number of annual reports provided to the CMAs on identified trends in critical incidents D: Total number of annual reports required to be provided to CMAs

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:
State's case management IT System Data and/or CDPHE Reports; Record Reviews

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
G.b.4 Number and percent of preventable critical incidents reported that have been effectively resolved. Numerator: Number of preventable critical incidents reported that have been effectively resolved. Denominator: 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** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
G.c.2 Number and percent of providers surveyed during the performance period that met requirements for use of physical or mechanical restraints. Numerator: Number of providers surveyed during the performance period that met requirements for use of physical or mechanical restraints Denominator: Total number of providers surveyed during the performance period.

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
G.c.3 Number and percent of providers surveyed in the performance period that met requirements for implementing Rights Modification Numerator: Number of surveyed providers surveyed in the performance period that met the requirements for implementing Rights Modification Denominator: Total number of providers surveyed during the performance period

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
G.c.4 Number and percent of providers surveyed that met the requirements for the use of training and support plans with restrictive procedures N: Number of providers surveyed that met the requirements for use of training and support plans with restrictive procedures. D: Total number of providers surveyed

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

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

Data Aggregation and Analysis:

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

Performance Measure:
G.c.6 Number and percent of waiver participants with Restrictive Intervention Plans where proper procedures were followed in initially establishing the Restrictive Intervention Plan N:# of wvr participants w/ Restrictive Intervention Plan where proper procedures were followed in initially establishing the Restrictive Intervention Plan D:# of wvr participants w/ a Restrictive Intervention Plan

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

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
G.d.3 Number and percent of waiver participants who received care from a medical professional within the past 12 months Numerator: The number of participants who received care from a medical professional within the last 12 months Denominator: The total number of participants reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The Dept. uses info entered into the State's case management IT system and the Critical Incident Reporting System (CIRS) and/or complaint logs as the primary method for discovery for the Health and Welfare assurance and performance measures.
CMAs are required to report critical incidents into the state prescribed CIRS and follow up on each Critical Incident Report (CIR) through the CIRS. Following the receipt of the initial CIR, the QIO reviews the documentation to determine if the instance was substantiated. If the documentation does not clearly state whether instance was substantiated, the QIO requests follow up by the CMA to gather the needed info from the parties involved.

G.a.1
An info packet developed by the Dept. must be provided to participants during initial intake and annual CSR. The info includes participant rights, how to file a complaint outside the system, info 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 (CI) to their provider(s), case manager, protective services, local ombudsman and/or any other advocate. The info also includes what types of incidents to report and to whom the incident should be reported.

Compliance w/ this performance measure requires that the signature section in the service plan indicates that participants (and/or family or guardian) have been provided info regarding rights, complaint procedures, and have received info/education on how to report abuse, neglect, exploitation (ANE) and other critical incidents.

G.a.2
CIs are reported to the Dept. via the web-based CIRS. CMAs and waiver service providers are required to report CIs w/in specific timeframes. The Dept 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 ombudsman, or additional follow-up w/ 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
CIs involving providers surveyed by CDPHE must be reported to the Dept. and CDPHE and are responded to by CDPHE. A hotline is set up for complaints about quality of care, fraud, abuse, and misuse of personal property. CDPHE evaluates the complaint and initiates an investigation if warranted. The investigation begins w/in 24 hours or up to 3 days depending upon the nature of the complaint and risk to the participant’s health and welfare.

G.a.6
CMAs and providers are required to attend preventative strategies trainings. Training records of preventative strategies training are maintained by the Dept.

G.b.3
The Dept. examines data for specific trends to include individuals that have multiple CIRs; identifies participants who have more than one CIR in 30 days, more than 3 CIRs in 6 months, and more than 5 CIRs in 12 months. The Dept. produces CI 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 CIs were preventable and whether resolutions were effective.

G.b.6
Root cause identified/trends reduced as a result of systemic intervention data are tracked and analyzed by the CIR Team on a monthly and quarterly basis, including through mortality review committee.

G.c.1
Oversight and discovery of Restrictive Interventions (RIs) where proper procedures were not followed are completed through the review of complaints regarding services and supports and conducting surveys of CMAs by Dept. staff and providers by CDPHE.

The Dept. also monitors for the inappropriate/ineffective use of RIs through the CIRS. These incidents receive additional scrutiny by the Dept. staff that includes review of the original written incident report to ensure restrictive intervention was used in compliance w/ statutory and regulatory requirements.

G.c.2, G.c.3, G.c.4
Providers must demonstrate during the survey process that they have met requirements for the use of physical or mechanical restraints,, requirements for implementing a RI, and the use of training and support plans w/ RIs.

Dept. staff review CDPHE reports that are submitted on the # and type of providers surveyed and the findings.

G.c.6
The Dept. takes remedial action to address w/ waiver service providers and/or CMAs when needed for deficient practice in following the proper procedures of restrictive interventions. This includes formal request for response, technical assistance, Dept. investigation, imposition of corrective action, termination of CMA contract, and termination of waiver service providers.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Issues or problems identified during annual program evaluations will be directed to the CMA administrator or director and reported in the individual's annual report of findings. CMAs deficient in completing accurate and required CIRs will receive technical assistance (TA) and/or training by Dept staff. CMAs are required to submit individual remediation action plans for all deficiencies identified within 30 days of notification. Following receipt of the CMA's remediation action plan, the Dept reviews the plan and confirms the appropriate steps have been taken to correct the deficiencies.

The 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, TA may be provided to CMA case manager, supervisor, or administrator, and a confidential report will be documented in the waiver recipient care file when appropriate. The Dept reviews and tracks the on-going referrals and complaints to ensure that a resolution is reached, and the participant's health and safety has been maintained.

G.a.1
The Dept provides remediation training CMAs annually to improve compliance with this measure, including a standardized template for individual CMA Corrective Action Plans (CAPs) to ensure all of the essential elements, including a root-cause analysis, are addressed in the CAP. Time limited CAPs are required for each performance measure below the 86% CMS compliance standard. The CAPs must also include a detailed account of actions to be taken, staff responsible for implementing the actions, and timeframes and a date for completion. The Dept reviews the CAPs, and either accepts or requires additional remedial action. The Dept follows up with each individual CMA quarterly to monitor the progress of the action items outlined in their CAP.

G.a.2
The Dept takes remedial action to address with waiver service providers and/or CMAs when needed for deficient practice in reporting and mgmt of Critical Incidents. This includes formal request for response, TA, 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 TA and/or training by Dept staff. CMAs are required to submit individual remediation action plans for all deficiencies identified within 30 days of notification. Following receipt of the CMA's remediation action plan, the Dept reviews the plan and confirms the appropriate steps have been taken to correct the deficiencies.

G.a.4
In instances where upon review of the complaint or occurrence report the Dept identifies individual provider issues, the Dept will address these issues directly with the provider and participant/guardian. If the Dept identifies trends or patterns affecting multiple providers or participants, the Dept will communicate a change or clarification of rules to all providers in monthly provider bulletins. If existing rules require an amendment the Dept will develop rules or policies to resolve widespread issues.

G.a.6
The Dept requires agencies who do not attend preventative strategies training as required to submit a corrective action plan. If remediation does not occur timely or appropriately, the Dept issues a "Notice to Cure" the deficiency to the CMA. This requires the agency to take specific action within a designated timeframe to achieve compliance.

G.b.3, G.b.4
The Dept utilizes this information to develop statewide trainings, determine the need for individual agency TA for case management and service provider agencies. In addition, the Dept utilizes this info to identify problematic practices with individual CMAs and/or providers and to take additional action such as conducting an investigation, referring the agency to CDPHE for complaint investigation or directing the agency to take corrective action. If problematic trends are identified by the Dept in the reports, the Dept will require a written plan of action by the CMA and/or provider agency to mitigate future occurrence.

G.b.6

Specific provider trends are relayed to the Benefits division to address and determine what additional remediation/improvement strategies need to be implemented.

G.c.1, G.c.6
The Dept takes remedial action to address with waiver service providers and/or CMAs when needed for deficient practice in following the proper procedures of restrictive interventions. This includes formal request for response, TA, Dept investigation, imposition of corrective action, termination of CMA contract, and termination of waiver service providers.

G.c.2, G.c.3, G.c.4
CDPHE notifies the provider agencies of deficiencies and determines the appropriate remedial actions: training, TA, Plan of Correction, license revocation.

G.d.3
The Department provides remediation training for CMAs annually to assist with improving compliance with the ensuring there is accurate RAE/CMA care coordination. The Department compiles and analyzes CMA CAPs to determine a statewide root cause for deficiencies. Based on the analysis, the Department identifies the need to provide policy clarifications, and/or technical assistance, design specific training, and determine the need for modifications to current processes to address statewide systemic issues.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

This Quality Improvement Strategy (QIS) encompasses all services provided in the DD waiver. The waiver specific requirements and assurances are included in the appendices.
The Department draws from multiple sources when determining the need for and methods to accomplish system design changes. Using data gathered from Colorado Department of Public Health and Environment (CDPHE), Critical Incident Reporting System (CIRS), annual programmatic and administrative evaluations, and stakeholder input, the Department's Office of Community Living Benefits and Services Management Division, in partnership with the Case Management Quality and Performance unit and Office of Information Technology (OIT), uses an interdisciplinary approach to review and monitor the system to determine the need for design changes, including those to the state's case management IT system. Work groups form as necessary to discuss prioritization and selection of system design changes.
Discovery and Remediation Information:
The Department maintains oversight over the (specify waiver) waiver in its contracts/interagency agreements through tracking of contract deliverables on a monthly, quarterly, semi-annually, and yearly basis, depending on the details of each agreement. The Department has access to, and reviews all required reports, documentation and communications. Delegated responsibilities of these agencies/vendors are monitored, corrected, and remediated by the Department's Office of Community Living.
Colorado selects a representative random sample (unless otherwise noted in the waiver application) of waiver participants for annual review, with a confidence level of 95% margin of error +/-5%, from the total population of waiver participants. The results obtained reflect systemic performance to ensure the waiver is responsive to the needs of all individuals served. The Department trends, prioritizes, and implements system improvements (i.e., design changes) prompted as a result of an analysis of the discovery and remediation information obtained.
To ensure the quality review process is completed accurately, efficiently, and in accordance with federal standards, the Department contracts with an independent Quality Improvement Organization (QIO) to complete the QIS Review Tool for the annual Case Management Agency (CMA) program case evaluations. Additionally, the Department performs an inter-rater reliability study of results provided by the QIO to determine accuracy of QIO reviews.
The Department uses standardized tools for level of care (LOC) eligibility determinations, person centered support planning, and critical incident reporting for waiver populations. Through use of the state's case management system, the data generated from LOC eligibility determinations, Person Centered Support Plans, and critical incident reports, and concomitant follow-up are electronically available to CMAs and the Department, allowing effective access and use for clinical and administrative functions as well as for system improvement activities. This standardization and electronic availability provides comparability across CMAs, waiver programs, and allows on-going analysis. In addition, the Department is on track to implement a new case management system in the Spring of 2022 to streamline processes for identifying member needs and coordinating support. This new system will eliminate the need for case managers to complete documentation in multiple systems which will reduce the chance for errors and/or missing information.

Waiver providers that are required by Medical Assistance Program regulations to be surveyed by CDPHE, must complete the survey prior to certification to ensure compliance with licensing, qualification standards and training requirements. The Department is provided with monthly and annual reports detailing the number and types of agencies that have been surveyed, the number of agencies that have deficiencies and types of deficiencies cited, the date deficiencies were corrected, the number of complaints received, and complaints investigated, substantiated, and resolved. Providers who are not in compliance with CDPHE and other state standards receive deficient practice citations. Department staff review all provider surveys to ensure deficiencies have been remediated and to identify patterns and/or problems on a statewide basis by service area, and by program. The results of these reviews assist the Department in determining the need for technical assistance, training resources, and other needed interventions. The Department initiates termination of the provider agreement for any provider who is in violation of any applicable certification standard, licensure requirements, or provision of the provider agreement and does not adequately respond to a plan of correction within the prescribed period of time.
Following Medicaid provider certification, the fiscal agent enrolls all providers in accordance with program regulations and maintains provider enrollment information in Colorado Medicaid Management Information System (MMIS), the interChange. All provider qualifications are verified by the fiscal agent upon initial enrollment and in a revalidation cycle; at least every five years.
The MMIS, interChange, is designed to meet federal certification requirements for claims processing and submitted claims are adjudicated against interChange edits prior to payment. Claims are submitted through the Department's fiscal agent for reimbursement. The Department also engages in a post-payment review of claims to ensure the integrity of provider billings.

The information gathered from the Department's monitoring processes is used to determine areas that need additional training/technical assistance, system improvements, and quality improvement plans.
Trending:
The Department uses performance results to establish baseline data, and to trend and analyze over time. The Department's aggregation and root cause analysis of data is incorporated into annual reports that provide information to identify aspects of the system which require action or attention.
Prioritization:
The Department relies on a variety of resources to prioritize changes in the BUS. In addition to using information from annual reviews, analysis of performance measure data, and feedback from case managers, the Department factors in appropriation of funds, legislation and federal mandates.
For changes to the MMIS, interChange, the Department has developed a Priority and Change Board that convenes monthly to review and prioritize system modifications and enhancements. Change requests are presented to the Board, which discusses the merits and risks of each proposal, then ranks it according to several factors including implementation dates, level of effort, required resources, code contention, contracting requirements, and risk. Change requests are tabled, sent to the fiscal agent for an order of magnitude, or cancelled. If an order of magnitude is requested, it is reviewed at the next scheduled Board meeting. If selected for continuance, the Board decides where in the priority list the project is ranked.
The Department continually works to enhance coordination with CDPHE. The Department engages in quarterly meetings with CDPHE to maintain oversight of delegated responsibilities; report findings and analysis; provider licensure/certification and surveys; provider investigations, corrective actions and follow-up. Documentation of inter-agency meeting minutes, decisions and agreements will be maintained in accordance with state record maintenance protocol.
Quality improvement activities and results are reviewed and analyzed amongst benefit administrators, case management specialists, and critical incidents administrators.
Implementation:
Prior to implementation of a system-level improvement, the Department ensures the following are in place:
- o Process to address the identified need for the system-level improvement;
- o Policy and instructions to support the newly created process;
- o Method to measure progress and monitor compliance with the system-level improvement activities including identifying the responsible parties;
- o Communication plan;
- o Evaluation plan to measure the success of the system-level improvement activities post-implementation;
- o Implementation strategy.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Quality Improvement Committee**	☒ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system

design changes. If applicable, include the state's targeted standards for systems improvement.

Monitoring and Analyzing System Design Changes:
The process used to monitor the effectiveness of system design changes will include systematic reviews of baseline data, reviews of remediation efforts and analysis of results of performance measure data collected after remediation activities have been in place long enough to produce results. Targeted standards have not been identified but will be created on baseline data once the baseline data has been collected.
Roles and Responsibilities:
The Office of Community Living Benefit and Services Management Division and the Case Management and Quality Performance Division hold primary responsibility for monitoring and assessing the effectiveness of system design changes to determine if the desired effect has been achieved. This includes incorporation of feedback from waiver participants, advocates, CMAs, providers, and other stakeholders.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Office of Community Living's Waiver Administration and Compliance Unit will review the QIS and its deliverables with management on a quarterly basis and will provide updates to CMS when appropriate. Evaluation of the QIS is the responsibility of the Benefit and Services Management Division, Waiver Administration and Compliance Unit and the Case Management and Quality Performance Division, Quality Performance Section. This evaluation will take into account the following elements:
1. Compliance with federal and state regulations and protocols.
2. Effectiveness of the strategy in improving care processes and outcomes.
3. Effectiveness of the performance measures used for discovery.
4. Effectiveness of the projects undertaken for remediation.
5. Relevance of the strategy with current practices.
6. Budgetary considerations.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- (●) **No**
- ( ) **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ( ) **HCBS CAHPS Survey :**
- ( ) **NCI Survey :**
- ( ) **NCI AD Survey :**
- ( ) **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the*

financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

(a) Pursuant to 2 CFR Part 200 - Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards Subpart F – Audit Requirements §200.502 (i), Medicaid payments to a sub-recipient for providing patient care services to Medicaid eligible individuals are not considered federal awards expended under this part unless a State requires the funds to be treated as federal awards expended because reimbursement is on a cost-reimbursement basis. Therefore, the Department does not require an independent audit of waiver service providers.

Community Centered Boards (CCBs) are subject to the audit requirements within 2 CFR Part 200 for all Medicaid administrative payments. To ensure compliance with components detailed in the OMB Uniform Guidance, CCBs contract with external Certified Public Accountant (CPA) firms to conduct an independent audit of their annual financial statements and conduct the Single Audit when applicable. The Department is responsible for overseeing the performance of the CCBs, reviewing the Single Audits of all CCBs who meet the $750,000 threshold, and issuing management decisions on any relevant audit findings.

(b) & (c) Title XIX of the Social Security Act, federal regulations, the Colorado Medicaid State Plan, state regulations, and contracts establish record maintenance and retention requirements for Medicaid services. A case record/medical record or file must be maintained for each waiver participant. Providers are required to retain records that document the services provided and support the claims submitted for a period of six years. Records may be maintained for a period longer than six years when necessary for the resolution of any pending matters such as an ongoing audit or litigation.

The Department maintains documentation of provider qualifications to furnish specific waiver services submitted during the provider enrollment process and updated according to applicable licensure and survey requirements. This documentation includes copies of the Medicaid Provider Participation Agreement, copies of the Medicaid certification, verification of applicable State licenses, and any other documentation necessary to demonstrate compliance with the established provider qualification standards. All providers are screened monthly against the exclusion lists. Providers are compared against the List of Excluded Individuals and Entities (LEIE), the System for Award Management (SAM), the Medicare Exclusion Database (MED), the Medicare for Cause Revocation Filed (MIG), and the state Medicaid Termination file. Comparing providers against these lists allows the Department to determine if a provider has been excluded by the Office of the Inspector General (OIG), terminated by Medicare, or terminated from another state's Medicaid or Children's Health Insurance Program.

Additionally, the Department monitors the action of licensing boards to ensure Medicaid providers are in good standing.

Claims are submitted to the Department's fiscal agent for reimbursement. Claims data is maintained through the Medicaid Management Information System (MMIS). The MMIS is designed to meet federal certification requirements for claims processing and submitted claims are adjudicated against MMIS edits prior to payment.

Duties of providers include a requirement of documentation of care, in/out times, and confirmation that care was provided per state rules and regulations. Additionally, there must be the completion of appropriate service notes regarding service provision each visit. Documentation shall contain services provided, date and time in and out, and a confirmation that care was provided. Such confirmation shall be according to agency policy. The Department specifies requirements for providers that are then surveyed and certified by CDPHE. In order for personal care providers to render services, they must ensure that individuals are appropriately trained and qualified.

Regarding the post-payment review of claims:

The Compliance Division within the Department exists to monitor provider and member compliance with state and federal regulations and Department policies. Division internal reviewers conduct post-payment reviews of provider claims submissions to ensure accuracy of provider billing and compliance with regulations and Department billing policies. Auditing under the Program Integrity and Contract Oversight (PICO) Section, housed within the Division, varies with the review project conducted—including the number and frequency of providers reviewed, the percentage of claims reviewed, and the time period of the claims reviewed. Review projects range in size and focus (i.e. whether on provider type or service type) and can either be a claims data-only review or include records submitted by providers. PICO Section reviewers are responsible for conducting research and creating annual work plans of what review projects will be completed. Data samples and records to be reviewed are typically selected at random.

Additionally, the PICO Section accepts and evaluates all referrals of possible fraud, waste, and abuse of a provider or member. The PICO Section also works with law enforcement agencies on all possible fraud investigations, as well as suspensions and terminations of provider agreements.

The PICO Section also oversees post-payment claims review contracts, specifically the Recovery Audit Contractor (RAC) program. As with the PICO Section's internal reviewers, the RAC is responsible for conducting research and creating annual work plans of what review projects will be completed under their respective scope of work. Data samples and records to be reviewed are typically selected at random, however, the RAC is allowed to utilize proprietary algorithms to select providers and claims to audit.

All audit and compliance monitoring activities conducted by PICO Section and the RAC program aim to ensure provider compliance with the requirements of the Provider Participation Agreement and the Health First Colorado Program, specifically the HCBS Waivers Program and as required under §1915(c) of the Social Security Act. Each year, PICO Section reviewers will select a provider claims sample of Medicaid-paid services provided to individuals receiving benefits under the Dept's HCBS Waivers program. The sample will include 5,000 or more HCBS waiver claims from a single state fiscal year, pulled at the claim header level, to be reviewed each year. Individual claim lines that fall under each header are included in the review. The provider claims sample will be a statistically valid sample, reflecting a 95 percent confidence level with no more than a 5 percent margin of error; however, the sample may be greater than the 95 percent confidence level with no more than 5 percent margin of error at the discretion of the Department.

HCBS waivers and procedure codes are governed by different state and federal rules, regulations, and policies; each claim will be reviewed for compliance in accordance with the rules, regulations, and policies that are applicable. PICO Section reviewers will audit the provider claims sample by conducting a medical records review of those claims to verify that provider documentation substantiates the claims that were submitted to the Department. The PICO Section will utilize the RAC to also conduct audits when practical to ensure all reviews for the claims sample are being conducted timely and efficiently. The scope of a review is determined by appropriate means such as state and federal rules, referrals, internal and RAC resources, prioritization of work plans and other reviews that may require immediate attention (such as fraud investigations) as well as data analysis and mining to determine the extent of an issue.

All PICO Section reviews and the RAC utilize multiple regulation sources at the state and federal level to create review projects, as part of the Department's overall compliance monitoring of providers. Research and creation of annual work plans come from multiple sources, including reviewing fraud, waste, and abuse trends occurring locally and nationally, preliminarily reviewing claims data, reviewing referrals and provider self-disclosures, and employing data analytics tools and algorithms to identify possible aberrancies. In accordance with 10 C.C.R. 2505-10 8.076.2, provider compliance monitoring includes, but is not limited to:

- *Conducting prospective, concurrent, and/or post-payment reviews of claims.*
- *Verifying Provider adherence to professional licensing and certification requirements.*
- *Reviewing goods provided and services rendered for fraud and abuse.*
- *Reviewing compliance with rules, manuals, and bulletins issued by the Department, board, or the Department's fiscal agent.*
- *Reviewing compliance with nationally recognized billing standards and those established by professional organizations including, but not limited to, Current Procedural Terminology (CPT) and Current Dental Terminology (CDT).*
- *Reviewing adherence to the terms of the Provider Participation Agreement.*

Depending on the type of review project completed, additional rules are included in the criteria of a review project. For instance, with regard to audits of HCBS Waiver services rendered by Medicaid providers, review projects by PICO Section reviewers and the RAC will include whether providers are compliant with multiple HCBS Waiver programs. All PICO Section and RAC reviews are required to follow audit and recovery rules set forth in C.R.S. 25.5-4-301 and 10 C.C.R. 2505-10 Section 8.076.3.

All reviews that are conducted will be desk reviews, however, the Department and its vendors are required to conduct on-site reviews as required under Colorado regulation. Under 10 C.C.R. 2505-10 Section 8.076.2.E., providers are given the option of an inspection or reproduction of the records by the Department or its designees at the providers' site. All identified overpayment recoveries and suspected false claims and/or fraud will be reported to the PICO Section for review, as well as any additional agencies, including the Colorado Medicaid Fraud Control Unit. Any identified overpayments stemming from the reviews will follow rules set forth in 10 C.C.R. 2505-10 Section 8.076.3.

For negotiated rates: As part of the Service Plan review and on-site survey processes detailed in Appendix D of this application, Department staff review the documentation of rate determination and service authorization activities conducted by case managers. Identification of rate determination practices that are inconsistent with Department policies may result in corrective action and/or recovery of the overpayment.

Additional information in Main B. Optional

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:
The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
I.a.1. Number and percent of waiver claims coded and paid according to the reimbursement methodology in the waiver N: Number of waiver claims coded and paid according to the reimbursement methodology in the waiver D: Total number of paid waiver claims in this sample

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Medicaid Management Information System (MMIS) Claims Data

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =*

		95% confidence level with +/- 5% margin of error
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
I.a.3 Number and percent of paid waiver claims with adequate documentation that services were rendered N: Number of claims with adequate documentation of services

rendered D: Total number of claims in the sample

Data Source *(Select one):*
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95% confidence level with +/- 5% margin of error*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
I.b.1 Number and percent of claims paid where the rate is consistent with the approved rate methodology in the approved waiver N: Number of claims paid where the rate is consistent with the approved rate methodology in the approved waiver D: Total number of paid waiver claims reviewed

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Medicaid Management Information System (MMIS) Claims Data

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***

☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95% confidence level with +/- 5% margin of error*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*

Performance Measure:
I.b.2 Number and percent of rates adjusted that demonstrate the rate was built in accordance with the approved rate methodology. N: Number of rates adjusted that demonstrate the rate was built in accordance with the approved rate methodology D: Total number of rates adjusted reveiwed

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Medicaid Management Information System (MMIS) Claims Data

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95% confidence level with +/- 5% margin of error*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

ii. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

The information gathered for the annual reporting of the performance measures serves as the Department's primary method of discovery.
The State ensures that claims are coded correctly through a number of mechanisms:
1. Rates are loaded with procedure code and modifier combinations, thus any use of incorrect coding results in a claim paid at $0.00 or a denied claim,
2. System edits exist to ensure that only specific (appropriate provider types) are able to bill for waiver services, and
3. Finally, performing a review of claims in conjunction with the Department's published billing manual identifies any incorrect coding which resulted in a paid claim.

Duties of providers include a requirement of documentation of care, in/out times, and confirmation that care was provided per State rules and regulations. Additionally, there must be the completion of appropriate service notes regarding service provision for each visit. Documentation shall contain services provided, date and time in and out, and a confirmation that care was provided. Such confirmation shall be according to agency policy. This is then reviewed by CDPHE upon survey.

All waiver services included in the participant's service plan must be prior authorized by case managers. Approved Prior Authorization Requests (PARs) are electronically uploaded into the MMIS. The MMIS validates the prior authorization of submitted claims. Claims submitted without prior authorization are denied.

When a claim is billed to Medicaid, in addition to the five elements above, the MMIS is configured to check for a Prior Authorization Request (PAR) that matches the procedure code, allowed units, a date span, and billing/attending provider prior to rendering payment. The claims data reported in the quality performance measures were pulled and analyzed from the MMIS.

I.a.1
This performance measure ensures that claims paid for waiver services have utilized the correct coding for each of the waiver services offered. Correct coding is defined as the use of the correct procedure code and modifier combination for each service as determined by the Department. Correct coding ensures that services are paid only when the services are approved, authorized, and billed correctly.

I.a.3
The Department utilizes the client's Prior Authorization Request (PAR) as documentation of services rendered. Case managers monitor service provision to ensure that services are being provided according to the service plan. Case managers inform the Department of discrepancies between a provider's claim and what the participant reports occur or if the participant reports that the provider is not providing services according to the service plan. The Department initiates an investigation to determine if an overpayment occurred.

I.b.1
This performance measure ensures paid claims for waiver services are paid at or below the rate as specified in the Provider Bulletin and HCBS Billing Manual. In addition, the Department posts all rates in the Provider Fee Schedule portion of the external website for providers to access at their convenience. This performance measure allows the Department to identify any system issues or errors resulting in incorrect reimbursement for services rendered.

I.b.2
Benefits and Services Management Division staff review the rate adjustments to confirm that rates adhere to the approved rate methodology in the waiver.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.*

Waiver administrators coordinate with the Department's Claims Systems and Operations Division staff to initiate any edits to the Medicaid Management Information System (MMIS) that are necessary for the remediation of any deficiencies identified by the annual reporting of performance measures.

Benefits and Services Management Division staff initiate any edits to the Medicaid Management Information System (MMIS) that are necessary for the remediation of any deficiencies identified by the annual reporting of performance measures. Any inappropriate payments or overpayments identified are referred to the PICO Section for investigation as detailed in Appendix I-1 of the application.

I.a.1
Any incorrect coding which resulted in paid claims is remediated by the Department. The Benefits and Services Management Division staff collaborates with the Department's Rates Division and Health Information Office to initiate any edits to the MMIS that are necessary for remediation of any deficiencies identified by the annual reporting of performance measures.
In the event an overpayment is discovered, an accounts receivable balance is established with the provider. Overpayments are referred to the PICO Section for investigation as detailed in Appendix I-1 of the waiver application.

I.a.3
In the event an overpayment is discovered, an accounts receivable balance is established with the provider. Overpayments are referred to the PICO Section for investigation as detailed in Appendix I-1 of the waiver application.

I.b.1
Errors identified during claims data analysis as paying in excess of the Department's allowable rate may be attributed to wrong rates in prior authorization forms or additional system safeguards not being in place by the Department. PAR entry errors are addressed with CMAs to prevent future billing errors. The providers receiving overpayments are notified of payment errors and the Department establishes an accounts receivable balance to recover overpayments. The Department reviews errors to determine what additional safeguards are needed to prevent future overpayments.

I.b.2
Benefits and Services Management Division staff coordinate with the Department's Claims Systems and Operations Division staff to initiate any edits necessary to the MMIS for the remediation of deficiencies identified during the performance measure reporting.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- (●) ***No***
- ( ) ***Yes***

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

The HCBS Waiver for Persons with Developmental Disability (DD) utilizes Fee-for-Service (FFS), negotiated market price, and public pricing rate methodologies. Each rate has a unit designation and reimbursement is equal to the rate multiplied by the number of units utilized. HCBS DD FFS rate schedules are published through the Dept's provider bulletin annually and posted to the Dept's website. The Dept has adopted a rate methodology incorporating the following factors for all services not included in the negotiated price or public pricing methodology described below:

A. Indirect and Direct Care Requirements:
Salary expectations for direct and indirect care workers 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 for service delivery. Finally, collaboration with policy staff ensures the salaried positions, wages, and hours required to conform to the program or service design and are in compliance with the Code of Colorado Regulations and statute.

B. Denver City Minimum Wage Consideration:
As a result of House Bill 19-1210 and Denver Council Bill 1237 (CB-1237), Denver has enacted a citywide annual minimum wage increase for all workers effective January 1, 2020. The implementation of this minimum wage will result in the following changes to minimum wage in subsequent years.

- *$12.85 an hour, effective January 1, 2020,*
- *$14.77 an hour, effective January 1, 2021, and*
- *$15.87 an hour, effective January 1, 2022.*

There will also be annual adjustments to the minimum wage based on the Consumer Price Index each year thereafter. This requirement for increases to Denver's minimum wage will affect services currently utilizing a Bureau of Labor Statistics (BLS) Colorado mean wage below the minimum wage threshold. As a result, the Department is using the Denver minimum wage in place of the Colorado BLS mean wage for providers within Denver city and county limits in order to account for geographic wage variances existing within the market. The Department will update Denver provider service rates as changes to minimum wages become effective.

C. Facility Expense Expectations:
Incorporates the facility type through the use of existing facility property records listing square footage and actual value. Facility expenses also include estimated repair and maintenance costs, utility expenses, and phone and internet expenses. Repair and maintenance price per square foot is determined by industry standards and vary for facilities that are leased and facilities that are owned. Utility pricing includes gas and electricity which are determined annually through the Public Utility Commission who provides summer and winter rates and thermostat conversions for appropriate pricing. Finally, internet and phone services are determined through the use of the Build Your Own Bundle tool available through the Comcast Enterprise website.

D. Administrative Expense Expectations:
Identifies computer, software, office supply costs, and the total number of employees to determine administrative and operating costs per employee.

E. Capital Overhead Expense Expectations:
Identifies and incorporates additional capital expenses such as medical equipment, supplies, and IT equipment directly related to providing the service to Medicaid clients. Capital Overhead Expenses are rarely utilized for HCBS services but may include items such as massage tables for massage therapy or supplies for art and play therapy.

All Facility, Administrative, and Capital Overhead expenses are reduced to per employee cost and multiplied by the total FTE required to provide services per Medicaid client. To ensure rates do not exceed funds appropriated by the Colorado State Legislature, a budget neutrality adjustment is applied to the final determined rate.

Following the development of the rate, stakeholder feedback is solicited and appropriate, necessary changes may be made to the rate. HCBS DD FFS rates utilizing the methodology described above include:
1. Supported Employment: Job Coaching (Individual)
2. Supported Employment: Job Development (Group)
3. Behavioral Services: Behavioral Line Staff
4. Behavioral Services: Behavioral Counseling (Individual or Group)

5. Behavioral Services: Behavioral Plan Assessment
6. Behavioral Services: Behavioral Consultation
7. Home Delivered Meals
8. Peer Mentorship
9. Peer Mentorship - Telehealth
10.Transition Setup

The HCBS DD waiver utilizes a negotiated market price methodology for services in which reimbursement will differ by client, by product, and frequency of use. The services utilizing the negotiated market price methodology include:
1. Non-Medical Transportation: Public Conveyance
2. Specialized Medical Equipment and Supplies (Disposable Supplies or Equipment)
3. Supported Employment: Job Placement (Individual)
4. Supported Employment: Job Placement (Group)

For the above services case managers coordinate with providers and determine a market price that incorporates the client's needs, products required, and frequency of use. The Dept reviews and approves the market price determined and authorized by the case manager.
After the implementation of the rate, only legislative increases or decreases are applied. These legislative rate changes are often annual and reflect inflationary increases or decreases. Rates for the HCBS DD waiver are reviewed for appropriateness every five years with the waiver renewal. The Department reviewed the rate-setting methodology and included rate-setting factors in 2018 when the rate methodology was used to rebase all waiver rates.
Rates are communicated via Dept noticing in provider bulletins, tribal notices and are made available on the Dept's external website to be accessed by stakeholders and providers at any time.

The Department's Waiver and Fee Schedule Rates Section is the responsible entity for rate determination. Oversight of the rate determination process is conducted internally by a review of the rates and methodology by internal staff in Policy, Budget, and members of leadership. The Department also hosts stakeholder feedback meetings in which the rates and rate determination factors are presented to external stakeholders such as providers, clients, and client advocacy groups in order to determine additional rate determination factors to be included in the rate methodology which were not captured during the initial rate-setting process.

The Dept regularly assesses rate efficiency, economy, quality of care, and sufficiency of provider populations by monitoring and analyzing paid claims utilization multiple times throughout the state fiscal year. The Dept also analyzes geographic provider density to ensure clients are able to access waiver services. In addition to these processes, the Dept regularly solicits external stakeholder feedback in order to assess whether rates are efficient, economic, allow for a high quality of care to be provided, and are sufficient to maintain the provider population.

The following services are reimbursed on a standard FFS basis but were not determined by the rate-setting model described above:
Dental Services
Vision Services
Residential Habilitation: Group Residential Services and Supports (Regional Center)

Dental is reimbursed according to a specialized fee schedule. Dental rates for all IDD Adult waivers were rebased in 2015 and were based upon the American Dental Association's (ADA) Survey of Dental Fees. Since rebasing upon the 2013 mean, the Dept has increased these rates with applicable across the board increases as approved by the Colorado legislature to assure reimbursement rates are adequate to retain a sufficient IDD Dental provider population. While the Dept has not received external stakeholder feedback to warrant a review of the current rates at this time, the Dept has reviewed IDD Dental rates regularly and utilizes the 2017 ADA Survey of Dental fees to ensure sufficiency in reimbursement rates.

Vision services are reimbursed according to the Fee Schedule for State EPSDT vision services.

Group Residential Services and Supports (GRSS) delivered at the Regional Centers in Grand Junction and Pueblo are provided by the Colorado Dept of Human Services (CDHS). Regional Center admission is limited to only those with complex mental health and/or behavioral needs, a history of a sex offense, and/or those who are medically fragile. A standard, per-diem rate was negotiated by the Dept and the CDHS Division for Regional Center Operations in order to

recognize the specialized needs of this higher-risk population. As indicated in I-3.e of this waiver renewal application, no public provider receives payments that, in aggregate, exceed its reasonable costs of providing waiver services. These costs are determined by audited cost reports. A new cost-based rate for each Regional Center has been in place since July 1, 2014.

Tiered rates are used to reimburse for those services for which the level of provider effort and the intensity of service are variables based upon the differing support needs of individuals. The difficulty of care factors been incorporated into the rate-setting model for rates. The Dept contracted with Healthcare Receivable Specialists Inc. (HRSI) to develop a methodology for the classification of individuals into Support Levels and to develop a uniform rate model that builds provider payment rates based upon those Support Levels and other underlying cost components.

Through an analysis of data compiled from the Supports Intensity Scales (SIS), historical funding consumption patterns, and other sources, HSRI developed a methodology that groups individuals into 6 Support Levels. These Support Levels are reflective of similar adaptive skills, behavioral and medical support needs, and the presence of safety risk factors individuals present to themselves or to the community. The SIS is a nationally recognized, norm-referenced, and statistically valid assessment tool endorsed and published by the American Association on Intellectual and Developmental Disabilities (AAIDD).

Participants may change Support Levels based upon changing needs and/or circumstances, and Support Level determinations may be disputed. Participants may submit a request for Support Level re-determination to the CMA at any time. A Dept-convened review panel considers the request – along with copies of the completed SIS Interview and Profile Form, the Support Level Calculation form, the Uniform Long-Term Care 100.2 assessment, the service plan, the Level of Need (LON) checklist, and any supplemental documentation asserting that the participant's Support Level should be re-determined. The review panel is comprised of at least three individuals with working knowledge of the SIS and of waiver services. A final decision is rendered at the conclusion of the review panel meeting. The review panel may decide that the current Support Level is appropriate, re-assign the participant to another Support Level, or request the re-administration of the SIS Interview and/or safety risk factors.

Additional information on rate determination methods located in Main B. Optional

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

Payments for all waiver services are made directly to providers through the Department's approved Medicaid Management Information System (MMIS). Waiver services may be rendered by qualified providers enrolled directly with the Department via an executed Medicaid provider agreement. Providers submit claims and are reimbursed directly through the MMIS for services rendered.

Waiver services may also be rendered by qualified providers acting under an Organized Health Care Delivery System (OHCDS) agreement. Waiver services delivered under such an agreement may be rendered by employees or contractors of the OHCDS agency. The OHCDS agency must ensure that its employees and contractors meet the provider qualifications detailed in Appendix C of the waiver application. The OHCDS agencies submit claims and are reimbursed directly through the MMIS for services rendered. Providers may also choose to contract with an Organized Health Care Delivery System (OHCDS) agencies. These providers submit documentation of service provision to and are reimbursed by the OHCDS. The OHCDS submits claims to the MMIS. Payments to qualified providers under contract with the CCBS are negotiated between the CCBs and those contractors. The Department does not reimburse for claims processing fees.

Providers may use the OHCDS arrangement for all HCBS-DD services.

The flow of billing is the same regardless of the type of service or if the service is provided by a family caregiver.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

◉ ***No. state or local government agencies do not certify expenditures for waiver services.***

○ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

Billing validation is accomplished primarily by the Department's Medicaid Management Information System (MMIS). The MMIS is designed to meet federal certification requirements for claims processing and submitted claims are adjudicated against MMIS edits prior to payment.

(a) The Colorado Benefits Management System (CBMS) is a unified system for data collection and eligibility. It allows for improved access to public assistance and medical benefits by permitting faster eligibility determinations, and allowing for higher accuracy and consistency in eligibility determinations statewide. The electronic files from CBMS are downloaded daily into the MMIS in order to ensure updated verification of eligibility for dates of service claimed. The first edit in the MMIS when a claim is filed ensures that the waiver client is eligible for Medicaid services. Claims submitted for clients who are not eligible on the date of service are denied.

(b) All waiver services included in the participant's service plan must be prior authorized by case managers. Approved Prior Authorization Requests (PARs) are electronically uploaded into the MMIS. The MMIS validates the prior authorization of submitted claims. Claims submitted without prior authorization are denied.

Case managers monitor service provision to ensure that services are being provided according to the service plan. Should a discrepancy between a provider's claim and what the client reports occur, or should the client report that the provider is not providing services according to the service plan, the case manager reports the information to the Department for investigation.

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 smart phone or tablet, a toll-free telephone number, or a web-based portal.

EVV captures six points of data as required by the 21st Century Cures Act: individual receiving the service, attendant providing the service, 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 which must be electronically verified: As of August 3, 2020, the Department implemented EVV for federally mandated and additional services that are similar in nature and service delivery. The Department mandates Electronic Visit Verification (EVV) per CCR 2505-10 Section 8.001. Required EVV waiver services include:
Behavioral Therapies
Independent Living Skills Training (ILST) and Life Skills Training (LST)

The Department also mandates EVV for the following State Plan Services:
Home Health
Hospice
Occupational Therapy
Pediatric Behavioral Therapies
Pediatric Personal Care
Physical Therapy
Private Duty Nursing
Speech Therapy

On February 1, 2022, the Department activated a pre-payment EVV claim edit. EVV-required services, excluding CDASS and hospice, require corresponding EVV records prior to payment. This has resulted in improved provider compliance and better oversight of service provision.

Provider agencies utilizing the State EVV Solution have access to a portal to view and modify visit activity, and in limited circumstances, create EVV records. All information entered via the provider portal is notated as manual entry or edit and is subject to Department audit.

In the event the caregiver is unable to collect EVV data at the time of service delivery, provider agencies will need to enter missing data. Within the State EVV Solution, an agency administrator may complete visit maintenance in the EVV Solution provider portal. The administrator will enter the missing data and select a reason code on why a manual entry was done. Manual entry may be entered on a case-by-case basis. Manual entries are subject to increased scrutiny by the Department and providers must maintain service records for these visits.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

- (●) ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***
- ( ) ***Payments for some, but not all, waiver services are made through an approved MMIS.***

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) ***Payments for waiver services are not made through an approved MMIS.***

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

  Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☒ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☐ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***

○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

○ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*

◉ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

The 3 State operated Regional Centers, Wheat Ridge Regional Center, Grand Junction Regional Center, and Pueblo Regional Center provide Residential Habilitation, Day Habilitation, Supported Employement, Behavioral and Transportation services.

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 Community Centered Board (CCB) is designated as an OHCDS. Agencies must be approved to provide Targeted Case Management services for this designation.

(b) Providers may enroll directly with the Department by submitting an application. Included in the application is a Claims Submission Method Form. On this form, providers elect to enroll directly with the Department or to contract with an OHCDS. Additional information on provider enrollment is available on the Department's website.

(c) Department regulations require that case managers provide participants, guardians, and/or authorized representatives a listing of all qualified providers in the area. The Department's website also contains a statewide list of qualified providers for waiver services.

(d) The Department maintains documentation of qualifications for all providers. This documentation includes copies of the Medicaid Provider Agreement, copies of the Medicaid certification, verification of applicable State licenses, and any other documentation necessary to demonstrate compliance with the established provider qualification standards.

(e) The OHCDS agencies subcontract with providers certified by the Department to provide specific waiver services or with independent contractors which have been verified by the OHCDS to have met all applicable licensing and/or established provider qualification standards. The Department assures provider qualifications are met by OHCDS subcontractors through administrative monitoring. Verifying and monitoring the service delivery of enrolled participants receiving a defined service from a qualified provider is the responsibility of the OHCDS. These standards are detailed at 10 CCR 2505-10 8.500.111.

(f) Financial accountability is assured for services delivered in the OHCDS arrangement through the same methods and processes used for services delivered in a direct service provider arrangement and as described in Appendix I-1 and Appendix I-2.d of this application.

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:*

The rate setting methodology approved by Health Care Policy & Financing (the Department) that establishes the residential habilitation payment excludes all costs associated with room and board. All individuals receiving Residential Habilitation services are required to utilize their income to pay the provider the amount established by the Department to cover room and board. The facility costs only include common space and do not include the actual residential space for the client (i.e. the client's room). Costs for raw food and meals are also not included in the rate setting methodology. Each year when the new Supplemental Security Income (SSI) standard is issued, the Department issues a room and board Advisory Notice to all providers and case management agencies identifying the dollar amount the individual may keep for personal needs and the amount required to pay for room and board. Case managers are responsible to provide this information to individuals already enrolled in the waiver and to each new individual being enrolled. The Department provides technical assistance and training on personal needs funds, which includes information regarding the individual's responsibility to pay for his or her room and board. The Department's rules specifically exclude the costs of room and board.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- (●) ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ( ) ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing *(1 of 5)*

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- (●) ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ( ) ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] ***Nominal deductible***
- [ ] ***Coinsurance***

☐ ***Co-Payment***

☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***

○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	73051.59	10585.00	83636.59	271480.00	8429.00	279909.00	196272.41
2	73996.48	10452.00	84448.48	283263.00	8564.00	291827.00	207378.52
3	77056.33	10780.00	87836.33	295556.00	8701.00	304257.00	216420.67
4	85966.25	11466.00	97432.25	308383.00	8840.00	317223.00	219790.75
5	86156.50	11657.00	97813.50	321767.00	8981.00	330748.00	232934.50

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		ICF/IID	
Year 1	7114		7114
Year 2	7525		7525
Year 3	8422		8422
Year 4	9076		9076
Year 5	9500		9500

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

The Department estimated the average length of stay (ALOS) on the waiver by reviewing historical data included in the annual 372 data report. Because of such large increases in enrollment for DD annually, ALOS is not expected to grow stronger every year. The Department calculated what percentage of the population will be added each year, assuming linear ramp-up, and adjusted ALOS based on how many days the monthly additions would be on the waiver. Then took a weighted average between yearly additions and existing waiver population to calculate future ALOS values.

The Department did not use specific years for the ALOS trend for the DD waiver because the DD waiver is experiencing unprecedented growth in enrollment due to newly appropriated enrollments. In SFY 2019-20, the General Assembly authorized several DD waiver enrollments. Because so many new people will join the waiver, the Department had to calculate what that effect would be on ALOS since most of the additions would not join July 1st which means the average length of stay is likely to drop given the enrollment additions throughout the year. In order to do this, the Department assumed that anyone who joins the waiver in the first month of the fiscal year would stay on for 345 days, the ALOS value from FY 2017-18. Anyone who joins the waiver in January would stay on for half of that value, as they would only be on the waiver for half of the year. The Department assumed a linear ramp up and calculated a weighted average using the calculation above.

Updates to WY 4-5 for amendment with requested effective date of 7/01/2022:
The Colorado State Legislature authorized an additional 667 enrollments onto the HCBS-DD waiver over FY 2021-22 and FY 2022-23. The Department calculated what percentage of the population will be added each year, assuming linear ramp-up, and adjusted ALOS based on how many days the monthly additions would be on the waiver. Then took a weighted average between yearly additions and existing waiver population to calculate future ALOS values.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

For each individual service, the Department considered the number of clients utilizing each service, the number of units per user, the average cost per unit, and the total cost of the service. The Department utilized data from 372 reports from FY 2014-15 to FY 2017-18 as the basis for these estimations.
The Department examined historical growth rates, the fraction of the total population that utilized each service, and graphical trends. Once the historical data was analyzed, the Department selected trend factors to forecast, the number of clients utilizing each service, the number of units per user, and the average cost per unit. Caseload, utilization per client, and cost-per-unit are multiplied together to calculate the total expenditure for each service and added to derive Factor D. For services that have multiple service levels, these service levels are shown separately.

Certain years of data are not included because they are considered to be outliers based on out-of-date policy, sudden changes in utilization, new limits placed on services, or some other reason. By policy and procedure, these characteristics are used to determine when data is an outlier. The state will make available to CMS upon request, the specific characteristics for the data outlier of a specific service.

Historical growth rates: The source of data is 372 waiver reports. The Department reviews data from FY 2007-08 through FY 2017-18 but might only include certain FYs in the development of trends. For example, the Department may look at data from FY 2007-08 and beyond but apply a trend that only incorporates growth rates from FY 2015-16 and FY 2017-18.

Fraction of growth rates: The source of data is 372 waiver reports which include the number of utilizers of each service and total waiver clients. The Department divides services utilizers into total waiver enrollments to calculate the fraction of the total population that uses services. Dates of data are all available historical data which for this waiver dates back to FY 2007-08 however the Department focuses on more recent data for trend development.

Graphical trends: In some cases, the Department will plot the data in a graph to try and discern a reliable trend. This could be done for the following forecast elements: number of utilizers or units per utilizer. Graphical trends would not be used for rates

Rates included in the Department's Cost Neutrality Demonstration may not match the Department's published rate schedule. In order to accurately project total expenditures for a service, the avg. cost/unit may be adjusted to account for a particular rate being implemented for less than a 12 month period.
The following is a list of the services in DD with a description of their legislative rate reduction/increase.

The following services received the (A) 1% reduction on 7/01/2020:

- *Day Habilitation-Specialized Habilitation Support Level 1*
- *Day Habilitation-Specialized Habilitation Support Level 2*
- *Day Habilitation-Specialized Habilitation Support Level 3*
- *Day Habilitation-Specialized Habilitation Support Level 4*
- *Day Habilitation-Specialized Habilitation Support Level 5*
- *Day Habilitation-Specialized Habilitation Support Level 6*
- *Day Habilitation-Specialized Habilitation Support Level 7*
- *Day Habilitation-Supported Community Connections (SCC) Support Level 1*
- *Day Habilitation-SCC Support Level 2*
- *Day Habilitation-SCC Support Level 3*
- *Day Habilitation-SCC Support Level 4*
- *Day Habilitation-SCC Support Level 5*
- *Day Habilitation-SCC Support Level 6*
- *Day Habilitation-SCC Support Level 7*
- *Prevocational Services Level 1*
- *Prevocational Services Level 2*
- *Prevocational Services Level 3*
- *Prevocational Services Level 4*
- *Prevocational Services Level 5*
- *Prevocational Services Level 6*
- *Supported Employment-Job Coaching Group Support Level 1*

• Supported Employment-Job Coaching Group Support Level 2
• Supported Employment-Job Coaching Group Support Level 3
• Supported Employment-Job Coaching Group Support Level 4
• Supported Employment-Job Coaching Group Support Level 5
• Supported Employment-Job Coaching Group Support Level 6
• Supported Employment-Job Coaching-Individual
• Supported Employment-Job Development-Individual Support Level 1-2
• Supported Employment-Job Development-Individual Support Level 3-4
• Supported Employment-Job Development-Individual Support Level 5-6
• Supported Employment-Job Development-Group
• Behavioral Services-Behavioral Line Staff Services
• Behavioral Services-Behavioral Consultation
• Behavioral Services-Behavioral Counseling-Individual
• Behavioral Services-Behavioral Counseling-Group
• Behavioral Services-Behavioral Plan Assessment
• Home Delivered Meals
• Non-Medical Transportation Mileage Range 0-10
• Non-Medical Transportation Mileage Range 11-20
• Non-Medical Transportation Mileage Range >20
• Peer Mentorship
• Transition Setup-Transition Setup Coordinator

The following services received the (A) 1% reduction on 7/01/2020 and then will receive a (C) Denver minimum wage increase:
(Note: The rates listed below will not match the Department's Cost Neutrality Demonstration. In order to accurately project total expenditures for the service, the avg. cost/unit is adjusted to account for the rate being implemented for less than a 12 month period).

• Residential Habilitation-Group Residential Services and Supports-Level 1: The Denver share of expenditure for this service is 4.66% with the Denver only provider wage of $122.73 for FY 2020-21 and $135.95 for FY 2021-22.

• Residential Habilitation-Group Residential Services and Supports-Level 2: The Denver share of expenditure for this service is 3.93% with the Denver only provider wage of $148.24 for FY 2020-21 and $164.82 for FY 2021-22.

• Residential Habilitation-Group Residential Services and Supports-Level 3: The Denver share of expenditure for this service is 1.44% with the Denver only provider wage of $168.40 for FY 2020-21 and $188.19 for FY 2021-22.

• Residential Habilitation-Group Residential Services and Supports-Level 4: The Denver share of expenditure for this service is 3.91% with the Denver only provider wage of $192.96 for FY 2020-21 and $216.84 for FY 2021-22.

• Residential Habilitation-Group Residential Services and Supports-Level 5 The Denver share of expenditure for this service is 2.28% with the Denver only provider wage of $212.65 for FY 2020-21 and $240.81 for FY 2021-22.

• Residential Habilitation-Group Residential Services and Supports-Level 6 The Denver share of expenditure for this service is 1.65% with the Denver only provider wage of $248.70 for FY 2020-21 and $284.11 for FY 2021-22.

• Residential Habilitation-Individual Residential Services and Supports-Level 1: The Denver share of expenditure for this service is 7.68% with the Denver only provider wage of $75.44 for FY 2020-21 and $85.35 for FY 2021-22.

• Residential Habilitation-Individual Residential Services and Supports-Level 2: The Denver share of expenditure for this service is 8.86% with the Denver only provider wage of $122.50 for FY 2020-21 and $139.47 for FY 2021-22.

• Residential Habilitation-Individual Residential Services and Supports-Level 3: The Denver share of expenditure for this service is 8.47% with the Denver only provider wage of $150.57 for FY 2020-21 and $172.62 for FY 2021-22.

• Residential Habilitation-Individual Residential Services and Supports-Level 4: The Denver share of expenditure for this service is 4.97% with the Denver only provider wage of $184.52 for FY 2020-21 and $213.21 for FY 2021-22.

• Residential Habilitation-Individual Residential Services and Supports-Level 5: The Denver share of expenditure for this service is 9.83% with the Denver only provider wage of $213.67 for FY 2020-21 and $249.07 for FY 2021-22.

• Residential Habilitation-Individual Residential Services and Supports-Level 6: The Denver share of expenditure for this service is 7.43% with the Denver only provider wage of $270.88 for FY 2020-21 and $318.93 for FY 2021-22.

• Residential Habilitation-Individual Residential Services and Supports/Host Home-Level 1: The Denver share of expenditure for this service is 4.39% with the Denver only provider wage of $69.58 for FY 2020-21 and $78.19 for FY 2021-22.

• Residential Habilitation-Individual Residential Services and Supports/Host Home-Level 2: The Denver share of expenditure for this service is 7.19% with the Denver only provider wage of $112.97 for FY 2020-21 and $127.73 for FY 2021-22.

• Residential Habilitation-Individual Residential Services and Supports/Host Home-Level 3: The Denver share of expenditure for this service is 6.56% with the Denver only provider wage of $138.78 for FY 2020-21 and $157.96 for FY 2021-22.

• Residential Habilitation-Individual Residential Services and Supports/Host Home-Level 4: The Denver share of expenditure for this service is 7.05% with the Denver only provider wage of $170.09 for FY 2020-21 and $195.09 for FY 2021-22.

• Residential Habilitation-Individual Residential Services and Supports/Host Home-Level 5: The Denver share of expenditure for this service is 8.54% with the Denver only provider wage of $196.90 for FY 2020-21 and $227.80 for FY 2021-22.

• Residential Habilitation-Individual Residential Services and Supports/Host Home-Level 6: The Denver share of expenditure for this service is 5.89% with the Denver only providers wage of $249.62 for FY 2020-21 and $291.67 for FY 2021-22.

The following services did not receive a legislative rate decrease/increase as they are negotiated rates for the Fall 2020 amendments:

• Residential Habilitation-Group Residential Services and Supports-Level 7
• Residential Habilitation-Individual Residential Services and Supports-Level 7
• Residential Habilitation-Individual Residential Services and Supports/Host Home-Level 7
• Supported Employment Job Placement-Group
• Supported Employment Job Placement-Individual
• Dental Services-Major
• Dental Services-Preventative-Basic
• Vision Services
• Non-Medical Transportation(except Public Conveyance and Taxi)
• Specialized Medical Equipment and Supplies-Equipment
• Specialized Medical Equipment and Supplies-Disposable Supplies
• Transition Setup-Transition Setup Expense

Additional information can be found in Main, Optional B

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

To calculate State Plan services costs associated with DD Waiver clients, the Department analyzed historical D' values. The Department utilized data from 372 reports through FY 2017-18. D' has been increasing fairly steadily since FY 2007-08. The Department has chosen the average cost per client growth rate in forecast years FY 2018-19 - FY 2023-24 from the Department's bi-annual forecast for the state for Acute Care for disabled individuals age 59 and younger. The claims information used in the derivation of Factor D' does not contain costs for prescribed drugs for those dually eligible for Medicare and Medicaid as those claims are not tracked in the MMIS system. Therefore, the costs of those drugs are not included in the estimate of Factor D'. The Department has selected trends consistent with the acute care per capita trends found in the Department's FY 2020-21 R-1 budget submission. The trends for FY 2019-20 and FY 2020-21 & beyond are 2.25% and -1.26%, respectively.

Update for WYs 3-5 for Amendment with requested effective date of 7/01/2021:
To calculate State Plan services costs associated with DD Waiver clients, the Department analyzed historical D' values. D' has been increasing fairly steadily since FY 2012-13. The Department has chosen the average cost per client growth rate in forecast years by calculating the average three-year growth of FY 2016-17, FY 2017-18, and FY 2018-19. The claims information used in the derivation of Factor D' does not contain costs for prescribed drugs for those dually eligible for Medicare and Medicaid as those claims are not tracked in the MMIS system. Therefore, the costs of those drugs are not included in the estimate of Factor D'.

Enrollment into the DD waiver is limited and there is currently a waiting list. New enrollments are a combination of reserved capacity, emergency, and additional enrollments authorized by the General Assembly. Enrollment trends between WY2 and 3 and WY3 and 5 are calculated based on new enrollments appropriated by the General Assembly, as well as the reserved capacity enrollments aforementioned. CMS 372 Reports are not an appropriate gauge for enrollment growth specific to this waiver. Historical trends in enrollment do not reflect the State's current enrollment goals and expectations.

Update for WYs 4-5 for Amendment with requested effective date of 7/01/2022:

To calculate State Plan services costs associated with DD Waiver clients, the Department analyzed historical D' values. D' has been increasing fairly steadily since FY 2012-13. The Department has chosen average cost per client growth rate in forecast years by calculating average three year growth of FY 2017-18, FY 2018-19, and FY 2019-20. The claims information used in the derivation of Factor D' does not contain costs for prescribed drugs for those dually eligible for Medicare and Medicaid as those claims are not tracked in the MMIS system. Therefore, the costs of those drugs are not included in the estimate of Factor D'.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

To calculate ICF/IID costs, the Department examined utilization and average per user ICF/IID costs. The Department trended expenditure using the average growth rate of the two previous years. The Department used 372 reports from FY 2007-08 to FY 2016-17 to calculate Factor G. For FY 2016-16 the growth rate was -4.50% and for FY 2016-17 the growth rate was 4.37%. The Department used FY 2016-17 growth rate to calculate Factor G.
The Department used the following data to project the WY1 value for Factor G:
FY2016-17 value: $238,993.46
Annual Trend: 4.34%
To project the WY1 value for Factor G the Department applied the annual trend of 4.34% to the starting value of $238,993.46 for 3 years to arrive at the FY 2019-20 value of $271,480.42.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

When determining the state plan costs for ICF/IID clients, the Department reviewed historical data from 372 reports from FY 2007-08 to FY 2016-17 to calculate Factor G'. The Department chose to apply a trend that is equal to the average growth rate of the two previous years. The growth rate for FY 2015-16 was -86.48% and the growth rate for FY 2016-17 was 1.60%. The Department used FY 2016-17 to trend the growth rate. To project WY1 value for Factor G' the Department started with the latest actuals data from FY 2016-17 and a value of $10,194.47. Then the Department applied two years of a trend of -9.79% due to ACC 2.0 which was going into effect during that time and is streamlining coordination of state plan services. The information used in the derivation of Factor G' does not contain costs for prescribed drugs for those dually eligible for Medicare and Medicaid as those claims are not tracked in the MMIS system. Therefore, the costs of those drugs are not included in the estimate of Factor G'.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Day Habilitation	
Prevocational Services	
Residential Habilitation	
Supported Employment	
Dental Services	
Vision Services	
Behavioral Services	
Home Delivered Meals	
Non Medical Transportation	
Peer Mentorship	
Specialized Medical Equipment and Supplies	
Transition Setup	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						85381013.60
Specialized Habilitation	15 min	320	1549.19	2.60	1288926.08	
				GRAND TOTAL:		519689003.08
				Total Estimated Unduplicated Participants:		7114
				Factor D (Divide total by number of participants):		73051.59
				Average Length of Stay on the Waiver:		331

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Support Level 1						
Specialized Habilitation Support Level 2	15 min	807	1866.55	2.86	4308034.73	
Specialized Habilitation Support Level 3	15 min	720	2065.39	3.18	4728916.94	
Specialized Habilitation Support Level 4	15 min	717	2111.26	3.75	5676650.32	
Specialized Habilitation Support Level 5	15 min	1024	2128.22	4.64	10111939.38	
Specialized Habilitation Support Level 6	15 min	666	2136.47	6.66	9476440.87	
Specialized Habilitation Support Level 7	15 min	172	2981.42	10.48	5374188.44	
Supported Community Connections Support Level 1	15 min	489	1491.00	3.16	2303952.84	
Supported Community Connections Support Level 2	15 min	1025	1815.83	3.45	6421228.84	
Supported Community Connections Support Level 3	15 min	815	1758.19	3.91	5602736.16	
Supported Community Connections Support Level 4	15 min	915	1848.72	4.48	7578273.02	
Supported Community Connections Support Level 5	15 min	1142	1947.48	5.40	12009719.66	
Supported Community Connections Support Level 6	15 min	792	1734.72	7.10	9754677.50	
Supported Community Connections Support Level 7	15 min	34	2091.74	10.48	745328.80	
Prevocational Services Total:						3822697.47
Prevocational Services Level 1	15 min	60	1626.70	2.59	252789.18	
Prevocational Services Level 2	15 min	141	1851.41	2.86	746599.60	
Prevocational Services Level 3	15 min	84	1540.42	3.18	411476.99	
Prevocational Services Level 4	15 min	83	1862.89	3.74	578278.31	

GRAND TOTAL:	519689003.08
Total Estimated Unduplicated Participants:	7114
Factor D (Divide total by number of participants):	73051.59
Average Length of Stay on the Waiver:	331

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Prevocational Services Level 5	15 min	79	2373.69	4.64	870099.81	
Prevocational Services Level 6	15 min	70	2066.61	6.66	963453.58	
Residential Habilitation Total:						376771552.60
Group Residential Services and Supports - Level 1	Day	83	292.76	107.15	2603646.42	
Group Residential Services and Supports - Level 2	Day	224	308.24	134.43	9281821.52	
Group Residential Services and Supports - Level 3	Day	146	314.80	155.06	7126681.65	
Group Residential Services and Supports - Level 4	Day	169	320.40	179.93	9742777.67	
Group Residential Services and Supports - Level 5	Day	222	286.08	197.91	12569216.60	
Group Residential Services and Supports - Level 6	Day	167	289.29	231.99	11207768.65	
Group Residential Services and Supports - Level 7	Day	180	332.70	483.80	28972846.80	
Individual Residential Services and Supports - Level 1	Day	378	323.24	71.49	8734985.63	
Individual Residential Services and Supports - Level 2	Day	464	293.58	115.51	15734901.57	
Individual Residential Services and Supports - Level 3	Day	292	282.52	141.15	11644287.82	
Individual Residential Services and Supports - Level 4	Day	256	283.16	171.85	12457227.78	
Individual Residential Services and Supports - Level 5	Day	412	292.48	197.47	23795482.55	
Individual Residential Services and Supports - Level 6	Day	338	273.22	248.16	22917169.02	
Individual Residential Services and Supports - Level 7	Day	36	258.04	363.37	3375503.81	
Individual Residential Services and Supports/Host	Day	319	288.39	66.31	6100281.95	

GRAND TOTAL:	519689003.08
Total Estimated Unduplicated Participants:	7114
Factor D (Divide total by number of participants):	73051.59
Average Length of Stay on the Waiver:	331

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home - Level 1						
Individual Residential Services and Supports/Host Home - Level 2	Day	813	310.21	107.13	27018264.20	
Individual Residential Services and Supports/Host Home - Level 3	Day	694	317.99	130.89	28885467.50	
Individual Residential Services and Supports/Host Home - Level 4	Day	802	303.80	159.38	38832554.49	
Individual Residential Services and Supports/Host Home - Level 5	Day	890	314.64	183.13	51281820.65	
Individual Residential Services and Supports/Host Home - Level 6	Day	601	308.19	230.17	42632591.47	
Individual Residential Services and Supports/Host Home - Level 7	Day	24	270.67	285.75	1856254.86	
Supported Employment Total:						24261803.65
Supported Employment - Job Coaching - Group Support Level 1	15 min	255	2058.90	3.47	1821817.66	
Supported Employment - Job Coaching - Group Support Level 2	15 min	336	1777.12	3.82	2280969.06	
Supported Employment - Job Coaching - Group Support Level 3	15 min	206	1893.30	4.24	1653683.95	
Supported Employment - Job Coaching - Group Support Level 4	15 min	177	1431.77	4.91	1244308.35	
Supported Employment - Job Coaching - Group Support Level 5	15 min	213	1860.26	5.85	2317976.97	
Supported Employment - Job Coaching - Group Support Level 6	15 min	175	1790.99	7.65	2397687.86	
Supported Employment - Job Coaching - Individual	15 min	888	977.63	14.34	12449062.21	

GRAND TOTAL:	519689003.08
Total Estimated Unduplicated Participants:	7114
Factor D (Divide total by number of participants):	73051.59
Average Length of Stay on the Waiver:	331

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Employment - Job Development - Individual Support Level 1-2	15 min	15	293.38	14.34	63106.04	
Supported Employment - Job Development - Individual Support Level 3-4	15 min	12	80.86	14.34	13914.39	
Supported Employment - Job Development - Individual Support Level 5-6	15 min	13	23.00	14.34	4287.66	
Supported Employment - Job Development - Group	15 min	8	408.00	4.57	14916.48	
Supported Employment Job Placement - Group	Session	1	72.00	1.00	72.00	
Supported Employment Job Placement - Individual	Session	1	1.00	1.00	1.00	
Supported Employment - Job Development - Individual	15 min	0	0.00	0.01	0.00	
Dental Services Total:						446009.74
Major	Session	278	1.00	1005.19	279442.82	
Preventative-Basic	Session	299	1.00	557.08	166566.92	
Vision Services Total:						774380.40
Vision Services	Item	2140	1.00	361.86	774380.40	
Behavioral Services Total:						9290731.13
Behavioral Line Staff Services	15 min	319	241.12	7.30	561496.14	
Behavioral Consultation	15 min	1938	41.44	25.80	2072016.58	
Behavioral Counseling - Individual	15 min	1930	114.92	25.80	5722326.48	
Behaviroal Counseling - Group	15 min	182	81.22	8.70	128603.75	
Behavioral Plan Assessment	15 min	1196	26.13	25.80	806288.18	
Home Delivered						10809.54

GRAND TOTAL:	519689003.08
Total Estimated Unduplicated Participants:	7114
Factor D (Divide total by number of participants):	73051.59
Average Length of Stay on the Waiver:	331

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Meals Total:						
Home Delivered Meals	Per meal	6	161.00	11.19	10809.54	
Non Medical Transportation Total:						18238792.97
Public Conveyance	Item	1239	1.00	1054.14	1306079.46	
Mileage Range 0-10	Trip	3928	285.55	6.65	7458908.66	
Mileage Range 11-20	Trip	1858	244.87	13.91	6328611.28	
Mileage Ranged >20	Trip	707	210.04	21.18	3145193.57	
Peer Mentorship Total:						136.08
Peer Mentorship	15 min	1	24.00	5.67	136.08	
Peer Mentorship - Telehealth	15 min	0	0.00	0.01	0.00	
Specialized Medical Equipment and Supplies Total:						685371.35
Equipment	Item	203	2.09	689.37	292479.01	
Disposable Supplies	Item	1268	5.40	57.38	392892.34	
Transition Setup Total:						5704.56
Transition Setup Coordinator	15 min	4	32.00	7.74	990.72	
Transition Setup Expense	Per Transition	4	1.00	1178.46	4713.84	
				GRAND TOTAL:		519689003.08
				Total Estimated Unduplicated Participants:		7114
				Factor D (Divide total by number of participants):		73051.59
				Average Length of Stay on the Waiver:		331

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						89147859.57
Specialized Habilitation Support Level 1	15 min	338	1638.73	2.57	1423499.20	
Specialized Habilitation Support Level 2	15 min	854	1866.55	2.83	4511115.37	
Specialized Habilitation Support Level 3	15 min	762	2085.01	3.15	5004649.50	
Specialized Habilitation Support Level 4	15 min	717	2111.26	3.71	5616099.39	
Specialized Habilitation Support Level 5	15 min	1084	2107.36	4.59	10485296.12	
Specialized Habilitation Support Level 6	15 min	704	2136.47	6.59	9911853.46	
Specialized Habilitation Support Level 7	15 min	182	2981.42	10.38	5632379.41	
Supported Community Connections Support Level 1	15 min	517	1523.69	3.13	2465650.39	
Supported Community Connections Support Level 2	15 min	1084	1826.72	3.42	6772162.52	
Supported Community Connections Support Level 3	15 min	862	1726.72	3.87	5760234.32	
Supported Community Connections Support Level 4	15 min	968	1848.72	4.44	7945650.66	
Supported Community Connections Support Level 5	15 min	1208	1970.85	5.35	12737209.38	
Supported Community Connections Support Level 6	15 min	838	1714.51	7.03	10100418.44	
Supported Community Connections Support Level 7	15 min	36	2091.74	10.38	781641.40	
Prevocational Services Total:						4026729.77
Prevocational Services Level 1	15 min	64	1626.70	2.57	267559.62	
Prevocational Services Level 2	15 min	149	1815.41	2.83	765503.93	
Prevocational					427004.42	

GRAND TOTAL:	556823487.96
Total Estimated Unduplicated Participants:	7525
Factor D (Divide total by number of participants):	73996.48
Average Length of Stay on the Waiver:	337

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services Level 3	15 min	88	1540.42	3.15		
Prevocational Services Level 4	15 min	87	1862.89	3.70	599664.29	
Prevocational Services Level 5	15 min	83	2490.12	4.59	948661.02	
Prevocational Services Level 6	15 min	74	2088.21	6.59	1018336.49	
Residential Habilitation Total:						405984477.52
Group Residential Services and Supports - Level 1	Day	88	292.76	116.96	3013226.44	
Group Residential Services and Supports - Level 2	Day	236	308.24	140.86	10246809.99	
Group Residential Services and Supports - Level 3	Day	155	314.80	159.29	7772396.26	
Group Residential Services and Supports - Level 4	Day	178	323.60	181.88	10476433.50	
Group Residential Services and Supports - Level 5	Day	235	283.86	199.14	13284051.89	
Group Residential Services and Supports - Level 6	Day	177	289.28	231.27	11841616.05	
Group Residential Services and Supports - Level 7	Day	190	332.70	483.80	30582449.40	
Individual Residential Services and Supports - Level 1	Day	435	324.96	70.96	10030735.30	
Individual Residential Services and Supports - Level 2	Day	491	293.04	114.71	16504777.63	
Individual Residential Services and Supports - Level 3	Day	309	279.55	140.20	12110609.19	
Individual Residential Services and Supports - Level 4	Day	271	285.24	170.49	13178883.82	
Individual Residential Services and Supports - Level 5	Day	436	293.50	196.40	25132522.40	
Individual Residential Services and Supports - Level 6	Day	357	273.22	246.62	24055201.35	
Individual Residential Services and	Day	38	259.18	363.37	3578772.99	

GRAND TOTAL:	556823487.96
Total Estimated Unduplicated Participants:	7525
Factor D (Divide total by number of participants):	73996.48
Average Length of Stay on the Waiver:	337

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supports - Level 7						
Individual Residential Services and Supports/Host Home - Level 1	Day	367	289.44	65.74	6983197.32	
Individual Residential Services and Supports/Host Home - Level 2	Day	934	310.81	106.31	30861425.17	
Individual Residential Services and Supports/Host Home - Level 3	Day	798	320.50	129.88	33217978.92	
Individual Residential Services and Supports/Host Home - Level 4	Day	802	303.80	158.23	38552359.75	
Individual Residential Services and Supports/Host Home - Level 5	Day	941	315.56	181.97	54034528.46	
Individual Residential Services and Supports/Host Home - Level 6	Day	690	308.19	228.51	48592902.86	
Individual Residential Services and Supports/Host Home - Level 7	Day	25	270.67	285.75	1933598.81	
Supported Employment Total:						26375632.87
Supported Employment - Job Coaching - Group Support Level 1	15 min	270	2058.90	3.44	1912306.32	
Supported Employment - Job Coaching - Group Support Level 2	15 min	355	1777.12	3.78	2384717.33	
Supported Employment - Job Coaching - Group Support Level 3	15 min	218	1909.59	4.20	1748420.60	
Supported Employment - Job Coaching - Group Support Level 4	15 min	187	1431.77	4.86	1301221.21	
Supported Employment - Job Coaching - Group Support Level 5	15 min	226	1860.26	5.79	2434224.62	
Supported Employment - Job Coaching - Group	15 min	185	1790.99	7.57	2508191.95	

GRAND TOTAL:	556823487.96
Total Estimated Unduplicated Participants:	7525
Factor D (Divide total by number of participants):	73996.48
Average Length of Stay on the Waiver:	337

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Support Level 6						
Supported Employment - Job Coaching - Individual	15 min	939	1048.48	14.20	13980222.62	
Supported Employment - Job Development - Individual Support Level 1-2	15 min	17	293.38	14.20	70821.93	
Supported Employment - Job Development - Individual Support Level 3-4	15 min	14	80.86	14.20	16074.97	
Supported Employment - Job Development - Individual Support Level 5-6	15 min	14	23.00	14.20	4572.40	
Supported Employment - Job Development - Group	15 min	8	408.00	4.53	14785.92	
Supported Employment Job Placement - Group	Session	1	72.00	1.00	72.00	
Supported Employment Job Placement - Individual	Session	1	1.00	1.00	1.00	
Supported Employment - Job Development - Individual	15 min	0	0.00	0.01	0.00	
Dental Services Total:						474558.82
Major	Session	294	1.00	1005.19	295525.86	
Preventative-Basic	Session	316	1.00	566.56	179032.96	
Vision Services Total:						819251.04
Vision Services	Item	2264	1.00	361.86	819251.04	
Behavioral Services Total:						10225390.18
Behavioral Line Staff Services	15 min	337	241.12	7.23	587491.29	
Behavioral Consultation	15 min	2050	42.39	25.54	2219413.23	
Behavioral Counseling - Individual	15 min	2042	123.42	25.54	6436683.77	
Behaviroal Counseling -					137591.24	

GRAND TOTAL:	556823487.96
Total Estimated Unduplicated Participants:	7525
Factor D (Divide total by number of participants):	73996.48
Average Length of Stay on the Waiver:	337

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Group	15 min	193	82.80	8.61		
Behavioral Plan Assessment	15 min	1265	26.13	25.54	844210.65	
Home Delivered Meals Total:						12904.15
Home Delivered Meals	Per meal	7	161.00	11.45	12904.15	
Non Medical Transportation Total:						19024144.11
Public Conveyance	Item	1311	1.00	1060.99	1390957.89	
Mileage Range 0-10	Trip	4155	288.08	6.58	7876078.39	
Mileage Range 11-20	Trip	1965	244.87	13.77	6625704.70	
Mileage Ranged >20	Trip	712	209.73	20.97	3131403.13	
Peer Mentorship Total:						142.08
Peer Mentorship	15 min	1	24.00	5.92	142.08	
Peer Mentorship - Telehealth	15 min	0	0.00	0.01	0.00	
Specialized Medical Equipment and Supplies Total:						725279.94
Equipment	Item	215	2.09	689.37	309768.41	
Disposable Supplies	Item	1341	5.40	57.38	415511.53	
Transition Setup Total:						7117.90
Transition Setup Coordinator	15min	5	32.00	7.66	1225.60	
Transition Setup Expense	Per Transition	5	1.00	1178.46	5892.30	

GRAND TOTAL:	556823487.96
Total Estimated Unduplicated Participants:	7525
Factor D (Divide total by number of participants):	73996.48
Average Length of Stay on the Waiver:	337

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						101591259.44
Specialized Habilitation Support Level 1	15 min	377	1733.45	2.63	1718733.01	
Specialized Habilitation Support Level 2	15 min	952	1866.55	2.90	5153171.24	
Specialized Habilitation Support Level 3	15 min	849	2104.82	3.23	5771984.74	
Specialized Habilitation Support Level 4	15 min	758	2111.26	3.80	6081273.30	
Specialized Habilitation Support Level 5	15 min	1208	2086.71	4.70	11847504.70	
Specialized Habilitation Support Level 6	15 min	785	2136.47	6.75	11320620.41	
Specialized Habilitation Support Level 7	15 min	203	2981.42	10.64	6439628.69	
Supported Community Connections Support Level 1	15 min	576	1557.10	3.21	2879015.62	
Supported Community Connections Support Level 2	15 min	1209	1837.68	3.51	7798360.47	
Supported Community Connections Support Level 3	15 min	961	1695.81	3.97	6469803.44	
Supported Community Connections Support Level 4	15 min	1079	1848.72	4.55	9076198.40	
Supported Community Connections Support Level 5	15 min	1348	1994.50	5.48	14733451.28	
Supported Community Connections Support Level 6	15 min	934	1694.54	7.21	11411269.60	
Supported Community Connections Support Level 7	15 min	40	2091.74	10.64	890244.54	
Prevocational Services Total:						3113871.35
Prevocational Services Level 1	15 min	56	1368.35	2.63	201530.59	
Prevocational Services Level 2	15 min	127	1470.20	2.90	541474.66	
Prevocational					430842.34	

GRAND TOTAL:	648968374.04
Total Estimated Unduplicated Participants:	8422
Factor D (Divide total by number of participants):	77056.33
Average Length of Stay on the Waiver:	329

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services Level 3	15 min	86	1551.02	3.23		
Prevocational Services Level 4	15 min	79	1826.68	3.80	548369.34	
Prevocational Services Level 5	15 min	78	1977.13	4.70	724815.86	
Prevocational Services Level 6	15 min	73	1353.30	6.75	666838.58	
Residential Habilitation Total:						481250520.73
Group Residential Services and Supports - Level 1	Day	92	289.09	123.27	3278523.44	
Group Residential Services and Supports - Level 2	Day	224	339.29	148.41	11279302.47	
Group Residential Services and Supports - Level 3	Day	153	306.23	167.54	7849783.45	
Group Residential Services and Supports - Level 4	Day	181	297.05	191.71	10307489.45	
Group Residential Services and Supports - Level 5	Day	227	259.43	209.64	12345827.48	
Group Residential Services and Supports - Level 6	Day	179	267.70	243.38	11662355.85	
Group Residential Services and Supports - Level 7	Day	216	314.27	483.80	32841466.42	
Individual Residential Services and Supports - Level 1	Day	561	297.46	75.06	12525642.00	
Individual Residential Services and Supports - Level 2	Day	625	270.65	121.53	20557559.06	
Individual Residential Services and Supports - Level 3	Day	381	277.33	148.56	15697255.17	
Individual Residential Services and Supports - Level 4	Day	336	280.41	180.09	16967676.40	
Individual Residential Services and Supports - Level 5	Day	516	287.11	208.79	30931979.60	
Individual Residential Services and Supports - Level 6	Day	437	279.72	261.66	31984700.88	
Individual Residential Services and	Day	47	266.42	363.37	4550024.66	

GRAND TOTAL:	648968374.04
Total Estimated Unduplicated Participants:	8422
Factor D (Divide total by number of participants):	77056.33
Average Length of Stay on the Waiver:	329

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supports - Level 7						
Individual Residential Services and Supports/Host Home - Level 1	Day	393	280.09	69.31	7629323.89	
Individual Residential Services and Supports/Host Home - Level 2	Day	996	296.12	112.39	33147803.09	
Individual Residential Services and Supports/Host Home - Level 3	Day	875	313.63	137.30	37678724.12	
Individual Residential Services and Supports/Host Home - Level 4	Day	1004	305.81	167.43	51406575.37	
Individual Residential Services and Supports/Host Home - Level 5	Day	1165	308.93	193.01	69464964.88	
Individual Residential Services and Supports/Host Home - Level 6	Day	791	294.14	241.84	56267640.72	
Individual Residential Services and Supports/Host Home - Level 7	Day	40	251.61	285.75	2875902.30	
Supported Employment Total:						29106123.85
Supported Employment - Job Coaching - Group Support Level 1	15 min	281	1911.01	3.53	1895588.15	
Supported Employment - Job Coaching - Group Support Level 2	15 min	371	1671.60	3.87	2400033.13	
Supported Employment - Job Coaching - Group Support Level 3	15 min	238	1796.71	4.31	1843029.18	
Supported Employment - Job Coaching - Group Support Level 4	15 min	189	1586.66	4.98	1493396.13	
Supported Employment - Job Coaching - Group Support Level 5	15 min	237	1853.44	5.93	2604843.11	
Supported Employment - Job Coaching - Group	15 min	213	1836.89	7.76	3036158.74	

GRAND TOTAL:	648968374.04
Total Estimated Unduplicated Participants:	8422
Factor D (Divide total by number of participants):	77056.33
Average Length of Stay on the Waiver:	329

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Support Level 6						
Supported Employment - Job Coaching - Individual	15 min	1052	1024.55	14.56	15693155.30	
Supported Employment - Job Development - Individual Support Level 1-2	15 min	0	0.00	0.01	0.00	
Supported Employment - Job Development - Individual Support Level 3-4	15 min	0	0.00	0.01	0.00	
Supported Employment - Job Development - Individual Support Level 5-6	15 min	0	0.00	0.01	0.00	
Supported Employment - Job Development - Group	15 min	9	269.67	4.64	11261.42	
Supported Employment Job Placement - Group	Item	4	406.00	1.00	1624.00	
Supported Employment Job Placement - Individual	Item	1	250.00	1.00	250.00	
Supported Employment - Job Development - Individual	15 min	51	170.74	14.56	126784.69	
Dental Services Total:						232453.09
Major	Session	151	1.00	1005.19	151783.69	
Preventative-Basic	Session	140	1.00	576.21	80669.40	
Vision Services Total:						761353.44
Vision Services	Item	2104	1.00	361.86	761353.44	
Behavioral Services Total:						10486262.55
Behavioral Line Staff Services	15 min	476	241.55	7.41	851985.50	
Behavioral Consultation	15 min	2317	39.07	26.16	2368138.97	
Behavioral Counseling - Individual	15 min	2312	100.18	26.18	6063711.07	
Behaviroal Counseling -					121948.30	

GRAND TOTAL:	648968374.04
Total Estimated Unduplicated Participants:	8422
Factor D (Divide total by number of participants):	77056.33
Average Length of Stay on the Waiver:	329

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Group	15 min	156	88.53	8.83		
Behavioral Plan Assessment	15 min	1509	27.35	26.18	1080478.71	
Home Delivered Meals Total:						13230.98
Home Delivered Meals	Per meal	7	161.00	11.74	13230.98	
Non Medical Transportation Total:						21570824.95
Public Conveyance	Item	1510	1.00	1067.89	1612513.90	
Mileage Range 0-10	Trip	4489	263.68	6.74	7977865.16	
Mileage Range 11-20	Trip	2304	234.13	14.11	7611435.19	
Mileage Ranged >20	Trip	966	210.46	21.49	4369010.70	
Peer Mentorship Total:						274.56
Peer Mentorship	15 min	1	24.00	6.07	145.68	
Peer Mentorship - Telehealth	15 min	1	24.00	5.37	128.88	
Specialized Medical Equipment and Supplies Total:						835050.80
Equipment	Item	250	2.03	689.37	349855.28	
Disposable Supplies	Item	1623	5.21	57.38	485195.53	
Transition Setup Total:						7148.30
Transition Setup Coordinator	15 min	5	32.00	7.85	1256.00	
Transition Setup Expense	Per Transition	5	1.00	1178.46	5892.30	
				GRAND TOTAL:		648968374.04
				Total Estimated Unduplicated Participants:		8422
				Factor D (Divide total by number of participants):		77056.33
				Average Length of Stay on the Waiver:		329

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						131226941.99
Specialized Habilitation Support Level 1	15 min	416	1833.64	3.35	2555360.70	
Specialized Habilitation Support Level 2	15 min	986	1866.55	3.62	6662314.25	
Specialized Habilitation Support Level 3	15 min	825	2124.82	3.96	6941786.94	
Specialized Habilitation Support Level 4	15 min	898	2111.26	4.54	8607438.12	
Specialized Habilitation Support Level 5	15 min	1120	2066.26	5.46	12635593.15	
Specialized Habilitation Support Level 6	15 min	760	2136.47	7.55	12259064.86	
Specialized Habilitation Support Level 7	15 min	239	2981.42	11.52	8208684.06	
Supported Community Connections Support Level 1	15 min	734	1591.24	3.94	4601802.43	
Supported Community Connections Support Level 2	15 min	1403	1848.71	4.24	10997458.15	
Supported Community Connections Support Level 3	15 min	1090	1665.46	4.71	8550305.09	
Supported Community Connections Support Level 4	15 min	1205	1848.72	5.30	11806850.28	
Supported Community Connections Support Level 5	15 min	1461	2018.43	6.25	18430788.94	
Supported Community Connections Support Level 6	15 min	1075	1674.80	8.02	14439288.20	
Supported Community Connections Support Level 7	15 min	188	2091.74	11.52	4530206.82	
Prevocational Services Total:						3988628.04
Prevocational Services Level 1	15 min	61	1368.35	3.35	279622.32	
Prevocational Services Level 2	15 min	137	1470.20	3.62	729130.99	
Prevocational					571209.65	

GRAND TOTAL:	780229654.10
Total Estimated Unduplicated Participants:	9076
Factor D (Divide total by number of participants):	85966.25
Average Length of Stay on the Waiver:	332

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services Level 3	15 min	93	1551.02	3.96		
Prevocational Services Level 4	15 min	85	1826.68	4.54	704915.81	
Prevocational Services Level 5	15 min	84	1977.13	5.46	906790.90	
Prevocational Services Level 6	15 min	78	1353.30	7.55	796958.37	
Residential Habilitation Total:						566147360.58
Group Residential Services and Supports - Level 1	Day	103	286.14	129.40	3813731.15	
Group Residential Services and Supports - Level 2	Day	199	327.47	156.34	10188135.30	
Group Residential Services and Supports - Level 3	Day	147	303.86	177.66	7935613.84	
Group Residential Services and Supports - Level 4	Day	174	318.61	203.67	11291085.97	
Group Residential Services and Supports - Level 5	Day	196	295.15	224.56	12990661.26	
Group Residential Services and Supports - Level 6	Day	152	267.70	262.85	10695471.64	
Group Residential Services and Supports - Level 7	Day	226	314.27	483.80	34361904.68	
Individual Residential Services and Supports - Level 1	Day	734	297.46	79.90	17445017.64	
Individual Residential Services and Supports - Level 2	Day	798	286.69	129.82	29700040.45	
Individual Residential Services and Supports - Level 3	Day	473	277.33	159.65	20942422.42	
Individual Residential Services and Supports - Level 4	Day	427	289.43	195.79	24197022.37	
Individual Residential Services and Supports - Level 5	Day	611	280.07	226.90	38827756.51	
Individual Residential Services and Supports - Level 6	Day	538	284.54	287.93	44077049.98	
Individual Residential Services and	Day	71	343.90	363.37	8872368.95	

GRAND TOTAL:	780229654.10
Total Estimated Unduplicated Participants:	9076
Factor D (Divide total by number of participants):	85966.25
Average Length of Stay on the Waiver:	332

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supports - Level 7						
Individual Residential Services and Supports/Host Home - Level 1	Day	391	281.86	73.64	8115662.63	
Individual Residential Services and Supports/Host Home - Level 2	Day	1012	298.67	119.62	36155628.26	
Individual Residential Services and Supports/Host Home - Level 3	Day	926	301.48	147.05	41052019.08	
Individual Residential Services and Supports/Host Home - Level 4	Day	1018	302.30	180.33	55495006.66	
Individual Residential Services and Supports/Host Home - Level 5	Day	1181	310.26	208.92	76551852.18	
Individual Residential Services and Supports/Host Home - Level 6	Day	817	320.78	265.13	69484543.94	
Individual Residential Services and Supports/Host Home - Level 7	Day	55	251.61	285.75	3954365.66	
Supported Employment Total:						38361130.90
Supported Employment - Job Coaching - Group Support Level 1	15 min	275	1911.01	4.26	2238748.22	
Supported Employment - Job Coaching - Group Support Level 2	15 min	358	1671.60	4.61	2758775.21	
Supported Employment - Job Coaching - Group Support Level 3	15 min	229	1796.71	5.06	2081919.75	
Supported Employment - Job Coaching - Group Support Level 4	15 min	181	1586.66	5.74	1648444.54	
Supported Employment - Job Coaching - Group Support Level 5	15 min	224	1853.44	6.71	2785794.46	
Supported Employment - Job Coaching - Group	15 min	206	1836.89	8.58	3246666.34	

GRAND TOTAL:	780229654.10
Total Estimated Unduplicated Participants:	9076
Factor D (Divide total by number of participants):	85966.25
Average Length of Stay on the Waiver:	332

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Support Level 6						
Supported Employment - Job Coaching - Individual	15 min	1431	1045.92	15.51	23213995.68	
Supported Employment - Job Development - Individual Support Level 1-2	15 min	0	0.00	0.01	0.00	
Supported Employment - Job Development - Individual Support Level 3-4	15 min	0	0.00	0.01	0.00	
Supported Employment - Job Development - Individual Support Level 5-6	15 min	0	0.00	0.01	0.00	
Supported Employment - Job Development - Group	15 min	10	363.17	5.40	19611.18	
Supported Employment Job Placement - Group	Item	1	406.00	1.00	406.00	
Supported Employment Job Placement - Individual	Item	4	250.00	1.00	1000.00	
Supported Employment - Job Development - Individual	15 min	138	170.89	15.51	365769.54	
Dental Services Total:						186928.53
Major	Session	123	1.00	1005.19	123638.37	
Preventative-Basic	Session	108	1.00	586.02	63290.16	
Vision Services Total:						711002.88
Vision Services	Item	1728	1.00	411.46	711002.88	
Behavioral Services Total:						12654134.85
Behavioral Line Staff Services	15 min	700	241.55	7.56	1278282.60	
Behavioral Consultation	15 min	2549	41.42	26.70	2818974.79	
Behavioral Counseling - Individual	15 min	2440	101.91	26.70	6639232.68	
Behaviroal Counseling -					141982.64	

GRAND TOTAL:	780229654.10
Total Estimated Unduplicated Participants:	9076
Factor D (Divide total by number of participants):	85966.25
Average Length of Stay on the Waiver:	332

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Group	15 min	178	88.53	9.01		
Behavioral Plan Assessment	15 min	2345	28.36	26.70	1775662.14	
Home Delivered Meals Total:						34018.74
Home Delivered Meals	Per meal	7	406.00	11.97	34018.74	
Non Medical Transportation Total:						25959370.01
Public Conveyance	Item	1653	1.00	858.27	1418720.31	
Mileage Range 0-10	Trip	4641	263.68	9.64	11796842.80	
Mileage Range 11-20	Trip	2395	234.13	14.38	8063460.61	
Mileage Ranged >20	Trip	1015	210.46	21.91	4680346.28	
Peer Mentorship Total:						297.12
Peer Mentorship	15 min	1	24.00	6.19	148.56	
Peer Mentorship - Telehealth	15 min	1	24.00	6.19	148.56	
Specialized Medical Equipment and Supplies Total:						952666.56
Equipment	Item	212	1.65	883.43	309023.81	
Disposable Supplies	Item	1889	5.66	60.20	643642.75	
Transition Setup Total:						7173.90
Transition Setup Coordinator	15 min	5	32.00	8.01	1281.60	
Transition Setup Expense	Per Transition	5	1.00	1178.46	5892.30	
				GRAND TOTAL:		780229654.10
				Total Estimated Unduplicated Participants:		9076
				Factor D (Divide total by number of participants):		85966.25
				Average Length of Stay on the Waiver:		332

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						137529345.46
Specialized Habilitation Support Level 1	15 min	435	1939.62	3.35	2826511.24	
Specialized Habilitation Support Level 2	15 min	1032	1866.55	3.62	6973132.15	
Specialized Habilitation Support Level 3	15 min	863	2145.01	3.96	7330528.77	
Specialized Habilitation Support Level 4	15 min	940	2111.26	4.54	9010013.18	
Specialized Habilitation Support Level 5	15 min	1173	2046.01	5.46	13103834.73	
Specialized Habilitation Support Level 6	15 min	795	2136.47	7.55	12823627.06	
Specialized Habilitation Support Level 7	15 min	250	2981.42	11.52	8586489.60	
Supported Community Connections Support Level 1	15 min	768	1626.13	3.94	4920539.29	
Supported Community Connections Support Level 2	15 min	1469	1859.80	4.24	11583875.89	
Supported Community Connections Support Level 3	15 min	1141	1635.65	4.71	8790163.02	
Supported Community Connections Support Level 4	15 min	1262	1848.72	5.30	12365348.59	
Supported Community Connections Support Level 5	15 min	1529	2042.65	6.25	19520074.06	
Supported Community Connections Support Level 6	15 min	1126	1655.29	8.02	14948129.45	
Supported Community Connections Support Level 7	15 min	197	2091.74	11.52	4747078.43	
Prevocational Services Total:						4171519.58
Prevocational Services Level 1	15 min	63	1368.35	3.35	288790.27	
Prevocational Services Level 2	15 min	143	1470.20	3.62	761063.73	
Prevocational					595777.80	

GRAND TOTAL:	818486772.27
Total Estimated Unduplicated Participants:	9500
Factor D (Divide total by number of participants):	86156.50
Average Length of Stay on the Waiver:	337

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services Level 3	15 min	97	1551.02	3.96		
Prevocational Services Level 4	15 min	89	1826.68	4.54	738088.32	
Prevocational Services Level 5	15 min	88	1977.13	5.46	949971.42	
Prevocational Services Level 6	15 min	82	1353.30	7.55	837828.03	
Residential Habilitation Total:						593739670.42
Group Residential Services and Supports - Level 1	Day	108	286.14	129.40	3998863.73	
Group Residential Services and Supports - Level 2	Day	208	327.47	156.34	10648905.24	
Group Residential Services and Supports - Level 3	Day	154	303.86	177.66	8313500.21	
Group Residential Services and Supports - Level 4	Day	182	323.25	203.67	11982211.60	
Group Residential Services and Supports - Level 5	Day	205	296.57	224.56	13652540.64	
Group Residential Services and Supports - Level 6	Day	159	267.70	262.85	11188026.26	
Group Residential Services and Supports - Level 7	Day	237	314.27	483.80	36034386.76	
Individual Residential Services and Supports - Level 1	Day	768	297.46	79.90	18253097.47	
Individual Residential Services and Supports - Level 2	Day	835	286.17	129.82	31020742.15	
Individual Residential Services and Supports - Level 3	Day	495	277.33	159.65	21916488.58	
Individual Residential Services and Supports - Level 4	Day	447	291.56	195.79	25516785.98	
Individual Residential Services and Supports - Level 5	Day	640	281.04	226.90	40811504.64	
Individual Residential Services and Supports - Level 6	Day	563	284.54	287.93	46125240.04	
Individual Residential Services and	Day	74	350.54	363.37	9425803.27	

GRAND TOTAL:	818486772.27
Total Estimated Unduplicated Participants:	9500
Factor D (Divide total by number of participants):	86156.50
Average Length of Stay on the Waiver:	337

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supports - Level 7						
Individual Residential Services and Supports/Host Home - Level 1	Day	409	282.88	73.64	8519994.83	
Individual Residential Services and Supports/Host Home - Level 2	Day	1059	299.25	119.62	37908265.82	
Individual Residential Services and Supports/Host Home - Level 3	Day	970	303.86	147.05	43342134.61	
Individual Residential Services and Supports/Host Home - Level 4	Day	1065	302.30	180.33	58057153.34	
Individual Residential Services and Supports/Host Home - Level 5	Day	1236	310.34	208.92	80137583.74	
Individual Residential Services and Supports/Host Home - Level 6	Day	855	320.78	265.13	72716383.20	
Individual Residential Services and Supports/Host Home - Level 7	Day	58	251.61	285.75	4170058.34	
Supported Employment Total:						40647054.55
Supported Employment - Job Coaching - Group Support Level 1	15 min	287	1911.01	4.26	2336439.05	
Supported Employment - Job Coaching - Group Support Level 2	15min	375	1671.60	4.61	2889778.50	
Supported Employment - Job Coaching - Group Support Level 3	15min	239	1796.71	5.06	2172833.27	
Supported Employment - Job Coaching - Group Support Level 4	15min	189	1586.66	5.74	1721303.97	
Supported Employment - Job Coaching - Group Support Level 5	15 min	234	1853.44	6.71	2910160.28	
Supported Employment - Job Coaching - Group	15 min	216	1836.89	8.58	3404271.50	

GRAND TOTAL:	818486772.27
Total Estimated Unduplicated Participants:	9500
Factor D (Divide total by number of participants):	86156.50
Average Length of Stay on the Waiver:	337

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Support Level 6						
Supported Employment - Job Coaching - Individual	15min	1498	1067.74	15.51	24807849.81	
Supported Employment - Job Development - Individual Support Level 1-2	15min	0	0.00	0.01	0.00	
Supported Employment - Job Development - Individual Support Level 3-4	15min	0	0.00	0.01	0.00	
Supported Employment - Job Development - Individual Support Level 5-6	15min	0	0.00	0.01	0.00	
Supported Employment - Job Development - Group	15min	10	363.17	5.40	19611.18	
Supported Employment Job Placement - Group	Item	1	406.00	1.00	406.00	
Supported Employment Job Placement - Individual	Item	4	250.00	1.00	1000.00	
Supported Employment - Job Development - Individual	15 min	145	170.48	15.51	383401.00	
Dental Services Total:						197017.51
Major	Session	129	1.00	1005.19	129669.51	
Preventative-Basic	Session	113	1.00	596.00	67348.00	
Vision Services Total:						746388.44
Vision Services	Item	1814	1.00	411.46	746388.44	
Behavioral Services Total:						13245868.73
Behavioral Line Staff Services	15 min	733	241.55	7.56	1338544.49	
Behavioral Consultation	15 min	2668	41.42	26.70	2950578.55	
Behavioral Counseling - Individual	15 min	2554	101.91	26.70	6949426.34	
Behaviroal Counseling -					148363.89	

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Factor D (Divide total by number of participants):	86156.50
Average Length of Stay on the Waiver:	337

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Group	15 min	186	88.53	9.01		
Behavioral Plan Assessment	15 min	2455	28.36	26.70	1858955.46	
Home Delivered Meals Total:						34018.74
Home Delivered Meals	Per meal	7	406.00	11.97	34018.74	
Non Medical Transportation Total:						27170849.52
Public Conveyance	Item	1730	1.00	858.27	1484807.10	
Mileage Range 0-10	Trip	4858	263.68	9.64	12348429.72	
Mileage Range 11-20	Trip	2507	234.13	14.38	8440541.03	
Mileage Ranged >20	Trip	1062	210.46	21.91	4897071.67	
Peer Mentorship Total:						297.12
Peer Mentorship	15 min	1	24.00	6.19	148.56	
Peer Mentorship - Telehealth	15 min	1	24.00	6.19	148.56	
Specialized Medical Equipment and Supplies Total:						997568.30
Equipment	Item	222	1.65	883.43	323600.41	
Disposable Supplies	Item	1978	5.66	60.20	673967.90	
Transition Setup Total:						7173.90
Transition Setup Coordinator	15 min	5	32.00	8.01	1281.60	
Transition Setup Expense	Per Transition	5	1.00	1178.46	5892.30	

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