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:
Supported Living Services (SLS)

C. Waiver Number:CO.0293
Original Base Waiver Number: CO.0293.

D. Amendment Number:CO.0293.R05.28

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

01/01/24

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

2. Purpose(s) of Amendment

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

The purpose of this amendment is to:

-Add language to Home Accessability Adaptation that work completed prior to approval may not be reimbursed.
-Increase the expense limit for Transition Services Setup from $1,500 to $2,000. This was approved through the passage of the Long Bill for State Fiscal Year (SFY) 23-24. The State increased the rate for Transition Services Setup in Appendix J WY 5 to $2,000. The State did not update the users or units/user or rate methodology.
-Add language to Vehicle Modification that work completed prior to approval may not be reimbursed.

3. Nature of the Amendment

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

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

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

☐ **Modify target group(s)**

☐ **Modify Medicaid eligibility**

☐ **Add/delete services**

☐ **Revise service specifications**

☐ **Revise provider qualifications**

☐ **Increase/decrease number of participants**

☐ **Revise cost neutrality demonstration**

☐ **Add participant-direction of services**

☐ **Other**

Specify:

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

1. Request Information (1 of 3)

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

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

Supported Living Services (SLS)

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.0293
Waiver Number:CO.0293.R05.28
Draft ID: CO.012.05.11

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

Regular Waiver

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

PRA Disclosure Statement

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

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

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

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

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

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

☐ **Nursing Facility**

Select applicable level of care

○ **Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**

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

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

☒ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

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

1. Request Information (3 of 3)

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

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

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

☐ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

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

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

☐ **§1915(b)(2) (central broker)**

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

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

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

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

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

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

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

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

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

2. Brief Waiver Description

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

The Supported Living Services waiver is characterized by the delivery of services and supports targeted specifically to identified and prioritized needs of the participant which assist the participant to live in his or her home and/or to be included as active participants in work and/or social communities and activities. With the assistance of the case manager, through a client-centered planning process, the participant chooses and directs the types of services to be included in the Service Plan. Additionally, the participant selects from among available qualified service providers who are willing to deliver supported living services. The participant retains maximum control over his/her lifes circumstances by controlling his or her own living arrangements through such means as home ownership, a freely-executed rental agreement, or a family residence; and by selecting and tailoring only those services and supports necessary to meet his or her needs. Supported living services may be provided under this waiver when the assistance or support is identified in the participants Service Plan, is directly tied to a need identified and prioritized in the participant's Service Plan, and when the service is not available from the Medicaid State Plan or a third party source.

The purpose of the Supported Living Services waiver is:
• To provide necessary services and supports to an individual with a developmental disability so that the individual can remain in his or her own home and community with minimal intrusion into the Individual’s community life and social supports;
• To promote individual choice and decision-making through the individualized planning process and the tailoring of services and supports to address prioritized unmet needs; and
• To supplement existing natural supports and generic community resources with targeted and cost-effective services and supports

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 08/10/2023 through 09/08/2023:

The process is summarized as follows: The Department sent, via electronic mail, a summary of all proposed changes to all Office of Community Living (OCL) stakeholders. Stakeholders include clients, contractors, families, providers, advocates, and other interested parties. Non-Web-Based Notice: The Department posted notice in the newspaper of the widest circulation in each city with a population of 50,000 or more on 08/10/2023 and 08/24/2023. The Department employed each separate form of notice as described. The Department understands that, by engaging in both separate forms of notice, it will have met the regulatory requirements, CMS Technical Guidance, as well as the guidance given by the CMS Regional Office. The Department posted on its website the full waiver and a summary of any proposed changes to that waiver at https://hcpf.colorado.gov/hcbs-public-comment. The Department made available paper copies of the summary of proposed changes and paper copies of the full waiver. These paper copies were available at the request of individuals. The Department allowed at least 30 days for public comment. The Department complied with the requirements of Section 1902(a)(73) of the Social Security Act by following the Tribal Consultation Requirements outlined in Section 1.4 of its State Plan on 08/10/2023. The Department had the waiver amendment reviewed by the State Medical Care Advisory Committee (otherwise known as “Night MAC”) in accordance with 42 CFR 431.12 and Section 1.4 of the Department’s State Plan on 08/10/2023. In addition to the specific action steps described above, the Department also ensured that all waiver amendment documentation included instructions about obtaining a paper copy. All documentation contains language stating: “You may obtain a paper copy of the waiver and the proposed changes by calling (303) 866-3684 or by visiting the Department at 1570 Grant Street, Denver, Colorado 80203.”

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

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

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

At the end of the 30-day public comment period the Department received 0 comments.

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

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

7. Contact Person(s)

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

Last Name:

Eggers

First Name:

Lana

Title:

Waiver Administration & Compliance Unit Supervisor

Agency:

Colorado Department of Health Care Policy & Financing

Address:

1570 Grant Street

Address 2:

City:

Denver

State: **Colorado**

Zip:

80203

Phone:

(303) 866-2050 **Ext:** ☐ **TTY**

Fax:

(303) 866-2786

E-mail:

Lana.Eggers@state.co.us

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Colorado**

Zip:

Phone:

Ext: TTY

Fax:

E-mail:

8. Authorizing Signature

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

Signature: Julie Masters

State Medicaid Director or Designee

Submission Date: Oct 17, 2023

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

Last Name: Flores-Brennan

First Name: Adela

Title: Medicaid Director

Agency: The Department of Health Care Policy & Financing

Address: 303 E 17th Ave

Address 2:

City: Denver

State: **Colorado**

Zip: 80203

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

Fax: (303) 866-2786

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

Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

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

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

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

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

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

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

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

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A-3: Waiver Administration and Operation: Use of Contracted Entities:

The Dept 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 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 IA, which requires the Dept. and DOH to meet no less than monthly to discuss continued program improvement. DOH's responsibilities include but are not limited to, recruiting and assisting providers with enrollment, reviewing PARs, inspecting completed home modifications, creating standards to ensure a consistent quality of work statewide, managing the client and provider grievance processes, and making regular reports to the Dept. on the quality of the Home Accessibility Adaptations benefit provided to clients.

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.

A-QIS a.ii Quality Improvement Admin Authority, Methods of Discovery(cont.)

A.20
The Dept. delegates responsibility to CMAs to perform waiver operative functions including waiver operational and administrative services, general case management, functional and level of care assessment, service planning, referral care coordination, utilization review, the prior authorization of waiver services within limits, and service monitoring, reporting, and follow up. On-going monitoring is completed through tracking administrative contract deliverables on a monthly, quarterly, semi-annually, and yearly frequency basis depending on the contract deliverable. The contracts require regular reporting to assure appropriate compliance with Dept. policies, procedures, and contractual obligations. The Dept. completes on-site performance and quality monitoring for CMAs that administer the waiver using a sampling process based on a four-year cycle. The Dept. audits CMAs for administrative functions including qualifications of individuals performing assessments and service planning; processes regarding the evaluation of need, service planning, participant monitoring (contacts), case reviews, complaint procedures, provision of participant choice, etc.

A.26
The FMS reviews 100% of CDASS attendants eligible for hire assuring they meet the waiver requirements. The FMS reports this data to the Department through monthly and quarterly reports. The Department utilizes the monthly and quarterly reports to conduct a full audit of enrollment procedures and documentation of cases, chosen at random, to ensure the FMS is completing the mandatory CBI criminal history and Board of Nursing checks and following approved FMS enrollment policies and procedures.

Additional information for E-2-a-ii:

The Department will provide and require oversight for attendants who have been hired through the exception process. Oversight measures for granted exceptions will include in-person monitoring by the case manager including the assessment that the attendant is meeting the member's needs; Department, FMS, Training and Operations vendor, and case manager monitoring of critical incidents; and reminding members and/or authorized representatives education about the state's processes for reporting critical incidents including mistreatment, abuse, neglect, and exploitation.

The CDASS attendant exception process will contain thorough oversight safeguards:

1. An outline of general attendant safety measures will be required for all newly enrolled CDASS members. It will be reviewed and approved by the case manager and Training and Operations Vendor before the member or authorized representative completes enrollment and services are rendered.
2. A formal safety plan will be required for all current CDASS members seeking an exception to hire an individual who was found ineligible. This plan will be created by the member/authorized representative and sent by them to the Department for review.
3. The member's safety plan must demonstrate that the member/authorized representative has considered and planned several defined safety elements related to the individual they are choosing to hire. If the plan does not have thorough responses for each of the elements, the exception will be denied and the individual will remain ineligible for hire as an attendant. The plan may be resubmitted.
4. The Department will notify the member/authorized representative upon approval of the exception and share the safety plan with the member's case manager, FMS, and the Training and Operations Vendor when an exception is processed.
5. Quarterly safety plan review and service assessment by the case manager.
6. Additional fraud, mistreatment, abuse, neglect, and exploitation (MANE) reporting tools developed by the Department and to be implemented by January 2023.
7. Robust educational and training resources for CDASS members/authorized representatives developed by the Training and Operations vendor and to be implemented by January 2023. Increased promotion of its current peer support services.
8. Continual stakeholder engagement will occur for ongoing policy and operational improvements where necessary.

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-2a - Rate Determination Methods:
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 state measures rate sufficiency and compliance with CMS regulations and measures efficiency, economy, quality of care, and sufficiency to enlist providers through analysis of paid claims which show both increases in service utilization and the number of providers year over year. In conjunction with the Department's rate methodology, these services are also reviewed through the Medicaid Provider Rate Review Advisory Committee which conducts geographic analyses related to waiver services which also include measures of efficiency and economy in order to determine if rates are sufficient to enlist providers. This report includes a stakeholder feedback period which is also incorporated into the rate review and claims data analysis and future rate updates to ensure the methodology allows for all elements of service delivery and quality of care.

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

The rate methodology has not been changed; however, rates were rebased in 2018 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 Department instead of an independent contractor (Navigant).

The rates for Life Skills Training and Individual Respite 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.

Dental rates for all IDD Adult waivers were rebased in 2015 and were based on the American Dental Association's Survey of Dental Fees. Since rebasing upon the 2013 mean, the Department 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 Department has not received external stakeholder feedback to warrant a review of the current rates at this time, the Department has reviewed IDD Dental rates regularly and utilizes the 2017 American Dental Association Survey of Dental Fees to ensure sufficiency in reimbursement rates.

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

The previous forecast in CO.0293.R05.03 for Personal Care (Standard), Homemaker – Basic (Standard), and Homemaker – Enhanced (Standard) included a preemptive estimated increase that was implemented during the 2019 Fall Amendments for increased provider cost due to Electronic Visit Verification (EVV) requirements and local municipalities raising the minimum wage. The Dept had put this higher rate into the previous forecast as an estimate. The actual rate in CO.0293.R05.09 turned out to be lower than the previous estimate which accounts for the slight decrease in rates during this forecast. The Dept received legislative approval to increase the rates for this service due to the Denver Minimum Wage increase. The percentage increases as it incorporates the multi-year rate increase.

The previous forecast in CO.0293.R05.03 for Homemaker-Enhanced (CDASS), Personal Care (CDASS), and Homemaker-Basic

(CDASS) included a preemptive estimated increase that was implemented during the 2019 Fall Amendments for increased provider cost due to Electronic Visit Verification (EVV) requirements and local municipalities raising the minimum wage. Once the final policy was established, CDASS was removed from the services that received a rate increase due to EVV. The rate is lower in CO.0293.R05.09 because the 1% reduction and the Denver minimum wage were applied to a lower rate than previous forecasts.

Case managers determine the features required in a PERS (GPS location services, wireless network capability, traditional landline capability, etc.) and the most cost-effective system required to meet the needs of the participant. Case managers must also document the systems and vendors considered and the justification for the system selected in the participant's service plan.

The Dept requires case managers to obtain at least two (2) competitive bids for the Home Accessibility Adaptation and Vehicle Modification services. Payment is authorized to the provider with the most cost-effective bid which meets the needs of the participant.
Assistive Technology and Specialized Medical Equipment and Supplies not covered by the State Plan are reimbursed at a negotiated, manually set price. The rate methodology for Assistive Technology and Specialized Medical Equipment and Supplies is a negotiated, manually set price.

The Assistive Technology benefit requires three competitive bids when items over $2,500 are requested.

Dept guidance for the Specialized Medical Equipment and Supplies benefit suggests CMAs obtain competitive bids when costs are beyond typical for any funding level. State-level approval is required for requests over $1,000, and competitive bids may be requested as part of the approval process.

The State will be utilizing funding from section 9817 of the American Rescue Act of 2021 for the Home Modification/Home Accessibility Adaptation budget enhancement of $10,000. The State will use 9817 ARP funds for the minimum wage rate increases through April of 2023 and then will utilize state general funds approved by legislation starting in April of 2023.

For the amendment with the requested effective date of 11/11/2023, the State is using ARPA funds to cover the first 3 months of rate increases for base wage increases and the non medical transportation rate increases.

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

Supported Employment, Behavioral Services, Life Skills Training, Mentorship, Movement Therapy, 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 SFY 2018-19.

Update for WYs 3-5 for Amendment with the 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: Day Habilitation - Specialized Habilitation Support Level 1-6, Day Habilitation - Supported Community Connections Support Level 1-6, Homemaker Services, Personal Care Services, Prevocational Services, Respite, Supported Employment - Job Coaching and Job Development, Behavioral Services, Hippotherapy, Home Delivered Meals, Life Skills Training, Massage Therapy, Mentorship, Movement Therapy, Non-Medical Transportation - To/From Day Program and Not to/From day Program, Peer Mentorship, and Transition Setup Coordinator. CDASS receives the 2.5% rate increase beginning 11/01/2021.

Information regarding the consolidation of the 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 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 unit descriptor for Supported Employment Job Placement – Group and Individual has been changed to “Item."

The Department included a rate increase associated with the Denver minimum wage increases effective 1/1/2022 for Homemaker - Basic (Standard), Homemaker - Basic (CDASS), Homemaker - Enhanced (Standard), Homemaker - Enhanced (CDASS), Personal Care (Standard), Personal Care (CDASS), and Health Maintenance Activities. The Denver minimum wage will increase from $14.77 an hour to $15.87 an hour.

For Supported Employment - Job Development services, the State used 372 data from SFY 2017-18 through SFY 2018-19 to develop the estimates for the average number of users.

To develop estimates for average units per user for Supported Employment - Job Development the State used 372 data from SFY 2017-18 through SFY 2018-19. The State used dampening factors where appropriate to adjust where certain service utilization is not expected to continue to grow at historical averages. For the Supported Employment - Job Placement services, the State used estimates based on programmatic expectations for utilization as these are new services with no historical reference for utilization estimates.

Update for WYs 4-5 for Amendment with the requested effective date of 07/01/2022:
The purpose of this amendment is to make adjustments on trends for utilizers, units per utilizer, and select rates due to new utilization data. The Department received lag 372 reports for SFY 2019-20 utilization data and has incorporated the latest data into this forecast. When applicable, the Department adjusted trends to incorporate more recent data.

The Department's main trend for units per utilizer is the average of the previous two years of actuals as reported on 372 reports. Utilization reported on the SFY 2019-20 372 report came in lower than expected, resulting in a decrease in utilization for future WYs. Additionally, during the COVID-19 pandemic, utilization trends changed significantly compared to previous year trends. This resulted in eighteen services decreasing in the number of units per user in WYs 4-5.

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. This resulted in the majority of services decreasing the number of units per user in WYs 4-5

The Department has estimated users and units per user for Remote Supports by analyzing similar utilization in other states that currently offer this service, specifically Ohio. Remote Supports data from Ohio were sourced from a 2017 study conducted by the Ohio State University in partnership with the Ohio Department of Developmental Disabilities. Using Ohio’s utilizer rates and the rate at which clients substitute Remote Support for other agency-based services, the State estimated the utilizers and units per utilizer for each waiver.

The units/utilizer for the new Remote Supports options were calculated by estimating the substitution rate for the existing Homemaker and Personal Care services. In this case, the State estimated that 10.37% of existing Personal Care and Homemaker units would be substituted for the new Homemaker - Remote Supports and Personal Care - Remote Supports delivery options.

The cost per unit for Personal Care - Remote Supports and Homemaker - Remote supports was based upon the unit rate for Ohio's Remote Support option and has a cost/hour of $8.56, 15-minute cost of $2.14.

The State has used the average cost per utilizer of the Personal Emergency Response System (PERS) Installation service from previous fiscal years to estimate the unit rate for Remote Support Technology. The estimated rate for the SLS waiver is $58.40. This amount is based upon SFY 2019-20 actuals for PERS Installation.

Update for WY 4-5 for Amendment with a 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 Level 1-6
Day Habilitation - Supported Community Connections Support Level 1-6

Homemaker - Basic (Standard) (in person)
Homemaker - Basic (CDASS) (in person)
Homemaker - Enhanced (Standard) (in person)
Homemaker - Enhanced (CDASS) (in person)
Homemaker Remote Supports
Personal Care (Standard) (in person)
Personal Care (CDASS) (in person)
Personal Care Remote Supports
Prevocational Services Support Level 1-6
Respite - Individual (15 min)
Respite - Individual (Day)
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 Consultation
Behavioral Services - Behavioral Counseling - Individual
Behavioral Services - Behavioral Counseling - Group
Behavioral Services - Behavioral Line Staff Services
Behavioral Services - Behavioral Plan Assessment
Health Maintenance Activities
HippoTherapy - Individual
HippoTherapy - Group
Home Delivered Meals
Life Skills Training
Life Skills Training - Telehealth
Massage Therapy
Mentorship
Movement Therapy - Bachelor
Movement Therapy - Masters
Non-Medical Transportation - To/From Day Program - Mileage Range 0-10
Non-Medical Transportation - To/From Day Program - Mileage Range 11-20
Non-Medical Transportation - To/From Day Program - Mileage Range >20
Non-Medical Transportation - Not To/From Day Program
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-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%
Homemaker Basic (Standard (in person) Outside Denver - 13.948%
Homemaker Basic (CDASS) (in person) Outside Denver - 14.239%
Homemaker Enhanced (Standard (in person) Outside Denver - 8.609%
Homemaker Enhanced (CDASS) (in person) Outside Denver - 8.769%
Homemaker Enhanced (CDASS) (in person) In Denver - 7.128%
Personal Care (Standard) (in person) Outside Denver - 10.762%
Personal Care (CDASS) (in person) Outside Denver - 10.807%

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%
Respite Individual (15 min) - 8.844%
Respite Individual (day) - 11.575%
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%
Health Maintenance Activities Outside Denver - 8.510%
Health Maintenance Activities In Denver - 6.572%
Mentorship - 5.692%

Notes: The State received approval for the above rate increases through Appendix K CO.0293.R05.20 effective 7/01/2022. The State estimates rates based on a weighting of the location in which services are rendered and the rates in each location. The State received a base wage adjustment for services outside of Denver County and updated the weighted rates for this service based on new utilization trends and the updated rates. Due to this weighting, rate increases may not align with the rate increases that were approved in the long bill for counties outside of Denver.

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

The Department used the last two years of 372 reports including state fiscal years 2020 and 2021 and the department’s most recent fee schedule.

Update for WY 5 for Amendment with the requested effective date of 07/01/2023:
For each individual service, the Department considered the number of clients utilizing each service, the number of units per user, the average cost per unit, and the total cost of the service. The Department examined historical growth rates, the fraction of the total population that utilized each service, and graphical trends. Once the historical data was analyzed, the Department selected trend factors to forecast, the number of clients utilizing each service, the number of units per user, and the average cost per unit. Caseload, utilization per client, and cost per unit are multiplied together to calculate the total expenditure for each service and added to derive Factor D. For services that have multiple service levels, these service levels are shown separately.

Historical growth rates: The source of data is 372 waiver reports. The Department reviews data from SFY 2007-08 through SFY 2020-21 but might only include certain 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 between SFY 2018-19 to SFY 2019-20 and between SFY 2019-20 and SFY 2020-21.

Fraction of growth rates: The source of data is 372 waiver reports which include the number of utilizers of each service and total waiver clients. The Department divides services utilizers into total waiver enrollments to calculate the fraction of the total population that uses services. Dates of data are all available historical data which for this waiver dates back to SFY 2007-08 however the Department focuses on more recent data for trend development. In this amendment cycle, for utilizer trends, the Department uses the fraction of total waiver members who used each service in SFY 2019-20 and SFY 2020-21.

Because of impacts on service utilization resulting from the COVID-19 pandemic, the Department has not changed utilizers or units per utilizer projections for services with decreased utilization during the Public Health Emergency (PHE). Most in-person services saw a decrease in utilization beginning in early 2020 of SFY 2019-20 through SFY 2020-21. This includes Behavioral, Dental, Health Maintenance, Hippotherapy, Home Delivered Meals, Homemaker, Life Skills Training, Non-Medical Transportation, Peer Mentorship, Personal Care, Prevocational Services, Respite, Specialized Habilitation, Supported

Community Connections, Job Coaching, Supported Employment, Transition Setup, Vehicle Modification, and Vision services.

Users: As a base trend to estimate utilizers of each service, the Department multiplied the total expected waiver members times the percent of members who used each service in the previous two state fiscal years (SFYs 2019-20 and 2020-21). For example, SFY 2021-22 Behavioral Consultation estimates equal SFY 2021-22 total members times SFY 2019-20 and SFY 2020-21 percent of total members who used that service.

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

There are a number of exceptions to the application of the base utilization trends described above. Due to a decrease in utilization of some services during the public health emergency (PHE), the Department did not forecast utilization for many services using actuals from the PHE (SFY 2019-20 and SFY 2020-21). For example, prevocational services saw fewer utilizers during the peak of the PHE; however, utilization is expected to increase back to pre-pandemic levels in the future.

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

Regarding the new waiver service Benefits Planning and the new Supported Employment Services' subcomponent Workplace Assistance, the Department was granted authority to cover these services in Colorado’s Senate Bill SB21-039 Elimination of Subminimum Wage Employment. The Department used estimates from SB21-039’s fiscal note. To calculate benefits planning utilization in the fiscal note, the Department used SFY 2019-20 Supported Employment Utilizer data times an estimated-take up rate of 5% based on similar service utilizations from other states with similar laws around eliminating subminimum wage employment, most prominently Oregon. The Department assumed half of the utilizers using Job Coaching Group services would utilize Workplace Assistance.

To determine the utilizers of Supported Employment - Workplace Assistance, the Department did not have access to data regarding the utilization of this service and assumed it may be similar to other supported employment services, but that utilization would take time to ramp up following implementation. Thus, the Department selected a utilization rate of half of Job Coaching Group services for the first year of Workplace Assistance implementation.

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

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

The 3% ATB increase is being implemented for the following services: Day Habilitation (Specialized Habilitation Support Levels 1-6, Supported Community Connections Support Levels 1-6, Supported Community Connections Tier 3), Homemaker (Homemaker - Basic (Standard) (in person), Homemaker - Basic (CDASS) (in person), Homemaker - Enhanced (Standard) (in person), Homemaker - Enhanced (CDASS) (in person), Homemaker Remote Supports), Personal Care (Personal Care (Standard) (in person), Personal Care (CDASS) (in person), Personal Care Remote Supports), Prevocational Services Support Levels 1-6, Respite (Individual (15 min), Individual (Day)), Supported Employment (Supported Employment - Job Coaching - Group Support Levels 1-6, Supported Employment - Job Coaching - Individual, Supported Employment - Job Development - Group, Supported Employment - Job Development - Individual), Behavioral Services (Behavioral Consultation, Behavioral Counseling Individual, Behavioral Counseling - Group, Behavioral Line Staff Services, Behavioral Plan Assessment), Health Maintenance Activities, Hippotherapy (Individual, Group), Home Delivered Meals, Life Skills Training, Life Skills Training - Telehealth, Massage Therapy, Movement Therapy (Bachelors, Masters), Mentorship, Peer Mentorship, Peer Mentorship - Telehealth, and Transition Setup Coordinator.

The base wage increase for services outside Denver County is being implemented for the following services: Day Habilitation (Specialized Habilitation Support Levels 1-6, Supported Community Connections Support Levels 1-6), Homemaker (Homemaker - Basic (Standard) (in person), Homemaker - Basic (CDASS) (in person), Homemaker - Enhanced (Standard) (in person), Homemaker - Enhanced (CDASS) (in person), Homemaker Remote Supports), Personal Care (Personal Care (Standard) (in person), Personal Care (CDASS) (in person), Personal Care Remote Supports), Prevocational Services Support Levels 1-6,

Respite (Individual (15 min), Individual (Day)), Supported Employment (Supported Employment - Job Coaching - Group Support Levels 1-6, Supported Employment - Job Coaching - Individual, Supported Employment - Job Development - Group, Supported Employment - Job Development - Individual), Health Maintenance Activities, and Mentorship.

The Denver County minimum wage increase is being implemented for the following services: Day Habilitation (Specialized Habilitation Support Levels 1-6, Supported Community Connections Support Levels 1-6), Homemaker (Homemaker - Basic (Standard) (in person), Homemaker - Basic (CDASS) (in person), Homemaker - Enhanced (Standard) (in person), Homemaker - Enhanced (CDASS) (in person), Homemaker Remote Supports), Personal Care (Personal Care (Standard) (in person), Personal Care (CDASS) (in person), Personal Care Remote Supports), Prevocational Services Support Levels 1-6, Respite (Individual (15 min), Individual (Day)), Supported Employment (Supported Employment - Job Coaching - Group Support Levels 1-6, Supported Employment - Job Coaching - Individual, Supported Employment - Job Development - Group, Supported Employment - Job Development - Individual), Health Maintenance Activities, and Mentorship.

The Department adjusted rates for non-medical transportation services to align with comparable services on other waivers. Rates were adjusted from 0% up to increasing the rates by 53.6%.

Supported Employment - Job Development - Individual Support Level 1-2, Level 3-4 and Level 5-6 - rates were corrected to $0.01. These tiers were removed with waiver amendment CO.0293.R05.14 effective 1/1/2022 and rates were accidently updated during waiver amendment CO.0293.R05.23 effective 7/01/2023. Homemaker - Basic (Standard) (in person), Homemaker - Enhanced (Standard) (in person), Personal Care (Standard) show a decrease in rates as the proportion of Denver County vs Non-Denver County member utilization has changed.

Update for Amendment with a requested effective date of 1/1/2024:
Increase the expense limit for Transition Services Setup from $1,500 to $2,000. This was approved through the passage of the Long Bill for State Fiscal Year (SFY) 23-24. The State increased the rate for Transition Services Setup in Appendix J WY 5 to $2,000. The State did not update the users or units/user or rate methodology.

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 Dept of Health Care & Policy Financing (the Dept) maintains an Interagency Agreement (IA) with the Colorado Dept of Public Health and Environment (CDPHE) to perform quality assurance and quality improvement activities. This agreement allows CDPHE to conduct surveys of and investigate complaints against service providers who provide Specialized Habilitation, Homemaker, Respite, Supported Community Connections, Hippotherapy, Behavioral Therapy, Massage Therapy, Movement Therapy, Supported Employment, Prevocational Services, Life Skills Training, Home Delivered Meals, Transition Set Up and Peer Mentorship.

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

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

The Dept contracts with a Fiscal Agent to maintain the Medicaid Management Information System (MMIS), process claims, assist in the provider enrollment and application processes, 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 Dept. contracts with Fiscal Management Services (FMS) vendors that serve as the financial intermediaries for the Colorado Consumer-Directed Support Services (CDASS) program. In addition, the Dept. contracts with one training and operations vendor that trains participant-directed members, authorized representatives, IHSS provider agencies, and case management agencies. The FMS provides administrative and financial services to CDASS members and/or Authorized Representatives to complete employment-related functions for CDASS attendants and to record, monitor, and report on CDASS member allocations and utilization. The FMS vendor collects and processes attendant timesheets, conducts payroll functions, completes attendant enrollment with required background checks, and services customer complaints and questions. The FMS fulfills requirements to comply with Electronic Visit Verification (EVV) regulations, implement Americans with Disabilities Act accommodations and produce reports demonstrating contractual performance standards. Additionally, the FMS is required to implement necessary systems and services to fully administer newly mandated local, state, and federal laws impacting CDASS. The vendor provides technical assistance, records management, and payment processing for Colorado state employee Sick Time (SB 20-205) and Family and Medical Leave (Proposition 118). This model allows the client the most choice in directing and managing their services as they are the sole employer of the attendant.
Please refer to Appendix E for additional detail on the FMS responsibilities.

The Dept contracts with a Quality Improvement Organization (QIO) in order to consolidate long-term care utilization management functions for waiver programs and Medicaid clients. For the Over Cost Containment (OCC) process the QIO will review for duplication, medical orders, limits prescribed in rule and waiver, assessments outlining needs, and service plans to ensure all items are appropriate for the client. The QIO will also manage appeals that arise from an OCC review denial.

The Dept contracts with a QIO in order to review requests to exceed SLS waiver limitations, the SLS Waiver Exception Review, made by the member and IDT to exceed identified spending limits and service limitations within the SLS waiver. This process will include a review of all services authorized, a review for duplication, medical orders, and other documentation that will justify the request to exceed spending limits and service limitations. The QIO will manage appeals that arise from a denial of the SLS Waiver Exception Review.

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

- duplication of state plan benefits,
- medical orders,
- limits prescribed in rule and waiver,
- assessments outlining needs, and

· service plans to ensure all items are appropriate for the client.
The QIO also testifies, when necessary, at appeals that arise from an HMA review denial.

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

Additional information in Main B. Optional

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

Appendix A: Waiver Administration and Operation

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

○ **Not applicable**

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

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

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

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

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

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

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

Appendix A: Waiver Administration and Operation

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

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

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

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

The administrative evaluation is used to monitor compliance with agency operations and functions as outlined in waiver and department contract requirements. The Department will evaluate CMAs through the on-going tracking of administrative contract deliverables on a monthly, quarterly, semi-annually, and yearly frequency basis depending on the contract deliverable. These documents include: operations guide, personnel descriptions (to ensure the appropriateness of qualifications), complaint logs and procedures, case management training, appeal tracking, and critical incident trend analysis. The review also evaluates agency, community advisory activity, and provider, and other community service coordination. Should the Department find that a CMA is not in compliance with policy or regulations, the agency is required to take corrective action. Technical assistance is provided to CMAs via phone, e-mail, and through meetings. The Department conducts follow-up monitoring to assure corrective action implementation and ongoing compliance. In addition, the contract with the 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 client-specific data. Data includes client referrals, screening, Level of Care (LOC) assessments, individualized service plans, case notes, reassessment documentation, and all other case management activities. Additionally, the BUS is used to track and evaluate timelines for assessments, reassessments, and a notice of action requirements to assure that processes are completed according to Department prescribed schedules. The Department reviews a sample of client files to measure the accuracy of documentation and track the appropriateness of services based upon the LOC determination. Additionally, the sample is used to evaluate compliance with the aforementioned case management functions. These methods are outlined in more detail in Appendix H of this waiver application. The contracted case management agency submits deliverables to the Department on an annual and quarterly basis for review and determination of approval. Case management agencies are evaluated through quality improvement strategy reviews annually which is completed by a quality improvement organization.

The Department oversees the fiscal agent operating the Medicaid Management Information System (MMIS). The fiscal agent is required to submit weekly reports to the Department on meeting performance standards as established in the

contract. The reports include summary data on timely and accurate coding, claims submission, and claims reimbursement, time frames for completion of data entry, processing of claims, and Prior Authorizations. The Department monitors the fiscal agent's compliance with Service Level Agreements through reports submitted by the fiscal agent on customer service activities including provider enrollment, provider publication, and provider training. The Department is able to request ad hoc reports as needed to monitor any additional issues or concerns.

The contract for the Financial Management Services (FMS) vendors was established through a competitive bid process. It is monitored by the Department on an ongoing basis through monthly and quarterly reporting, monthly meetings and ad hoc audits as needed. The Department has an established Participant-Directed Programs Policy Collaborative that meets at least on a quarterly basis. The committee is comprised of clients, family members, Department staff, FMS staff, advocates, and other community stakeholders. The committee discusses a variety of issues that impact participant-directed services. Issues that require quick action are resolved through the use of workgroups comprised of volunteers from the committee. In addition, Department staff have monthly and ad hoc meetings with FMS contractors to resolve issues and maintain open and on-going communication. Additional information about CDASS operations is provided in Appendix E of the waiver application.

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

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

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

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

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

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

Appendix A: Waiver Administration and Operation

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

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

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

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
A.6 Number and Percent of fiscal intermediary service level agreements reviewed by the Dept demonstrating financial monitoring of the SLS waiver N: # of fiscal intermediary service level agreements reviewed by the Dept demonstrating financial monitoring of the SLS 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**
	☐ **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 # of reports required from 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% 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.10 # and % of data reports submitted by the FMS vendor as specified in the contract reviewed by the Dept showing CDASS services are paid in accordance with regs N: # of data reports submitted by FMS vendors as specified in contract reviewed by Dept showing CDASS services are paid in accordance with regs D: Total data reports required to be submitted by FMS vendors 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: FMS Vendors	☐ **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.11 Number and percent of trainings completed by the CDASS training vendor within the timeframe designated and reviewed by the Dept. N: # of trainings completed by the CDASS training vendor within the timeframe designated and reviewed by the Dept. D: Total # of trainings required to be completed within the timeframe designated by the Dept

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: Training 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.13 # and % of payments paid to legally responsible persons and family members by the FMS that do not exceed 40 hours of work per week reviewed by the Dept N: # of payments paid to legally responsible persons and family members by the FMS that do not exceed 40 hours of work per week reviewed by the Dept D: Total # of payments paid to legally responsible persons and family members by the FMS

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: FMS 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.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**

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

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

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

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: DOLA-DOH	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and**	☐ **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:
A.16 Number and percent of quality inspections performed by DOLA-DOH during the performance review period N: Number of quality inspections completed for Home Modifications during the performance period D: Total number of inspections for Home Modification required to be completed during the performance period

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

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

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

Data Aggregation and Analysis:

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

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

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**
☐ **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 suring 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.26 # & % of background check requirements completed by the FMS vendor for newly enrolled CDASS attendants audited by the Dept who meet the requirements in the approved waiver N:# of bkgrnd chk requirements completed by the FMS for new CDASS attendants audited by the Dept who meet the requirements in the apvd wvr D:Total # of bkgrnd chk requirements completed by the FMS for new CDASS attendants

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 level with +/-5% margin of error
☒ **Other** Specify: FMS 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:

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 required reports, documentation and communications to ensure compliance with 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.10, A.13, A.26
To assure oversight of FMS entities, the contractual deliverables are overseen by an administrator at the Dept. and performance is assessed quarterly. An on-site review is conducted at least annually.

A.10
FMS is required to monitor the client’s and/or authorized representative’s submittal of required timesheet information to determine that it is complete, accurate and timely; work with the case manager to address client performance problems; provide monthly reports to the client and/or authorized representative for the purpose of financial reconciliation; and monitoring the expenditure of the annual allocation. Monitoring consists of an internal evaluation of FMS procedures, review of reports, review of complaint logs, re-examination of program data, on-site review, formal audit examinations, and/or any other reasonable procedures.

A.11
The CDASS Training Vendor provides training to assure that case managers, clients and/or authorized representatives understand the philosophy and responsibilities of participant directed care. At minimum, this training includes: an overview of the program, client and/or authorized representative rights and responsibilities, planning and organizing attendant services, managing personnel issues, communication skills, recognizing and recruiting quality attendant support, managing health, allocation budgeting, accessing resources, safety and prevention strategies, managing emergencies, and working with the FMS.

A.13
The Dept. reviews FMS vendor reports to ensure that payments made to legally responsible persons and family members that do not exceed 40 hours or work per week.

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

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

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

Further discussion on Remediation can be found in Main B Optional

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.10, A.11, A.13, A.14, A.15, A.16, A.19, A.20, A.26
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 Department (Dept.) works with sister agencies and/or contracted agencies to provide technical assistance, or some other appropriate resolution based on the identified situation.

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

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

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

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

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

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

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

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

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

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

ii. Remediation Data Aggregation

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

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	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), 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	5569
Year 2	5713
Year 3	5785
Year 4	5881
Year 5	5979

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

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

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

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

e. Allocation of Waiver Capacity.

Select one:

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

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

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

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

Each Community Centered Board administers the waiting list for its service area. Waiting lists must be administered in accordance with Department rules set forth at 10 CCR 2505-10 8.500.96. The guidelines apply to all persons, children and adults, who would receive services through the Community Centered Board (CCB). 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-SLS waiver, an individual can move to any location in the state and maintain waiver enrollment and full choice of available and willing providers.

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**
- ☒ **SSI recipients**
- ☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- ☒ **Optional state supplement recipients**
- ☐ **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

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

Specify percentage:

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

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

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

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

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

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

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

Specify:

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

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

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

Select one and complete Appendix B-5.

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

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

Check each that applies:

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

Select one:

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

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

Specify percentage:

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

Specify dollar amount:

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

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

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

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

Select one:

○ **100% of FPL**

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

- (●) **The following standard included under the state plan**

  Select one:

  - ( ) **SSI standard**
  - ( ) **Optional state supplement standard**
  - ( ) **Medically needy income standard**
  - (●) **The special income level for institutionalized persons**

    (*select one*):

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

      Specify the percentage: [ ]
    - ( ) **A dollar amount which is less than 300%.**

      Specify dollar amount: [ ]
  - ( ) **A percentage of the Federal poverty level**

    Specify percentage: [ ]
  - ( ) **Other standard included under the state Plan**

    Specify:

    [ ]

- ( ) **The following dollar amount**

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

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

  Specify:

  [ ]

- ( ) **Other**

  Specify:

  [ ]

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

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

Specify:

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

- ( ) **SSI standard**
- ( ) **Optional state supplement standard**
- ( ) **Medically needy income standard**
- ( ) **The following dollar amount:**

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

- ( ) **The amount is determined using the following formula:**

Specify:

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

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

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

- ( ) **The amount is determined using the following formula:**

Specify:

- ( ) **Other**

Specify:

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

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

Select one:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

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

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

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

Specify formula:

○ **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 LOC Screen utilizing the state-prescribed LOC Screen instrument, to determine an individual's need for an intermediate care facility for individuals with intellectual disabilities (ICS-IID) level of care. The LOC Screen measures six defined Activities of Daily Living (ADL) and the need for supervision for behavioral or cognitive dysfunction. ADLs include bathing, dressing, toileting, mobility, transferring, and eating. For initial evaluations, the Professional Medical Information Page (PMIP) is also required to be completed by a treating medical professional who verifies the individual's level of care.

Copies of the LOC Screen form and the laws, regulations, policies concerning the level of care criteria are available to the Centers for Medicare and Medicaid Services (CMS) upon request.

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

◉ **The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.**

○ **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

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

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

On initial evaluation, the case manager performs a face-to-face LOC Screen of the participant's abilities to perform activities of daily living and need for supervision due to behavioral, memory, or cognitive issues. The LOC Screen is conducted at the individual's place of residence through observation, participant, and collateral interviews (e.g. family, legal guardian, and natural supports). The participant's primary care provider and medical professionals may also provide information. Case managers are required to complete a participant re-screening within twelve months of the previous 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 he 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 (MMIS) 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 LOC Screens and re-screens are being completed correctly and timely.

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

CCBs maintain the evaluation/re-evaluation records in the State's case management IT system. The Department electronically accesses the documentation 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**

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

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

Performance Measures

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

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

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

Performance Measures

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

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

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

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

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

☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

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

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

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

b. Methods for Remediation/Fixing Individual Problems

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

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

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

ii. Remediation Data Aggregation

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

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

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

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 LOC Screen, the Person-Centered Support Planning process and during the continued stay reviews on alternatives for service delivery, including choice of types of services available through the waiver and among qualified providers. All forms completed through the Person-Centered Support Planning process are available for signature through digital or wet signatures based on the member's preference. The case manager documents that the choice was offered in the PCSP on the state's case management IT system.

Eligible clients with an assessed need may choose to self-direct their care through a combination of the 1915(c) services (Personal Care, Homemaker, and/or Health Maintenance Activities).

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 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	**Homemaker**		
Statutory Service	**Personal Care**		
Statutory Service	**Prevocational Services**		
Statutory Service	**Respite**		
Statutory Service	**Supported Employment**		
Extended State Plan Service	**Dental Services**		
Extended State Plan Service	**Vision Services**		
Other Service	**Assistive Technology**		
Other Service	**Behavioral Services**		
Other Service	**Benefits Planning**		
Other Service	**Health Maintenance Activities**		
Other Service	**Hippotherapy**		
Other Service	**Home Accessibility Adaptations**		
Other Service	**Home Delivered Meals**		
Other Service	**Life Skills Training**		
Other Service	**Massage Therapy**		
Other Service	**Mentorship**		
Other Service	**Movement Therapy**		
Other Service	**Non-Medical Transportation**		
Other Service	**Peer Mentorship**		
Other Service	**Personal Emergency Response**		

Service Type	Service		
Other Service	Recreational Facility Fees/Passes		
Other Service	Remote Support Technology		
Other Service	Specialized Medical Equipment and Supplies		
Other Service	Transition Setup		
Other Service	Vehicle Modifications		

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:	Sub-Category 1:

Category 2:	Sub-Category 2:

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 arrangements, except when due to 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 person's Service Plan. Personal care/assistance may be a component part of day habilitation services as necessary to meet the needs of a participant but may not comprise the entirety of the service. Assistance with activities of daily living provided in this service cannot be duplicative of the ADL assistance provided through the Personal Care Service. 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, which allows the person to gain an increased level of self-sufficiency. These services include the opportunity to select 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. Personal care/assistance may be a component part of day habilitation services as necessary to meet the needs of a participant but may not comprise the entirety of the service. Assistance with activities of daily living provided in this service cannot be duplicative of the ADL assistance provided through the Personal Care Service.

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 and personnel to accompany and support the participant in community settings, resources necessary for participation in activities, and supplies related to skill acquisition, retention, or improvement. Personal care/assistance may be a component part. Assistance with activities of daily living provided in this service cannot be duplicative of the ADL assistance provided through the Personal Care Service. 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.

Day Habilitation services have 3 tiers for service provision:

• Tier 1 - Specialized Habilitation and Supported Community Connections services are provided virtually via telehealth. Tier 1 services should be billed at the Tier 2 rate, according to the member’s Support Level.

• Tier 2 - Traditional Specialized Habilitation and Supported Community Connections services provided in a group setting, apart from the member’s residence, and billed for at the Tier 2 rate, according to the member’s Support Level. Tier 2 Supported Community Connections services may also be provided to a single member, utilizing the community as the learning environment. Tier 2 services are delivered in person.

• Tier 3 - Supported Community Connections services are provided 1:1, to a single member, and billed for at Tier 3 Supported Community Connections rate. Members who receive Supported Community Connections services under Tier 3 are also required to stay within the member’s individual annual dollar limit for the combination of group Tier 2 and Tier 3 Day Habilitation services. Tier 3 services must be delivered in person.

Telehealth is an allowable mode for delivering Specialized Habilitation and Supported Community Connections services. Tier 3 services can not be delivered through telehealth. 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 encouraging and promoting 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 state's 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 at 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. Telehealth is available as an option for members who may not be inclined to participate in person but may still want to participate in services and engage with their community and their friends, when they choose or when they would otherwise be unable 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 at the center. In order to ensure the health and safety of members, case managers and providers must assess the appropriateness of virtual services with members. If it is determined that hands-on assistance is required, virtual services may not be provided. This process will be outlined in each provider's 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.

• Individuals who need assistance utilizing remote delivery of the service will be provided training initially and ongoing if needed on how to use the equipment, including how to turn it on/off.

• Video cameras/monitors are not permitted in bathrooms. Video cameras/monitors may be permitted in bedrooms for members who are bedridden and request to allow the telehealth service delivery option.

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 and Supported Employment Services is 7112 units.

Day Habilitation services cannot be billed during the same time of day as Prevocational Services and Supported Employment Services.

Tier 3 Supported Community Connections services may be billed for at Tier 3 Supported Community Connections rate and when this occurs, the combination of Tier 2 and Tier 3 Day Habilitation services are required to stay within the member's individual annual dollar limit, as well as the unit limit. Members who have an exceptional need to exceed one's individualized annual dollar limit can request additional funding through the Department's exception process.

The HCBS-SLS waiver is not targeted to participants requiring care 24 hours a day, seven days a week. In the event the combined 7,112 unit limitation of Day Habilitation Services and Supports, Prevocational Services, and Supported Employment is not sufficient to meet a participant's needs, the client will be referred to another waiver program such as the HCBS-DD waiver.

Reimbursement for telehealth services is limited to enrolled Colorado Medicaid providers and excludes the purchasing or installation of telehealth equipment or technologies. Tier 3 services can not be provided through telehealth.

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	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

Provider Qualifications

License *(specify):*

None

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.

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

- HIPAA compliant platforms;
- Client support given when client needs include translation, or limited auditory or visual capacities are present;
- Have a contingency plan for provision of services if technology fails; and
- Professionals do not practice outside of their respective scope

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: 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):*

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.

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

- HIPAA compliant platforms;
- Client support given when client needs include translation, or limited auditory or visual capacities are present;
- Have a contingency plan for provision of services if technology fails; and
- Professionals do not practice outside of their respective scope

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: 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, orFour 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.

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

- HIPAA compliant platforms;
- Client support given when client needs include translation, or limited auditory or visual capacities are present;
- Have a contingency plan for provision of services if technology fails; and
- Professionals do not practice outside of their respective scope

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:

Statutory Service

Service:

Homemaker

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

Homemaker Service (in person):
Basic Homemaker Services:

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

Enhanced Homemaker:

Services provided by a qualified homemaker consist of the same household tasks as described under Basic Homemaker services with the addition of either habilitation or extraordinary cleaning. Habilitation includes direct training and instruction to the participant, which is more than basic cueing to prompt the participant to perform a task. Habilitation shall include a training program with specific objectives and anticipated outcomes. There may be some amount of incidental basic homemaker services that are provided in combination with enhanced homemaker services, however, the primary purpose must be to provide habilitative services to increase the independence of the participant. Habilitation may include some hands-on assistance (actually performing a task for the participant) or cueing to prompt the participant to perform a task, only when such support is incidental to the habilitative services being provided and the primary duties must be to
provide habilitative services to increase the independence of the participant. Enhanced Homemaker services also include the need for extraordinary cleaning as a result of the participant's behavioral or medical needs.

Homemaker Remote Supports Service:
Assistance with general household tasks (e.g. meal preparation and routine household care) provided by staff at a remote location who are engaged with the individual to respond to the individual’s health, safety, and other needs through technology/devices with the capability of live two-way communication.
The individual’s interaction with support staff may be scheduled, on-demand, or in response to an alert from a device in the technology integrated system. The type of technology and where it is placed will depend upon the needs and preferences of the individual. Should immobile devices be used for two-way communication, the device must be located in a common area; otherwise, individuals will have the ability to move two-way communication devices freely throughout their residence.

• Each provider of Homemaker Remote Supports must demonstrate policies and procedures that include the use of a HIPAA compliant platform. Each provider will sign an attestation that they are using a HIPAA compliant platform for the technology/devices used. The provider requirements and assurances regarding HIPAA have been approved by the state's HIPAA Compliance Officer.
• The privacy rights of individuals will be assured. The individual has full control of the device. The individual can turn off the device and technology being used and end services any time they choose.
• There will always be an option for in-person support available.
• Policy requires providers to maintain emergency contact protocols in the event the individual requests in-person assistance.
• Policy requires the provider to maintain contact with the individual until the responsible backup person arrives or in the event of an emergency until emergency services personnel arrive.
• Policy requires providers to work collaboratively with the individual, and case manager at a minimum, for selecting Homemaker Remote Supports and identifying goals and desired outcomes in the individual’s Person-Centered Service Plan (PCSP).
• Individuals must have an informed choice between Homemaker and Homemaker Remote Supports.
• This service must be used in conjunction with Remote Support Technology for an integrated support approach.
• This service cannot be duplicative of tasks completed under other waiver services including Personal Care, Personal Care Remote Supports, or Homemaker.

The participant’s Home and Community-Based Services may not be delivered remotely 100% of the time. There will always be an option for in-person services available.

The use of the remote supports option will not block, prohibit or discourage the use of in-person services or access to

the community. When in-person service delivery is not possible or required individuals may not be inclined to receive the service and engage with their community and their providers when they otherwise would not be able to do so due to illness, inclement weather, pandemic, or other personal reasons.

If it is determined that hands-on assistance is required, remote support may not be provided. This process will be outlined in each provider's policies and procedures.

Remote support technology 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.

Individuals who need assistance utilizing remote delivery of the service will be provided training initially and ongoing if needed on how to use the equipment, including how to turn it on/off.

Individuals will maintain the right to revoke consent and discontinue the use of Remote Supports at any time.

Case managers will be responsible for ensuring the health and safety of individuals utilizing remote support during regular monitoring visits.

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

Homemaker service (in person):
N/A

Homemaker Remote Supports Service:
Homemaker Remote Supports must be provided in conjunction with Remote Supports Technology.

Homemaker Remote Supports is provider-managed and must be provided by a Homemaker Remote Supports enrolled Medicaid Provider.

Homemaker Remote Supports service may NOT be provided by:
- Legally Responsible Person
- Relative
- Legal Guardian

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
Individual	Attendants employed under the Consumer Directed Attendant Support Services (CDASS) delivery option
Agency	Community Centered Board (CCB)/Organized Health Care Delivery System (OHCDS)
Agency	Homemaker Remote Supports Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Agency

Provider Type:

Program Approved Service Agency

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

The Department of Health Care Policy & Financing Program Approval

Other Standard *(specify):*

Direct Care Staff: Be at least 18 years of age, have the ability to communicate effectively, complete required forms and reports, and follow verbal and written instructions. Have the ability to provide services in accordance with an 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, as well as through the DPHE survey process initially and every three years.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Individual

Provider Type:

Attendants employed under the Consumer Directed Attendant Support Services (CDASS) delivery option

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Any individual providing this service must be at least 16 years of age and must have the training and/or experience commensurate with the service or support being provided.

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management Services contractor

Frequency of Verification:

Upon employment and as requested by the participant

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Agency

Provider Type:

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

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

The Department of Health Care Policy & Financing Program Approval

Other Standard *(specify):*

Direct Care Staff: Be at least 18 years of age, have the ability to communicate effectively, complete required forms and reports, and follow verbal and written instructions. Have the ability to provide services in accordance with an 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, as well as through the DPHE survey process initially and every three years.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Agency

Provider Type:

Homemaker Remote Supports Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

The provider must meet the standards for a Certified Medicaid provider under 10 C.C.R. 2505-10 Section 8.487 and must receive the Department Remote Support Provider Training Completion Certificate.

Other Standard *(specify):*

• Must 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 competed minimum training based on State training guidelines
• Have necessary ability to perform the required job tasks
• Have the interpersonal skills needed to effectively interact with participants receiving waiver services

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Providers are surveyed at a minimum every 36.9 months. Risk-based surveys may occur more often if a credible complaint is received by CDPHE. Credible complaints are ones that are validated; when investigated they have not been found to be fabricated allegations or misinterpreted impressions of something that did not occur. During the investigation of a complaint by CDPHE, findings are severe - i.e. a systemic failure, patient harm, etc. it may cause an investigation to be converted to a full survey at the time the investigation is underway. The findings of the investigation may be grounds for CDPHE to initiate a full recertification survey of the provider agency regardless of the date of the 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:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

HCBS Taxonomy:

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

Service Definition *(Scope):*

Personal Care Service (in person):
A range of assistance to enable participants to accomplish tasks that they would normally do for themselves (i.e. hygiene, bathing, eating, dressing, grooming, bowel and bladder care, menstrual care, transferring, money management, grocery shopping), if they did not have a developmental disability. This assistance may take the form of hands-on assistance (actually performing a task for the person) or cueing to prompt the participant to perform a task. Personal Care services may be provided on an episodic, emergency, or on a continuing basis.

Self-Directed Personal care under the waiver differs in scope, nature, supervision arrangements, and/or provider type (including provider training and qualifications) from personal care services in the State Plan through Early and Periodic Screening, Diagnostic and Treatment(EPSDT)for waiver participants age 18-20.

The Department maintains a list of licensed Personal Care Agencies which is accessible to the public by request or through this webpage: https://www.colorado.gov/pacific/hcpf/find-doctor

Personal Care Remote Supports Service:
Assistance with eating, bathing, dressing, personal hygiene, activities of daily living that do not require hands-on assistance by staff at a remote location who are engaged with the individual to respond to the individual's health, safety, and other needs through technology/devices with the capability of live two-way communication. These services may include assistance with the preparation of meals but do not include the cost of the meals themselves. When specified in the service plan, this service may also include such housekeeping chores as bed making, dusting, and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the individual, rather than the individual's family.

The individual's interaction with support staff may be scheduled, on-demand, or in response to an alert from a device in the technology integrated system. The type of technology and where it is placed will depend upon the needs and preferences of the individual. Should immobile devices be used for two-way communication, the device must be located in a common area; otherwise, individuals will have the ability to move two-way communication devices freely throughout their residence.

- Each provider of Personal Care Remote Supports must demonstrate policies and procedures that include the use of a HIPAA compliant platform. Each provider will sign an attestation that they are using a HIPAA compliant platform for the technology/devices used. The provider requirements and assurances regarding HIPAA have been approved by the state's HIPAA Compliance Officer.
- The privacy rights of individuals will be assured. The individual has full control of the device. The individual can turn off the device and technology being used and end services any time they choose.
- There will always be an option for in-person support available.
- Policy requires providers to maintain emergency contact protocols in the event the individual requests in-person assistance.
- Policy requires the provider to maintain contact with the individual until the responsible backup person arrives or in the event of an emergency until emergency services personnel arrive.
- Policy requires providers to work collaboratively with the individual, and case manager at a minimum, for selecting Personal Care – Remote Supports and identifying goals and desired outcomes in the individual's Person-Centered Service Plan (PCSP).
- Individuals must have an informed choice between Personal Care and Personal Care Remote Supports.
- This service must be used in conjunction with Remote Support Technology for an integrated support approach.
- This service cannot be duplicative of tasks completed under other waiver services including Homemaker, Personal Care, or Personal Care Remote Supports

The participant's Home and Community-Based Services may not be delivered remotely 100% of the time. There will always be an option for in-person services available.

The use of the remote supports option will not block, prohibit or discourage the use of in-person services or access to the community. When in-person service delivery is not possible or required individuals may not be inclined to receive the service and engage with their community and their providers when they otherwise would not be able to do so due to illness, inclement weather, pandemics, or other personal reasons.

If it is determined that hands-on assistance is required, remote support may not be provided. This process will be outlined in each provider's policies and procedures.

Remote support technology 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.

Individuals who need assistance utilizing remote delivery of the service will be provided training initially and ongoing if needed on how to use the equipment, including how to turn it on/off.

Individuals will maintain the right to revoke consent and discontinue the use of Remote Supports at any time.

Case managers will be responsible for ensuring the health and safety of individuals utilizing remote support during regular monitoring visits.

Remote support technology 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.

Individuals who need assistance utilizing remote delivery of the service will be provided training initially and ongoing if needed on how to use the equipment, including how to turn it on/off.

Individuals will maintain the right to revoke consent and discontinue the use of Remote Supports at any time.

Case managers will be responsible for ensuring the health and safety of individuals utilizing remote support during regular monitoring visits.

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

Personal Care Service (in person):
When Personal Care and health-related services are needed, they may be covered to the extent the Medicaid State Plan, Third Party Resource or another waiver service is not responsible.

This waiver service is only provided to individuals age 21 and over. All medically necessary Personal Care services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit. Personal Care services in the waiver outside the scope of EPSDT (grocery shopping, meal planning and money management) may be accessed by children under age 21.

Waiver participants age 18-20 who utilize the CDASS service delivery option may access Personal Care services through the waiver as self-direction is not an option for service delivery in the State Plan.

Personal Care Remote Supports Service:
Personal Care Remote Supports must be provided in conjunction with Remote Supports Technology.

Personal Care Remote Supports is provider managed and must be provided by a Personal Care Remote Supports enrolled Medicaid Provider.

Personal Care Remote Supports service may NOT be provided by:
- Legally Responsible Person
- Relative
- Legal Guardian

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
Individual	Attendants employed under the Consumer Directed Attendant Support Services (CDASS) delivery option
Agency	Personal Care Remote Supports Provider
Agency	Community Centered Board/Organized Health Care Delivery System

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:

Agency

Provider Type:

Program Approved Service Agency

Provider Qualifications

License *(specify):*

Home Care Agency, Class A or B

Certificate *(specify):*

The Department of Health Care Policy and Financing Program Approval

Other Standard *(specify):*

Direct Care Staff: Be at least 18 years of age, have the ability to communicate effectively, complete required forms and reports, and follow verbal and written instructions. Have the ability to provide services in accordance with an 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.

The Colorado Department of Public Health and Environment (CDPHE) rules dictate training requirements and guidelines in licensure. Training must be delivered and completed prior to the start of services, and must include the following topics: employee duties, differences in personal care and skilled care, consumer rights, handwashing and infection control, emergency response protocols. Additional training required in the first 45 days of employment must include but is not limited to: communication skills, training specialized for people with disabilities, appropriate and safe personal care techniques, maintenance of a safe and clean environment, recognizing and acting in emergencies, etc.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Initially and every three years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:

Individual

Provider Type:

Attendants employed under the Consumer Directed Attendant Support Services (CDASS) delivery option

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Any individual providing this service must be at least 16 years of age and must have the training and/or experience commensurate with the service or support being provided.

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management Services contractor

Frequency of Verification:

Upon employment and as requested by the participant

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:

Agency

Provider Type:

Personal Care Remote Supports Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

The provider must meet the standards for a Certified Medicaid provider under 10 C.C.R. 2505-10 Section 8.487 and must receive the Department Remote Support Provider Training Completion Certificate.

Other Standard *(specify):*

• Must 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 competed minimum training based on State training guidelines
• Have necessary ability to perform the required job tasks
• Have the interpersonal skills needed to effectively interact with participants receiving waiver services

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Providers are surveyed at a minimum every 36.9 months. Risk-based surveys may occur more often if a credible complaint is received by CDPHE. Credible complaints are ones that are validated; when investigated they have not been found to be fabricated allegations or misinterpreted impressions of something that did not occur. During the investigation of a complaint by CDPHE, findings are severe - i.e. a systemic failure, patient harm, etc. it may cause an investigation to be converted to a full survey at the time the investigation is underway. The findings of the investigation may be grounds for CDPHE to initiate a full recertification survey of the provider agency regardless of the date of the last survey.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:

Agency

Provider Type:

Community Centered Board/Organized Health Care Delivery System

Provider Qualifications

License *(specify):*

Home Care Agency, Class A or B

Certificate *(specify):*

The Department of Health Care Policy and Financing Program Approval

Other Standard *(specify):*

Direct Care Staff: Be at least 18 years of age, have the ability to communicate effectively, complete required forms and reports, and follow verbal and written instructions. Have the ability to provide services in accordance with an 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.

The Colorado Department of Public Health and Environment (CDPHE) rules dictate training requirements and guidelines in licensure. Training must be delivered and completed prior to the start of services, and must include the following topics: employee duties, differences in personal care and skilled care, consumer rights, handwashing and infection control, emergency response protocols. Additional training required in the first 45 days of employment must include but is not limited to: communication skills, training specialized for people with disabilities, appropriate and safe personal care techniques, maintenance of a safe and clean environment, recognizing and acting in emergencies, etc.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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 habilitative rather than explicit 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.

While Prevocational Services may continue longer than five years when appropriate documentation show this need, the intended outcome of the service is employment within five years. If at the time of the five year evaluation or any time during those previous five years it is determined the participant is not demonstrating progress toward their goal of community employment, the interdisciplinary team shall review other day program options and the Prevocational Services shall be discontinued.

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 Prevocational Services in combination with Day Habilitation Services and Supported Employment Services is 7112 units.
The HCBS-SLS waiver is not targeted to participant's requiring care 24 hours a day, seven days a week. In the event the combined 7,112 unit limitation of Day Habilitation Services and Supports, Prevocational Services and Supported Employment is not sufficient to meet a participant's needs, the client will be referred to another waiver program such as the HCBS-DD waiver.

This language regarding Prevocational Services has been added to the application.

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 14(C) Certificate

Other Standard *(specify):*

Rules: 10CCR 2505-10 § 8.500.94

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 and Financing and Department of Public Health and Environment

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: 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 14(c) Certificate

Other Standard *(specify):*

Rules: 10 CCR 2505-10 § 8.500.94

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 Associate's 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 and Financing and Department of Public Health and Environment

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

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

Service Definition *(Scope):*

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

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

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

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

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

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

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

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

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

A full day is 10 hours (15 minute units x 4 x 10) or greater within a twenty-four (24) service period.

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

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

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

Program Approval

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Verification of provider qualification is completed 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: Respite

Provider Category:

Agency

Provider Type:

Program Approved Service Agency

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

Program Approval

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Verification of provider qualification is completed 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:

Supported Employment

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03021 ongoing supported employment, individual
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Supported Employment services are the ongoing supports to participants who, because of their disabilities, need intensive on-going support to obtain and maintain a job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce at or above the state's minimum wage, at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals. Supported employment is conducted in a variety of integrated settings in the general workforce, in a job that meets personal and career goals, in which participants interact regularly with non-disabled individuals (other than those individuals who are providing services to the participant).

Colorado is an Employment First state, meaning Competitive Integrated Employment (CIE) is the most preferred outcome for members utilizing HCBS. Supported Employment services are designed to be available on an individual basis to support each member in obtaining, sustaining, and advancing community employment. Supported Employment services are also available to a small group of members (two or more) when a member chooses group employment instead of an individual job. Supported Employment- Group supports members in obtaining, sustaining, and advancing in community employment settings that are in compliance with the HCBS Final Settings Rule. Supported Employment - Individual includes: Job Development, Job Coaching, Job Placement, and Workplace Assistance. Supported Employment - Group includes: Job Development, Job Coaching, and Job Placement.

Participants must be involved in work outside of a base site. Supported Employment Individual supports is not intended for people working in mobile work crews of small groups of people in the community. Group employment (e.g. mobile crews) are services and training activities provided in regular business and industry settings for workers with disabilities and shall not exceed eight persons. Group employment does not include services provided in facility-based work settings or other similar types of vocational services furnished in specialized facilities that are not part of general community workplaces.

Job Development services focus on the 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 support members and to assume full responsibilities for their jobs, including training, systematic instruction, and developing strategies to fade supports as much as possible. Supported Employment services do not include payment for supervision, training, support, and adaptations typically available to other workers without disabilities filling similar positions in the business.

Job Placement could be utilized for purchasing items that a member may need to be set up in a position at its onset. These items may be related to the member's disability/diagnosis or they may be specific to the job and may include a uniform, specific shoes/work boots, or other gear that may be required prior to starting the position. The items would not be covered through the waiver if those items would be considered the responsibility of the employer to provide under the Americans with Disabilities Act of 1990, or the items could be covered by the Division of Vocational Rehabilitation (DVR) via section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq), or the member could cover the cost out of pocket without hardship. Any item purchased under the auspice of Job Placement must directly relate to that member's need related to obtaining and/or sustaining community employment and thus would reduce the likelihood of institutionalization. If a member's needs related to employment are medical in nature, and not something that would be covered by the employer or DVR, the medically necessary items shall be accessed through the Durable Medical Equipment or EPSDT benefit within the Medicaid state plan. Additionally, if the item necessary for employment meets the criteria for Assistive Technology within the Supported Living Services (SLS) Waiver, then the item would be covered under the Assistive Technology waiver service. The state will ensure this is done (no duplication of service/payment) via the member's Case Manager who will coordinate with the Supported Employment provider to identify the employment-specific item and will ensure that all other funding options have been explored and exhausted before authorizing the Job Placement service.

Workplace Assistance services provide support at a member's place of employment for members with elevated supervision needs who, because of valid safety concerns, may need assistance from a paid caregiver to maintain an individual job in an integrated work setting for which the member is compensated at or above minimum wage. The aim of Workplace Assistance is to support members who have been identified as having specific needs that are above and beyond what could be regularly supported by the workplace supervisor or co-workers and are outside the

scope of intermittent Job Coaching support. The degree to which the member must be supported by a paid caregiver directly (as opposed to natural supports), should be based on actual needs related to the member, and the nature and specific details of their position and work location. The goal of the Workplace Assistance service is to address the safety-related needs of the member in order to maintain/sustain community employment or self-employment while promoting the member's independence and integration at the worksite.

Workplace Assistance services should encourage members to maximize their independence through the development of safety skills and the engagement of natural supports (e.g., supervisors and co-workers). Workplace Assistance is provided on a one-on-one basis and may be delivered intermittently, regularly, throughout the member's shift, or at times adjacent to the shift.

Workplace Assistance supports the member by promoting integration, furthering natural support relationships, reinforcing/modeling safety skills, assisting with behavioral support needs (including implementation of behavioral support plans), redirecting, and reminders to follow work-related protocols/strategies. Workplace Assistance can also support the member with activities that are beyond job-related tasks that ensure they are integrated and successful at work, such as: assisting, if necessary, during breaks, lunches, occasional informal employee gatherings, and employer-sponsored events.

Prior to Workplace Assistance being utilized, efforts have been made to promote the member's independence with job tasks and minimize the need for the consistent presence of a paid caregiver by ensuring adequate job training, advocating for appropriate accommodations, leveraging natural supports, integrating technology, and using systematic instruction techniques.

Personal care/assistance may be a component part of Supported Employment services but may not comprise the entirety of the service.

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 encouraging and promoting 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 state's 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 at 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. Telehealth is available as an option for members who may not be inclined to participate in person but may still want to participate in services and engage with their community and their friends, when they choose or when they would otherwise be unable 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 members. If it is determined that hands-on assistance is required, virtual services may not be provided. This process will be outlined in each provider's 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.
•Individuals who need assistance utilizing remote delivery of the service will be provided training initially and ongoing if needed on how to use the equipment, including how to turn it on/off.
•Video cameras/monitors are not permitted in bathrooms. Video cameras/monitors may be permitted in bedrooms for members who are bedridden and request to allow the telehealth service delivery option.

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

The number of units available for Supported Employment Services in combination with Day Habilitation Services and Prevocational Services is 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. The HCBS-SLS waiver is not targeted to participant's requiring care 24 hours a day, seven days a week. In the event the combined 7,112 unit limitation of Day Habilitation Services and Supports, Prevocational Services and Supported Employment is not sufficient to meet a participant's needs, the client will be referred to another waiver program such as the HCBS-DD waiver.

Reimbursement for Telehealth services is limited to enrolled Colorado Medicaid providers. Workplace Assistance services are not to be delivered via Telehealth.

Reimbursement for Workplace Assistance services is primarily available during the member's hours of paid employment. However, when there is an identified recurring need, such as the member needing to set-up prior to clocking in, Workplace Assistance can be available for a time-limited period adjacent to the member's work hours. Workplace Assistance is not to be used for staff time in traveling to and from members' worksites.

Prior to Workplace Assistance being utilized, the member and support team have determined that alternatives to paid caregiver support have been fully considered and Workplace Assistance is necessary for maximizing independence and integration at work.

Workplace Assistance is only used for activities related to sustaining a member's individual job, activities taking place in a group, (e.g. work crews) would be considered Supported Employment - Group.

Supported Employment services do not include payment for typical employer responsibilities, including training, general safety measures, support and adaptations available to other workers without disabilities filling similar positions in the business.

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)

Provider Category	Provider Type Title
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):*

HCPF Rules: 10 CCR 2505-10 § 8.500.94

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 associate 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 and Financing and Department of Public Health and Environment

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: 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):*

HCPF Rules: 10 CCR 2505-10 § 8.500.94

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 associate 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 and Workplace Assistance 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

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 or Workplace Assistance Training service delivery.

Workplace Assistance Training: should include concepts of fading, building natural supports, and building awareness of the staff’s expectations at the member’s worksite.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health Care Policy and Financing and the Colorado Department of Health and Environment.

Frequency of Verification:

All agency provider qualifications are verified upon initial Medicaid enrollment and in a revalidation cycle; at least every 5 years. Additionally, an agency survey is completed by CDPHE according to the survey cycle.

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 individuals 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 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's Fiscal Year. Major services are limited to $10,000 for the five (5) year renewal period of the waiver.

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	Dental Therapist
Individual	Dentist
Individual	Dental Therapist
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:

Dental Therapist

Provider Qualifications

License *(specify):*

Per Colorado Dental Board

Certificate *(specify):*

Other Standard *(specify):*

C.R.S. 12-220-102 et. seq. 3 CCR 709-1: Colorado Dental Board, Dentists & Dental Hygienists 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: 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 Colorado Dental Board

Certificate *(specify):*

Other Standard *(specify):*

C.R.S. 12-220-102 et. seq. 3 CCR 709-1: Colorado Dental Board, Dentists & Dental Hygienists Rules and Regulations

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy and Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Dental Therapist

Provider Qualifications

License *(specify):*

Per Colorado Dental Board

Certificate *(specify):*

Other Standard *(specify):*

C.R.S. 12-220-102 et. seq. 3 CCR 709-1: Colorado Dental Board, Dentists & Dental Hygienists 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: 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 Colorado Dental Board

Certificate *(specify):*

Other Standard *(specify):*

C.R.S. 12-220-102 et. seq. 3 CCR 709-1: Colorado Dental Board, Dentists & Dental Hygienists Rules and Regulations

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy and Financing

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

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

Service Definition *(Scope):*

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	Ophthalmologist

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 and Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Ophthalmologist

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 and Financing

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Assistive Technology

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Assistive technology device means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of participants. Assistive technology service means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device. Assistive technology includes:

1. The evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant;
2. Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;
3. Training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and
4. Devices that help the participant to communicate such as electronic communication devices (excluding cell phones, pagers, and internet access unless prior authorized by the state); skill acquisition devices which are proven to be a cost-effective and efficient means to meet the need and which make learning easier, such as adaptations to computers, or computer software related to the persons disability.

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

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

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

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Enrolled Medicaid Provider

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Program Approval

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy & Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

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

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Program Approval

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy and Financing

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

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.

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 Associate 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:

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

Frequency of Verification:

Verification of provider qualification is completed upon initial Medicaid enrollment and every five years through provider revalidation, as well as 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 and Financing and Department of Public Health and Environment

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Benefits Planning

HCBS Taxonomy:

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

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Benefits Planning is analysis and guidance by a certified Benefits Planner to help the member and their family/support network understand the potential impact of employment on the member's public benefits, such as Supplemental Security Income (SSI), Medicaid, Social Security Disability Insurance (SSDI), Medicare, food/nutrition programs, housing assistance, and other federal, state, and local benefits. As part of that process, certified Benefits Planners assist members with identifying work incentives associated with those benefits. Colorado is an Employment First state, and this service is designed to increase access to work and the community by providing members with accurate, individualized information about how they can work and earn an income while maintaining the benefits they need. Understanding the interaction between income and benefits can be an entry point to employment for unemployed members and support career advancement for employed members facing a potential change in status. The Benefits Planning services are available to members regardless of employment history or lack thereof. This service is intended to address fears about work-related income-compromising benefits by providing the member with the information they need to make an informed choice regarding pursuing employment or career advancement. Certified Benefits Planners support the member by providing intensive individualized benefits counseling, benefits analysis, developing a work incentive plan, and/or benefits planning for a member considering employment, changing jobs, or for career advancement/exploration. In order to support the member in obtaining or maintaining employment, the Benefits Planner may collaborate with the Case Manager and team in order to assist with referrals, provide information regarding Medicaid or Social Security benefits and federal/state/local programs, that may be beyond the knowledge or scope of the Case Manager. The service may be delivered virtually, or in the member's home, the community, the Benefits Planner's office, or a location of the member's choice.

The Benefits Planner may assist in the initiation of a referral and application to the Division of Vocational Rehabilitation (DVR) if the member wishes. If the member's Case Manager determines that the member does not have access to DVR's Benefits Counseling or other comparable services, then Benefits Planning may be authorized through the Waiver. Case Managers are responsible for summarizing efforts made to determine whether another source (such as DVR's Benefits Counseling) is available. Benefits Planning does not take the place of nor is it duplicative of services received through the Division of Vocational Rehabilitation. Documentation is maintained in the file of each member 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.).

Telehealth is an allowable mode for delivering Benefits Planning. Telehealth use is by the choice of the member and policy requires assessment for use through the support planning process by the Case Management Agency (CMA). Policy requires the provider to maintain member consent and assessment for Telehealth use. The purpose of the telehealth option in this service is to maintain and/or improve a member's ability to support relationships while also encouraging and promoting 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 state's 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 complete control of the device. The participant can turn off the device and end services at 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. Telehealth is available as an option for members who may not be inclined to participate in person but may still want to participate in services and engage with their community and their friends, when they choose or when they would otherwise be unable 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 at the center. In order to ensure the health and safety of members, case managers and providers must assess the appropriateness of virtual services with members. If it is determined that hands-on assistance is required, virtual services may not be

provided. This process will be outlined in each provider's 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.
• Individuals who need assistance utilizing remote delivery of the service will be provided training initially and ongoing if needed on how to use the equipment, including how to turn it on/off.
• Video cameras/monitors are not permitted in bathrooms. Video cameras/monitors may be permitted in bedrooms for members who are bedridden and request to allow the telehealth service delivery option.

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

Benefits Planning services are limited to 40 units per Service Plan year. One unit is equal to 15 minutes of service.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Program Approved Service Agency
Individual	Certified Benefits Planner
Agency	Enrolled Medicaid Providers - Benefits Planning

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Benefits Planning

Provider Category:

Agency

Provider Type:

Program Approved Service Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Program Approval

To be a Benefits Planner, the individual(s) must hold/maintain an approved certification in Benefits Counseling/Benefits Planning.

A certified Benefits Planner must hold at least one of the following credentials, or an equivalent certification subject to approval by Health Care Policy and Financing: from Virginia Commonwealth University: Community Work Incentives Coordinator (CWIC), or Community Partner Work Incentives Counselor (CPWIC); or Cornell University's Credentialed Work Incentives Practitioner (WIP-C TM)

Other Standard *(specify):*

The individual(s) providing Benefits Planning services must:

- Maintain current knowledge base of federal, state, and local benefits through completion of continuing education requirements.
- Sustain working knowledge regarding Colorado's Medicaid Waiver system.
- Consult with technical assistance liaisons as needed for complex benefits situations, to support the member in getting solid information and having continuity of care.

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

• HIPAA-compliant platforms;

• Member support is given when a member's needs include: accessibility, translation, or limited auditory or visual capacities are present;

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

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

• Assessment of members and caregivers that identifies a member'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 member choice to use telehealth and indicate in the service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health Care Policy and Financing

Frequency of Verification:

All agency provider qualifications are verified upon initial Medicaid enrollment and in a revalidation cycle; at least every 5 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Benefits Planning

Provider Category:

Individual

Provider Type:

Certified Benefits Planner

Provider Qualifications

License *(specify):*

Certificate *(specify):*

To be a Benefits Planner, the individual(s) must hold/maintain an approved certification in Benefits Counseling/Benefits Planning. A certified Benefits Planner must hold at least one of the following credentials, or an equivalent certification subject to approval by Health Care Policy and Financing: from Virginia Commonwealth University: Community Work Incentives Coordinator (CWIC), or Community Partner Work Incentives Counselor (CPWIC); or Cornell University's Credentialed Work Incentives Practitioner (WIP-C TM)

Other Standard *(specify):*

The individual(s) providing Benefits Planning services must:

- Maintain current knowledge base of federal, state, and local benefits through completion of continuing education requirements.
- Sustain working knowledge regarding Colorado's Medicaid Waiver system.
- Consult with technical assistance liaisons as needed for complex benefits situations, to support the member in getting solid information and having continuity of care.

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

- HIPAA-compliant platforms;
- Member support is given when a member's needs include: accessibility, translation, or limited auditory or visual capacities are present;
- Have a contingency plan for the provision of services if technology fails;
- Professionals do not practice outside of their respective scope; and
- Assessment of members and caregivers that identifies a member'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 member choice to use telehealth and indicate in the service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health Care Policy and Financing

Frequency of Verification:

All Individual provider qualifications are verified by the Department's Fiscal Agent upon initial enrollment and in a revalidation cycle; at least every 5 years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Benefits Planning

Provider Category:

Agency

Provider Type:

Enrolled Medicaid Providers - Benefits Planning

Provider Qualifications

License *(specify):*

Certificate *(specify):*

To be a Benefits Planner, the individual(s) must hold/maintain an approved certification in Benefits Counseling/Benefits Planning. A certified Benefits Planner must hold at least one of the following credentials, or an equivalent certification subject to approval by Health Care Policy and Financing: from Virginia Commonwealth University: Community Work Incentives Coordinator (CWIC), or Community Partner Work Incentives Counselor (CPWIC); or Cornell University's Credentialed Work Incentives Practitioner (WIP-C TM)

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 8.500.98.

Other Standard *(specify):*

The individual(s) providing Benefits Planning services must:

- Maintain current knowledge base of federal, state, and local benefits through completion of continuing education requirements.
- Sustain working knowledge regarding Colorado's Medicaid Waiver system.
- Consult with technical assistance liaisons as needed for complex benefits situations, to support the member in getting solid information and having continuity of care.

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

- HIPAA-compliant platforms;
- Member support is given when a member's needs include: accessibility, translation, or limited auditory or visual capacities are present;
- Have a contingency plan for the provision of services if technology fails;
- Professionals do not practice outside of their respective scope; and
- Assessment of members and caregivers that identifies a member'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 member choice to use telehealth and indicate in the service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health Care Policy and Financing

Frequency of Verification:

All agency provider qualifications are verified upon initial Medicaid enrollment and in a revalidation cycle; at least every 5 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:

Health Maintenance Activities

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:

Health maintenance activities include routine and repetitive health-related tasks furnished to an eligible member in the community or in the member's home, which are necessary for health and normal bodily functioning that a person with a disability is physically unable to carry out.

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	Attendants employed under the Consumer Directed Attendant Support Services (CDASS) delivery option.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Health Maintenance Activities

Provider Category:

Individual

Provider Type:

Attendants employed under the Consumer Directed Attendant Support Services (CDASS) delivery option.

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

Any individual providing services must be 16 years of age and must have the training and/or experience commensurate with the service or support being provided

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management Services contractor

Frequency of Verification:

Upon employment and as requested by the participant

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Hippotherapy

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

Hippotherapy is a therapeutic treatment strategy that uses the movement of the horse to assist in the development/enhancement of skills: gross motor, sensory integration, attention, cognitive, social, behavioral and communication. The use of this service is only available from a provider who is licensed, certified, registered and/or accredited by an appropriate national accreditation association. This service must be used as a treatment strategy for an identified medical or behavioral need. The need should be outlined in the individualized service plan. A Medicaid State Plan therapist/physician must identify the need this treatment strategy shall meet with a goal. The Medicaid State Plan therapist/physician will monitor the progress towards meeting this goal at least quarterly. Hippotherapy cannot be available under the regular Medicaid State Plan, EPSDT or from a third-party source.

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

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Hippotherapy

Provider Category:

Agency

Provider Type:

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

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

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

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy and Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Hippotherapy

Provider Category:

Agency

Provider Type:

Program Approved Service Agency

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

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

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home Accessibility Adaptations

HCBS Taxonomy:

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

Service Definition *(Scope):*

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

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

It may be necessary to make home modifications to an individual’s place of residence before they transition from an institution to the community. Such modifications may be made while the person is institutionalized if the individual is in the process of transitioning. Home modifications, included in the individual’s plan of care, may be furnished up to 180 consecutive days prior to the individual’s discharge from an institution. However, such modifications will not be considered complete until the date the individual leaves the institution and is enrolled in the waiver. Home modifications made under this circumstance may not be billed to the HCBS waiver authority until the date the individual leaves the institution and enters the HCBS waiver.

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

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Contractor Agency

Provider Category	Provider Type Title
Individual	Licensed Building Contractor
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: Home Accessibility Adaptations

Provider Category:

Individual

Provider Type:

Contractor Agency

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Program Approval

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy and Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Accessibility Adaptations

Provider Category:

Individual

Provider Type:

Licensed Building Contractor

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Program Approval

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy and Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Accessibility Adaptations

Provider Category:

Agency

Provider Type:

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

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Program Approval

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy and Financing

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: 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 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.

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; or be approved by Medicaid as a home delivered meals provider in their home state.

Certificate *(specify):*

The provider must meet the certification standards in §8.500.98 (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 and Financing and the Department of Public Health and 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:

Life Skills Training

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:

Life Skills Training (LST) supports the client through skills training designed and directed with the client to develop and maintain their ability to sustain themselves physically, emotionally, socially and economically in the community. Skills training includes assessing, training, supervising, or assisting the client with self-care and the activities of daily living, medication reminders and supervision, time management skill building, safety awareness skill development and training, task completion, communication skill building, interpersonal skill development, socialization training, community mobility training, identifying and accessing mental and behavioral health services, reduction or elimination of maladaptive behaviors, understanding and following plans for occupational or sensory skill development, problem solving, benefits coordination, resource coordination, financial management and household management.

LST also includes working with the client and the client's providers to achieve an integrated Service Plan that will reinforce skills training during and beyond the provision of LST. LST shall be delivered according to the Service Plan.

To access LST, 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 training designed and directed with the client to develop and maintain their ability to sustain themselves physically, emotionally, socially and economically in the community;
- The need demonstrates risk to health, safety, or institutionalization; and
- The client demonstrates that with training they have ability to acquire these skills or services necessary within 365 days.

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 LST up to 24 units (six hours) a day over a period of 365 days following the first day the service is provided. LST shall be delivered no more than 40 hours per week.

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	Life Skills Training Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Life Skills Training

Provider Category:

Agency

Provider Type:

Life Skills Training Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified as a Medicaid provider of Life Skills Training: 10 C.C.R. 2505-10, Section 8.500.98.

Other Standard *(specify):*

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 Public Health and Environment.

Frequency of Verification:

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:

Massage Therapy

HCBS Taxonomy:

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

Service Definition (Scope):

Massage is the physical manipulation of muscles to ease muscle contractures, spasms, increase extension and muscle relaxation and decrease muscle tension including WATSU. The use of this service is only available from a provider who is licensed, certified, registered and/or accredited by an appropriate national accreditation association. This service must be used for an identified medical or behavioral need. The need should be outlined in the individualized service plan. A Medicaid State Plan therapist/physician must identify the need this service shall meet with a goal. The Medicaid State Plan therapist/physician will monitor the progress towards meeting this goal at least quarterly. Massage cannot be available under the regular Medicaid State Plan, EPSDT or from a third-party source.

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

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Massage Therapy

Provider Category:

Agency

Provider Type:

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

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

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

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy and Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Massage Therapy

Provider Category:

Agency

Provider Type:

Program Approved Service Agency

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

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

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Mentorship

HCBS Taxonomy:

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

Service Definition *(Scope):*

Service provided to participants to promote self-advocacy through methods such as instructing, providing experiences, modeling and advising. This service includes assistance in interviewing potential providers, understanding complicated health and safety issues, and assistance with participation on private and public boards, advisory groups and commissions. This service may also include training in child and infant care for parent(s) who themselves have a developmental disability. This service does not duplicate case management or waiver services such as Day Habilitation.

Telehealth is an allowable mode for 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:

Mentorship is limited to 192 units per year. Units to provide training to participants for child and infant care may be authorized beyond the 192 units per year.

Mentorship and Peer Mentorship are different services and shall not be accessed at the same time. Peer Mentorship is available/accessed during a transition period and provided by a direct care professional that has a shared experience and supports community independence through the acquisition of daily living skills. Mentorship promotes independence with skills around more formal activities in the community, such as being a member of a board, advisory group, or commission.

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

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Mentorship

Provider Category:

Agency

Provider Type:

Program Approved Service Agency

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

Program Approval

Other Standard *(specify):*

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

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 and Financing and Department of Public Health and Environment

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Mentorship

Provider Category:

Agency

Provider Type:

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

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Program Approval

Other Standard *(specify):*

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

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

•HIPAA compliant platforms;

•Client support given when 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 and Financing and Department of Public Health and Environment

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Movement Therapy

HCBS Taxonomy:

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

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Movement Therapy is the use of music therapy and/or dance therapy as a therapeutic tool for the habilitation, rehabilitation, and maintenance of behavioral, developmental, physical, social, communication, pain management, cognition and gross motor skills. The use of this service is only available from a provider who is licensed, certified, registered and/or accredited by an appropriate national accreditation association. This service must be used as a treatment strategy for an identified medical and/or behavioral need. The need should be outlined in the individualized service plan. A Medicaid State Plan therapist/physician must identify the need this service shall meet with a goal. The Medicaid State Plan therapist/physician will monitor the progress towards meeting this goal at least quarterly. Movement Therapy cannot be available under the regular Medicaid State Plan, EPSDT or from a third-party source.

Telehealth is an allowable mode for delivering for 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:

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

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Movement Therapy

Provider Category:

Agency

Provider Type:

Program Approved Service Agency

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

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

Other Standard *(specify):*

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

•HIPAA compliant platforms;

•Client support given when 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 and Financing and the Department of Public Health and Environment

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Movement Therapy

Provider Category:

Agency

Provider Type:

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

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

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

Other Standard *(specify):*

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

•HIPAA compliant platforms;

•Client support given when 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 and Financing

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

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 provided in order to enable waiver participants to gain access to waiver and other community services, activities and resources, as specified by the Service 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 participants Service Plan. Whenever possible, family, neighbors, friends, or community agencies, which 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 services. Transportation in addition to Day Habilitation and Supported Employment is limited to 4 trips per week reimbursed at transportation band one.

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)

Provider Category	Provider Type Title
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:

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):*

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 and Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: 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 and Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: 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:

The Department of Health Care Policy and Financing

Frequency of Verification:

Verification of provider qualification is completed upon initial Medicaid enrollment and prior to becoming a Program Approved Service Agency; then every three years through recertification survey 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.

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

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.

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 8.500.98.

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 as defined by the Department.

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 and Financing and Department of Public Health and 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:

Personal Emergency Response

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:**

PERS is an electronic device that enables waiver participants to secure help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is connected to the participant's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. The participant and their case manager develop a protocol for identifying who is to be contacted if/when the system is activated.

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

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

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	Personal Alert Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response

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 manufacturer specifications.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy and Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response

Provider Category:

Agency

Provider Type:

Personal Alert Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Program Approval

Other Standard *(specify):*

The product or service to be delivered must meet all applicable manufacturer specifications.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy and Financing

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Recreational Facility Fees/Passes

HCBS Taxonomy:

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

Service Definition *(Scope):*

Passes to community recreation centers when used to access hippotherapy, massage or movement therapy services are allowed. Recreational passes shall be purchased in the most cost-effective manner (i.e. day passes or monthly passes.)

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

Passes may only be purchased for access to hippotherapy, massage or movement therapy. This service excludes additional passes for families or caregivers. This service may only be used in conjunction with the use of the following services: hippotherapy, massage or movement therapy.

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

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Recreational Facility Fees/Passes

Provider Category:

Agency

Provider Type:

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

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Program Approval

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy and Financing

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: Recreational Facility Fees/Passes

Provider Category:

Agency

Provider Type:

Enrolled Medicaid Provider

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Program Approval

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy and Financing

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: 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:

Remote Support Technology

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

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

Remote Support Technology means any item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used in conjunction with Personal Care Remote Supports and/or Homemaker Remote Supports to increase, maintain, or improve functional capabilities of participants. Remote Support Technology does not include the cost of cell phones, internet access, landline telephone lines, cellular phone voice, and/or data plans necessary for the provision of services.

Real-time staff at an offsite remote location are responsible for the remote support technology.

The remote support methodology is accepted by the state's HIPAA Compliance Officer.

Remote Support Technology will assist individuals by facilitating service delivery when in-person options may not be available or are not needed or wanted. By accessing the necessary HCBS supports and services via Remote Support Technology, individuals will be able to continue living in their homes and engaging in their communities without the need for out-of-home placement in a more restrictive living environment.

Remote Support Technology will enhance/increase the individual's independence by providing real-time support with tasks that do not require hands-on assistance and that would otherwise require an in-home visit by a provider.

Remote support technology will help individuals increase opportunities to fully integrate into the community and participate in community activities by allowing individuals to connect with providers and their community at times when inclement weather or a health condition would confine them to their homes.

Remote support technology providers will have written policies and procedures regarding the safeguarding of member privacy. The use of any video or audio monitoring or recording in the provision of this service is not allowed.

The Remote Support Technology provider will have a backup power system (such as battery power and/or generator) in place at the monitoring base in the event of electrical outages.

The Department will not allow the use of video or audio monitoring technology in bedrooms and/or bathrooms. If an individual were to request a device in their bedroom/bathroom the request would be reviewed on a case by case basis by the state, person-centered planning team, and the state's Human Rights Committee respectively to ensure that the individual's rights are protected.

Individuals will be fully trained initially and ongoing if needed on the use of equipment, including how to turn it on/off. Individuals will maintain the right to revoke consent and discontinue the use of Remote Supports at any time. Case managers will also be responsible for ensuring equipment is functioning and that the member has the training and ability to use the equipment during regular monitoring visits.

The case manager is required to work with the member and their family/guardian to ensure member choice and appropriateness in selecting any home and community-based service, including Remote Supports. These discussions and decisions will be documented by the case manager in the Person-Centered Service Plan.

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

Must be provided in conjunction with Personal Care Remote Supports and/or Homemaker Remote Supports.

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	Remote Supports Technology Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Remote Support Technology

Provider Category:

Agency

Provider Type:

Remote Supports Technology Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

The provider must meet the standards for a Certified Medicaid provider under 10 C.C.R. 2505-10 Section 8.487

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

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:

Specialized Medical Equipment and Supplies

HCBS Taxonomy:

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

Service Definition *(Scope):*

Specialized Medical Equipment and supplies include:

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

Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State plan 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	Medical Supply Company
Agency	Pharmacy
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:

Medical Supply Company

Provider Qualifications

License *(specify):*

Business License

Certificate *(specify):*

Program Approval

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy and Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Pharmacy

Provider Qualifications

License *(specify):*

Pharmacy License

Certificate *(specify):*

Program Approval

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy and Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

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

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy and Financing

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

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 $2,000 per eligible client, unless otherwise authorized by the Department. The Department may authorize additional funds above the $2,000 unit limit, not to exceed a total value of $2,500, 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 8.500.98.

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 Public Health and Environment.

Frequency of Verification:

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:

Vehicle Modifications

HCBS Taxonomy:

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

Service Definition *(Scope):*

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

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

(2) Purchase or lease of a vehicle; and

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

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

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

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

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

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Vehicle Modifications

Provider Category:

Agency

Provider Type:

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

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Program Approval

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy and Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Vehicle Modifications

Provider Category:

Agency

Provider Type:

Enrolled Medicaid Provider

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Program Approval

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy and Financing

Frequency of Verification:

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

Appendix C: Participant Services

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

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

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

Check each that applies:

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

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

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

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

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

Appendix C: Participant Services

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

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

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

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

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

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

For clients who choose CDASS, the FMS performs Colorado Bureau of Investigation (CBI) criminal history check on all prospective attendants. The Department maintains a list of high risk crimes that initially prohibit a potential attendant from employment. After over two years of engagement, stakeholders voted to implement an exception process that enables a member and/or authorized representative to make the final hiring decision for certain individuals found initially ineligible for employment. The exception process requires that the Department receive from the member/AR a written acknowledgement that: the Colorado Criminal Background Check report was received and reviewed, that the reason for initial ineligibility is understood, that the member and/or authorized representative chooses to hire this person, and that a safety plan is in place. Support resources and education are available to members and/or authorized representatives to learn more about best practices regarding hiring employees with criminal backgrounds and what protective resources are available if the member becomes unsafe. Ongoing oversight of the safety plan and quality of care occurs quarterly by the case manager. Employment decisions are made at the discretion of the client and/or authorized representative.

In addition, all prospective attendants for CDASS and IHSS are subject to a Board of Nursing and certified nurse aide background check, and Office of Inspector General (OIG) check. Any person who has had their license as a nurse or certification as a nurse aid suspended or revoked or their application for such license or certification denied shall be denied employment as an attendant. Any person who has failed the OIG check shall be denied employment as an attendant.

The Department audits the employment records of the FMS annually to ensure they are completing the mandatory Board of Nursing and certified nurse aide background checks.

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.

Appendix C: Participant Services

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

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

Appendix C: Participant Services

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

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

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

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

a. A spouse may be paid to furnish extraordinary care through the CDASS delivery option. Extraordinary care is determined by assessing whether an individual who is the same age without a disability, the same level of care, the activity is one that a spouse would not normally provide as part of a normal household routine and the activity is one that a spouse is not legally responsible to provide.
b. A spouse may not provide more than 40 hours of attendant services through the CDASS delivery option in a seven-day period.
c. A participant and/or Authorized Representative must provide an attendant support management plan outing attendant tasks to be performed and budgeting for services.
An individual must be offered a choice of providers. If participants or his/her Authorized Representative chooses a spouse as a care provider, it must be documented on the Attendant Support Management Plan. A spouse who is a participant's Authorized Representative may not also be paid to be a participant's attendant. In addition to case management, monitoring, and reporting activities required for all waiver services, the following requirements are employed when a spouse is paid as a care provider:

1. At least quarterly reviews of expenditures, and health, safety, and welfare status of the participant by the case manager.
2. Monthly reviews by the fiscal agent of time claimed for care provided by the spouse.
3. The Financial Management Service vendor system identifies attendants who are relatives to ensure timesheets submitted and paid do not exceed service hour limitations.

Participants in Consumer Directed Attendant Support Services (CDASS) waiver service may receive Homemaker, Enhanced Homemaker, Personal Care, and Health Maintenance Activities. A Legally Responsible Individual may provide up to 40 hours of services weekly to a CDASS Participant. The CDASS FMS vendors have systems in place to maintain and enforce established program limits.

☒ **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 under the waiver: Personal Care, Homemaker, Health Maintenance Activities, Mentorship, Respite, Day Habilitation, Supported Employment, Non-medical Transportation, Peer Mentorship, Home Delivered Meals, Life Skills Training and Transition Set Up. 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. Only those approved services may be reimbursed. Family members may be employed by the participant/Authorized Representative to provide services rendered under the Consumer Directed Attendant Support Services (CDASS) delivery option and are subject to the conditions below: 1. A family member who is an individual’s Authorized Representative may not be reimbursed for the provision of services rendered under the CDASS delivery option. 2. A family member can be reimbursed for providing up to 40 hours of services in a seven-day period from 12:00am on Sunday to 11:59pm on Saturday. 3. Clients and/or Authorized Representatives who choose to hire a family member as a care provider must document their choice on the Attendant Support Management Plan. In addition to case management, monitoring, and reporting activities required for all waiver services, the following requirements are employed when a family member is paid as a care provider for CDASS clients: 1. At least quarterly reviews of expenditures, and the health, safety, and welfare status of the client. 2. Monthly reviews by the fiscal agent of hours billed for family member-provided care.

○ **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 Service (HCBS) providers have access to required forms and instructions for completing the forms on the Department of Health Care Policy and Financing (the Department) website. Applications to become an HCBS provider are submitted to the Department.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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

i. Sub-Assurances:

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

Performance Measures

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

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

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

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:
Colorado Department of Public Health and Environment (CDPHE) Survey Reports

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

Colorado Department of Public Health & Environment (CDPHE)		
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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 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:

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

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

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

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

Data Aggregation and Analysis:

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

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

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

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

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

Data Aggregation and Analysis:

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

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

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

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

Performance Measure:
C.b.1 Number and percent of non-surveyed non-licensed/non-certified providers that initially and continually meet waiver requirements Numerator: Number of non-surveyed non-licensed/non-certified providers that initially and continually meet waiver requirements Denominator: Total number of non-surveyed non-licensed/non-certified waiver providers

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
C.b.3 Number and percent of newly enrolled CDASS attendants who meet the background check requirements monitored by the FMS vendors and Department N: Number of newly enrolled CDASS attendants who meet the background check requirements monitored by the FMS vendors and the Department D: Total number of newly enrolled CDASS attendants

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: Financial Management Service (FMS)	☒ **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):*

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

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

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

Colorado Department of Public Health & Environment		
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Data Source (Select one):
Other

If 'Other' is selected, specify:
MMIS

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

Data Aggregation and Analysis:

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

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

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

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

C.b.3
FMS provides the Department with reports of the number of CDASS attendants that are deemed eligible for hire based on background and registry screening prior to providing services under the CDASS option. The Department reviews FMS reports as the primary discovery method 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 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 noncompliance with standards exist, the Department issues a list of deficiencies to the provider. The Provider is required to submit an acceptable Plan of Correction to the Department within a specified timeframe. Applications for providers for 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.b.1
If areas of non-compliance with standards exist, the Department issues a list of deficiencies to the provider. The provider is required to submit an acceptable Plan of Correction to the Department within a specified timeframe. If areas of non-compliance exist where the health and welfare of participants receiving services are in jeopardy, then the provider is required to correct the problem immediately and provide documentation of corrections to Department. Providers that do not remediate deficiencies in accordance with the POC are terminated from the program.

C.b.3
The FMS ensures that attendants that do not meet these requirements or have not been requested to be hired by a member and/or authorized representative through the Department established process are not eligible for hire by waiver participants. The Department’s review of the FMS reports and documentation ensures deficiencies are remediated.

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**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

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

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

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

(a) The Department applies a maximum expenditure of $10,000 over the waiver renewal period (July 1, 2019 through June 30, 2024) for the combination of the following services:

- •Home Accessibility Adaptations
- •Vehicle Modifications
- •Assistive Technology

The Department applies an authorization limit of $66,351.88 per service plan year for the combination of services listed below. The Department applies a Denver County authorization limit of $83,069.84 per service plan year for the combination of services listed below.

- •Assistive Technology
- •Behavioral Services
- •Day Habilitation
- •Dental Services
- •Home Accessibility Adaptations
- •Homemaker
- •Mentorship
- •Non-Medical Transportation
- •Personal Care
- •Personal Emergency Response Systems
- •Prevocational Services
- •Professional Services
- •Respite
- •Specialized Medical Equipment and Supplies
- •Supported Employment
- •Vehicle Modifications
- •Vision Services
- •Transition Set-Up
- •Peer Mentorship
- •Life Skills Training
- •Home Delivered Meals
- •Benefits Planning

Health Maintenance Activities are authorized according to the participant's assessed need and are not subject to limits on sets of services. Duplication of Health Maintenance Activities with Home Health services provided through the State Plan is prohibited. Health Maintenance Activities are limited to individuals living in their own or family's private home.

(b) Analysis of the utilization over the past five years indicates that, in general, the limit is appropriate to meet the needs of participants.

(c) The authorization limit may be adjusted to incorporate adjustments to the appropriation made by the Colorado General Assembly. Any decreases to the limits on sets of services will be requested through a waiver amendment application.

(d) The limit on Home Accessibility Adaptations, Vehicle Modifications, and Assistive Technology can be exceeded on a case by case basis based on demonstrated need to ensure the health, welfare, and safety of the participant, to enable the participant to function with greater independence in the home, or to decreases the need for paid assistance in another waiver service on a long-term basis. Requests to exceed the expenditure limit must be submitted to the Department for review.

There is an exception to the authorization limit for the set of services listed above through the SLS Waiver Exception Review. This review is completed by the Quality Improvement Organization (QIO) and allows for the authorization of services to exceed limitations as stated above when the member demonstrates a need. This review may delay or eliminate the need for an individual to move onto the DD waiver, thereby allowing the member to remain in the community of their choice.

(e) The HCBS-SLS waiver provides a broad range of supports for a participant and combines waiver services with non-waiver supports in order to address the participant's needs sufficiently enough to allow the participant to live successfully in the community. Supports include paid and unpaid resources such as family, work, social, and community supports. The case manager meets with the individual to develop a Service Plan that identifies discrete services to meet specific assessed needs. The HCBS-SLS waiver does not provide full 24-hour support services. If the case manager identifies that a participant's needs are more extensive than the combined resources are able to support, the case manager informs the participant that his or her health and safety cannot be assured in the community through receipt of HCBS-SLS waiver services and therefore, he or she is not eligible to be served in the waiver. The case manager provides the participant with notification of his or her appeal rights as identified in Appendix F-1.

Should the participant's service needs change so that they can no longer be met in the HCBS-SLS waiver, the Case Management Agency could make a request for emergency enrollment into the HCBS-DD waiver, which has reserved capacity for emergency enrollment. The HCBS-DD waiver provides a higher level of support.

(f) The participant/guardian is informed at enrollment and during the Service Plan development of any limitations associated with the program.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☒ **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.

The maximum expenditure for waiver services is determined by the individual's assessed Service Plan Authorization Limit (SPAL), which the state established to justify Medicaid expenditures under this waiver and equitably distribute funds available within the appropriation.

Case Managers provide Service Plan Authorization Limit information to participants at the time of Service Plan Development. Participants are informed of their CDASS monthly allocation at the time of Service Plan Development and receive a copy of their Allocation and Task worksheet.

The SPAL is based on a uniform method for assessing support levels using the Supports Intensity Scale (SIS) tool and factors related to public safety risk. The SIS assessment measures the practical support requirements of adults with developmental disabilities. Participants who are assessed with higher needs have a higher authorization limit than those assessed with lower needs. The SPAL sets an annual maximum total dollars available to address all ongoing service needs, with the following exclusions:

- •Assistive Technology
- •Dental Services
- •Health Maintenance Activities
- •Home Accessibility Adaptations
- •Non-Medical Transportation
- •Vehicle Modifications
- •Vision Services
- •Transition Set-Up
- •Peer Mentorship
- •Life Skills Training
- •Home Delivered Meals
- •Benefits Planning
- •Supported Employment - Job Development - Individual
- •Supported Employment - Job Placement
- •Supported Employment - Job Coaching - Individual
- •Supported Employment - Workplace Assistance

There are six support levels which correspond directly to six SPALs (SPAL 1-6) as well as to rates for services with varied levels (i.e. Day Habilitation and Group Supported Employment) as identified in Appendix I. Participants assessed at Support Level 1 are subject to Service Plan Authorization Limit 1 (SPAL-1). Participants at Support Level 2 are subject to SPAL-2, etc. The method for determining the dollar values associated with each of the SPALs is based on analysis of historical utilization of authorized waiver services by participants, appropriated funds available for the waiver, plus consideration of the affordability of minimal service expectations considering new rates (i.e. Day Habilitation).

Pursuant to 10 CCR 2505-10 8.600- Section 8.612 SUPPORTS INTENSITY SCALE ASSESSMENT AND SUPPORT LEVELS- Supports Intensity Scale (SIS) assessments are conducted by the Case Management Agency (CMA) personnel certified to administer the SIS. The participant’s direct Case Manager will not administer the SIS assessment for that person. The methodology for determining the budget limit based on the level of support is open to public inspection in rule 10 CCR 2505-10- Section 8.613 SUPPORT LEVELS. There are two documents describing determining the level of support posted on Division’s website: “Supports Intensity Scale (SIS) and Support Level Flow Chart” and “HRSI/DDD Support Level Algorithm".

These Service Plan Authorization Limits may be altered during the course of the waiver, as necessary to reflect changes in utilization patterns and changes in appropriation funds available for this waiver. SPALS are implemented in a uniform manner statewide and will not be subject to Medicaid Fair Hearing as they strictly apply to funding and the State's management of the appropriated funds. The support levels used to place a participant into a SPAL can be disputed as identified in Appendix I. Those support levels may also change based on changes to the participant's needs and re-assessment using the SIS tool, if that results in a change in level. Changes in SPALs will typically be phased-in at the time of each participant's annual Continued Stay Review to reduce disruption in service delivery. However, the Department may, at their option, require new or updated SPAL amounts to be effective at a specified point in time, such as the beginning of any fiscal year, if

deemed necessary.

Pursuant to 10 CCR 2505-10 8.600- Section 8.612 SUPPORTS INTENSITY SCALE ASSESSMENT AND SUPPORT LEVELS:

A participant is assigned into one of six Support Levels according to his or her overall support needs and based upon the standardized algorithm for the HCBS-SLS waiver which includes the results of the Supports Intensity Scale (SIS) assessment. SIS Assessments are conducted by the Case Management Agency (CMA) personnel trained to administer the SIS. The participant's direct case manager will not administer the SIS for that person. Each Support Level corresponds with the standardized reimbursement rates for individual waiver services and the Service Plan Authorization Limits (SPAL) in HCBS-SLS. The CMA shall inform each client, his or her legal guardian, authorized representative, or family member, as appropriate, of his or her Support Level at the time of the Service Plan development or when the Support Level changes for any reason. Notification of a Support Level change shall occur within ten (10) business days of the date after the Service Plan development or Support Level change. The client, his or her legal guardian, authorized representative, family member, or CMA, as appropriate, may request a review regarding the Support Level assigned to meet the client's needs. The Department shall convene a review panel to examine Support Level review requests monthly or as needed. The Department shall provide the CMA and the client, his or her legal guardian, authorized representative, or family member, as appropriate, with the written decision regarding the requested review of the client's Support Level within fifteen (15) business days after the panel meeting.

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

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Person-Centered Support Plan (PCSP)

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

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

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

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

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

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

The minimum qualifications for HCBS Case Managers that conduct the person-centered service plan is:
1. A bachelor's degree; or
2. Five (5) years of experience in the field of LTSS, which includes Developmental Disabilities; or
3. Some combination of education and relevant experience appropriate to the requirements of the position.
4. Relevant experience is defined as:
a. Experience in one of the following areas: long-term care services and supports, gerontology, physical rehabilitation, disability services, children with special health care needs, behavioral science, special education, public health or non-profit administration, or health/medical services, including working directly with persons with physical, intellectual or developmental disabilities, mental illness, or other vulnerable populations as appropriate to the position being filled; and
b. Completed coursework and/or experience related to the type of administrative duties performed by case managers may qualify for up to two (2) years of required relevant experience.
Safeguards to assure the health and welfare of waiver participants, including response to critical events or incidents, remain unchanged.

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

☐ **Social Worker**
Specify qualifications:

☐ **Other**
Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

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

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

While the Department implements changes to the business processes and structure of case management services, the State Medicaid Agency allows for entities to provide both case management and direct care waiver services only when no other willing and qualified providers are available. The state currently allows an individual's HCBS provider to develop the 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 regards to mitigating conflict:

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

- Standardize PCSP Documents- Community Centered Boards are required to complete each participant's 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 assessments and PCSPs. The programmatic tool used in the assessment as well as the waiver participants selected in the sample will be specified by the Department. Aggregated data from the desk reviews will be reviewed and analyzed by the Department's oversight committee to evaluate performance and identify the need for quality improvement projects.

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

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

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

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

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

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

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

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

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

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

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

The PCSP defines the type of services, frequency, and duration of services needed. The PCSP also documents that the client and/or legal guardian have been informed of the choice of providers and the choice to have services provided in the community or in an institution. Health and safety risks are identified within the contingency planning section. This includes who should be contacted in the event of an emergency and plans to address needs in these circumstances. The client may contact the case manager for ongoing case management such as assistance in coordinating services, conflict resolution, or crisis intervention. The client may contact the case manager for ongoing case management such as assistance in coordinating services, conflict resolution, or crisis intervention. The service plan must be finalized in

accordance with CFR 441.301 c (2)(ix), "Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation."

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

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

This complaint log is reviewed by the Department on a quarterly basis. Department staff is able to identify trends or discern if a particular case manager or CMA is receiving an unusual number or increase in complaints and remediate accordingly.
The client may also contact the case manager's supervisor or the Department if they do not feel comfortable contacting the case manager directly. The contact information for the case manager, the case manager's supervisor, the CMA administrator, and the Department is included in the copy of the PCSP that is provided to the client. The client also has the option of lodging an anonymous complaint to the case manager, CMA, or the Department.

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

The case manager is required to complete a reevaluation, at a time and location chosen by the client, within twelve months of the initial client evaluation 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 evaluation and/or development of the PCSP may be completed by the case manager at an alternate location or via the telephone. Such approval may be granted for situations where 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 Support Plan to be implemented by June 2021 to comply with the Person-Centered Support Planning requirements in the HCBS Setting Final Rule. This plan will include documenting individual strengths, preferences, abilities, and individually identifying goals and how progress towards identified goals, and how progress will be measured. The future timeline and milestones for implementing this PCSP are as follows:
- March 2019-April 2020: The Department pilots the new LTSS Assessment and Person-Centered Support Planning 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 a comprehensive assessment and support planning process in the field and feedback meetings conducted
- December 2019-January 2020: The Department will analyze the data gathered from the PCSP pilot and hold additional stakeholder meetings, as necessary.
- January 2020: Department will update the automation of the PCSP based on feedback
- January-March 2020: The Department will collect data regarding additional time needed due to the new Assessment and PCSP

The new LOC Screen, Assessment, and 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 new case management system.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Risk Assessment and Mitigation: The initial step of risk assessment includes completion of the 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 PCSP. All case managers are provided with training and written instructions on completing the PCSP.

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 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 and 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 PCSPs 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) has developed a web-based system called the state's case management IT system that contains the LOC Screen, the PCSP, and the monthly case management log notes. The case manager is required to enter the PCSP into the state's case management IT system in order to receive prior authorization of services. 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 PCSPs, 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, PCSPs 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 PCSP development, implementation, and monitoring. Case managers are required to meet with clients annually for PCSP development. When scheduling to meet with the client and or the client's legal guardian or representative, the case manager makes reasonable attempts to schedule the meeting at a time and location convenient for all participants. Once the PCSP is implemented case managers are required to conduct monitoring with the participant 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.

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

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

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

Case Managers are required to conduct monitoring with all individuals. Part of monitoring includes follow-up when situations arise when an individual is not able to receive the services authorized and to ensure the contingency plan documented on the PCSP was adequate and met the needs of the individual. Additionally, case management monitoring includes follow-up to the incident and critical incident reports, as well as using observation to document and discuss/address any concerns regarding health and welfare. The Department 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) must 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 that time, the Department added acute care benefits and Behavioral Health Organizations breakout sessions to the annual case managers training conference to ensure case managers have a greater understanding of the additional health services available to long-term care clients.

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

Assists with 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 or problems with services. If a case manager is notified about an issue that requires prompt follow-up and/or remediation the case manager is required to assist the client. Case managers document the issue and the follow-up in the state's case

management IT system.

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

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

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

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

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

b. Monitoring Safeguards. *Select one:*

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

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

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

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

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

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

Implementation of the Global QIS will include desk review by the Department of a representative sample of the level of participant's care assessments and PCSP. The 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 a choice from among qualified providers at the time of PCSP development. Documentation of the confirmation is maintained on the state's case management IT system. Lastly, all case managers have been directed by the Department to monitor participants' satisfaction with choices in service providers at the time of PCSP development and during monitoring contact(s). Such monitoring must be documented in the PCSP and in case manager contact notes maintained on the state's case management IT system. The Department's On-site Program Quality Surveys: Every three years, the Department staff complete surveys of CCBs and review, specifically, separation of case management from service delivery, the PCSP development

process, provider selection processes, and monitoring of participant satisfaction with services and provider choice. The on-site survey process also includes interviews with participants and guardians regarding PCSP development and choice 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:	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

Data Aggregation and Analysis:

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

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

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

Performance Measures

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

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

Performance Measure:
D.c.1 Number and percent of waiver participants whose PCSPs were revised, as needed, to address changing needs Numerator: Number of waiver participants whose PCSPs were revised, as needed, to address changing needs Denominator: Total number of participants who required a revision to their PCSP to address changing needs that were reviewed

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
D.c.3 # and % of SLS 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 SLS 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 SLS 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 SLS waiver participants and/or family members responding to the NCI survey who indicate they received services and supports outlined in their PCSP N: # of SLS 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 SLS waiver participants responding to NCI Survey

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

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

Data Aggregation and Analysis:

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

Performance Measure:
D.d.2 Number and percent of waiver participants whose scope and type of services are delivered as specified in the PCSP N: # of waiver participants whose scope and type of services are delivered as specified in the PCSP D: Total # of waiver participants in the sample

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

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

☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95 % confidence level with +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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's record in the State's case management IT system/Bridge records and Medicaid Management Information System (MMIS) Data

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

	Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
D.d.5 Number and percent of waiver participants whose frequency and duration of services are delivered as specified in the PCSP Numerator: # of waiver participants whose frequency and duration of services are delivered as specified in the PCSP Denominator: Total # of waiver participants in the sample

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

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

		Review
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95 % confidence level with +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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 SLS waiver participants and/or family members responding to the NCI survey who indicate they had a choice of servicer providers N: Number of SLS waiver participants and/or family members responding to the NCI survey who indicate they had a choice of service providers D: Total number of SLS waiver participants and/or family members responding to the NCI survey

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

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

Data Aggregation and Analysis:

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

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

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

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 programs, private health insurance, or private pay). The reviewers use the state's case management IT system and/or Bridge to discover deficiencies for this performance measure and report in the QI Review Tool.

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

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

D.c.1
If PCSP revision need is indicated, the revision must be included in the participant's record; supported by documentation in the applicable areas of the LOC Screen, Log notes, or CIRS, and address all service changes per Department policy, delivered to the participant or the participant's representative; and, signed by the participant or the legal guardian, as appropriate. All forms completed through the assessment and person-centered support planning process are available for signature through digital or wet signatures based on the member's preference. The reviewers use the BUS and/or Bridge to discover deficiencies for this performance measure and report in the QI Review Tool.

D.c.2
The 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 needs updating; PCSP meets the participant's expectations; and, that participants had a choice of providers.

D.d.2-5

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

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

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

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

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

ii. Remediation Data Aggregation

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

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

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

◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

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

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

○ **Yes. The state requests that this waiver be considered for Independence Plus designation.**

◉ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

(a) Participants may direct Personal Care Services, Homemaker Services, and Health Maintenance Activities through the Consumer-Directed Attendant Support Services (CDASS) delivery option. Participants and/or legal guardians may choose to direct their own services or appoint an Authorized Representative to direct services on behalf of the participant. An Authorized Representative is required for those participants whose physician has determined are unable to conduct the activities associated with participant direction. The CDASS delivery option includes both employer and budget authorities. All participants that choose the CDASS service delivery option are required to operate within an allocated budget.

Employer authority grants the participant and/or an Authorized Representative the ability to recruit, select, discharge, train, schedule, supervise, and set wages for attendants of their choosing. Employer authority is executed using the Fiscal/Employer Agent (F/EA) model.

Under the budget authority, participants and/or Authorized Representatives are able to direct their services within an allocated budget. The case manager calculates the participant's individual allocation based on the participant's needs using the Department's guidelines and prescribed methods. The needs determined for allocation must reflect the needs identified by a comprehensive assessment using the Level of Care Eligibility Determination Screen (LOC Screen) and documented in the Person-Centered Support Plan (PCSP). The CDASS delivery option also allows for the reallocation of funds to allow for the substitution among the services included in the allocation.

(b) As part of the PCSP development process described in Appendix D-1.d of this application, the case manager informs the participant and/or legal guardian of all possible service alternatives, including opportunities for participant direction. Participants and/or legal guardians are responsible for ensuring that all needed documents are submitted to the case manager such as; Physician Attestation of Consumer Capacity, Authorized Representative paperwork if needed, and the CDASS participant or Authorized Representative Responsibilities forms and are referred to the Training and Operations contractor where they will receive mandatory CDASS training which includes principals, benefits, rights and responsibilities and information on Financial Management Services (FMS) providers to manage consumer-directed services.

(c)Case management agencies provide information about participant direction opportunities; determine whether participants meet the additional criteria described in Appendix E-1.d of this application; assist the participant and/or legal guardian in obtaining and completing required documents; assist in the development and execution of an Attendant Support Management Plan (ASMP); determine the participant’s CDASS allocation; coordinate with the Financial Management Services and Training and Operations contractors; and monitor participant-directed service effectiveness, quality, and expenditures.

All CDASS forms are available for signature through digital or wet signatures based on the member's preference.

The CDASS training provides the participant, legal guardian, and/or Authorized Representative with information about participant direction through the CDASS delivery option, participant rights, participant responsibilities, planning, and organizing attendant services, managing personnel issues, recognizing and recruiting quality attendant support, managing health and emergencies, using resources effectively, and working with the FMS contractor. The Training and Operations contractor also provides training and technical assistance for case managers.

Participants may choose from the Department’s contracted Financial Management Services agencies, which are private companies. The Financial Management Services contractor makes financial transactions on behalf of the participant and maintains a separate account for each participant in order to track and report the expenditures and balance of the participant’s allocation. The Financial Management Services contractor also supports the participant in performing certain employer-related functions such as verifying attendant citizenship or legal residency status, conducting criminal history background investigations, processing payroll, and managing the payment of state-required sick time and family and medical leave benefits on behalf of CDASS clients and/or authorized representatives. The participant or Authorized Representative serves as the common law employer under the F/EA model with the responsibility to recruit, select, discharge, train, schedule, supervise, and set wages for attendants. The FMS contractors also provide the following customer services which are above and beyond the minimal supports listed above:

- Guidance in understanding the Department’s rules related to CDASS and FMS
- Training on enrollment in FMS
- Guidance on attendants’ worker’s compensation insurance claims
- Guidance on understanding tax forms

• Training on completing and understanding timesheets
• Provide a Contact Center that provides customer support

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

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

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

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

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

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

Specify the criteria

The Consumer Directed Attendant Support Services (CDASS) delivery option is limited to those participants who:

1. Choose the CDASS service delivery option;

2. Demonstrate a current assessed need for the services available through the CDASS delivery option;

3. Provide a statement from the primary care physician attesting that the participant is in stable health and requires a predictable pattern of attendant support;

4. Provide a statement from the primary care physician attesting to the participant's ability to direct his or her care with sound judgment or that the participant has an Authorized Representative with the ability to direct the care on the participant's behalf;

5. Demonstrate the ability to adequately manage the financial/budgeting aspects of self-directed care and/or have an Authorized Representative who is able to effectively manage financial/budgeting aspects of the eligible participant's care. This ability is demonstrated through completion of the required training and approval of the Attendant Support Management Plan (ASMP); and

6. Have not been involuntarily terminated for a reason that disallows future participation in the CDASS delivery option, as described in Appendix E-1.m of this application.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

a. Participants are informed of all possible service alternatives, including opportunities for participant direction. Participants are told that through CDASS they can hire, train, set wages and dismiss their attendants. They are also informed of the responsibility to complete CDASS training, develop an Attendant Support Management Plan (ASMP), work with a Fiscal Management Service (FMS), approve attendant timesheets and follow all relevant laws and regulations applicable to participant's supervision of attendants. Participants are informed that misrepresentation or false statements may result in administrative penalties, criminal prosecution, and/or termination from CDASS
b. Case managers are responsible for providing information on self-direction. Once a participant chooses CDASS the case manager refers the participant to the Training and Operations contractor for CDASS training.
c. Case managers provide information during the development of the initial Service Plan, at the annual Service Plan review, at any time the Service Plan is updated due to a significant change in the participant's condition, or at any other time it is requested by the participant and/or the legal guardian.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

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

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

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

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

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

Participants and/or legal guardians may choose to direct their own services or to appoint an Authorized Representative to direct services on his/her behalf. All participants and/or legal guardians interested in participant direction must obtain a completed Physician Attestation of Consumer Capacity form. This Department approved form requires the participant's physician to indicate whether the participant is in stable health, is of sound judgment, and has the ability to direct his/her care, or if the participant requires the assistance of an Authorized Representative to direct care on his/her behalf. In order to ensure that the physician's judgment can be consistently applied, the Physician Attestation of Consumer Capacity includes definitions of the following: stable health, ability to manage the health aspects of his/her life, ability to direct his/her own care, and Authorized Representative. If the physician indicates that the participant is unable to direct his/her care, the case manager must ensure that the participant or legal guardian designates an Authorized Representative. If a participant has a legal guardian agreement the legal guardian designates an Authorized Representative. Participants that have been designated as able to direct his/her care may also elect to designate an Authorized Representative.

The Authorized Representative must have the judgment and ability to direct attendant support services and must complete the Authorized Representative Designation and Affidavit form. On this form, the Authorized Representative must assert that he/she does not receive compensation to care for the participant; is at least eighteen years of age; has known the participant for at least two years; has not been convicted of any crime involving exploitation, abuse, or assault on another person; and does not have a mental, emotional, or physical condition that could result in harm to the participant. The form also requires that the Authorized Representative disclose information about his/her relationship with the participant and informs the Authorized Representative about the responsibilities associated with the CDASS delivery option. All CDASS forms are available for signature through digital or wet signatures based on the member's preference.

Authorized Representatives may not receive compensation for providing representation nor attendant support services to the participants they have agreed to represent. In order to assess the participant's, guardian's, and/or Authorized Representative's effectiveness in participant direction and satisfaction with the quality of services being provided; the case manager must contact the participant and/or the Authorized Representative at least monthly for the first three months, quarterly for the remainder of the first year, and twice a year thereafter. During this contact, the case manager assesses that the Authorized Representative is fulfilling the obligations of the role and acting in the best interests of the participant. The case manager reviews monthly statements provided by the FMS contractor and contacts the FMS, participant, guardian, and/or Authorized Representative if an issue with the utilization of the monthly allocation has been identified

Should the case manager determine that the Authorized Representative is not acting in the best interests of the participant or demonstrates an inability to direct the attendant support services, the case manager must take action in accordance with Department guidelines. These guidelines include the development of a plan for progressive action that may include: mandatory retraining, the designation of a new Authorized Representative, and/or the termination of the CDASS delivery option.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

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

Waiver Service	Employer Authority	Budget Authority
Health Maintenance Activities	☒	☒
Personal Care	☒	☒

Waiver Service	Employer Authority	Budget Authority
Homemaker	☒	☒

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

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

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

☐ **Governmental entities**

☒ **Private entities**

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

◉ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

The Department contracts with the FMS vendor(s) in accordance with the State of Colorado Procurement C.R.S.25.5-6-12 et seq. Criteria for the selection of the FMS contractor(s) includes the ability to provide appropriate and timely personnel, accounting, and fiscal management services to participants and/or their authorized representatives.

The FMS contractors offer participant-directed supports that ensure payments to participants' service providers are appropriately managed., tax and insurance compliance is maintained, accrued sick time and family medical leave are managed, and program fiscal rules are upheld.

In accordance with the Colorado Procurement Code, we solicited the FMS vendors through a request for proposals - #HCPFRFPFH14CDASSFMS. As described in that RFP, the Department's evaluation committee performed a value analysis and recommended the three vendors whose proposals it determined were most advantageous to the State for award. The Department then awarded contracts to those three vendors.

In December 2020, the Department and one FMS vendor agreed to end its contract term three months early. The vendor officially concluded its Colorado services in March 2021 and exited as an FMS vendor in the state. All active clients were transferred to the remaining two FMS providers. CDASS clients continue to maintain their right to provider choice.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

The FMS contractor receives an Administrative Services Fee (ASF) Per Member Per Month (PMPM) payment for each participant that is enrolled with the FMS contractor during the month.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- ☒ **Assist participant in verifying support worker citizenship status**
- ☒ **Collect and process timesheets of support workers**
- ☒ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- ☒ **Other**

  Specify:

Perform Colorado Bureau of Investigation criminal history and Board of Nursing background checks.

Ensure attendants meet the established minimum qualification.

Comply with any Federal and/or State statute, regulation, or policy that requires the provision of health care insurance.

Process paychecks in accordance with timelines established by the Colorado Department of Labor and Employment.

Track and report utilization of participant's allocations.

Manages and pays accrued sick time and family medical leave to attendants.

Manages and pays accrued sick time and family and medical leave to attendants.

The FMS contractors provide the following customer services which are above and beyond the minimal supports listed above:
• Guidance in understanding the Department’s rules related to CDASS and FMS
• Training on enrollment in FMS
• Guidance on attendants’ worker’s compensation insurance claims
• Guidance on understanding tax forms
• Training on completing and understanding timesheets
• Provide a Contact Center that provides customer support

Performs mandatory training to the participant and/or authorized representative related to FMS functions. Clients and case management training for CDASS is provided by a training vendor.

The Department contracts with FMS organizations. The Department does not consider the training vendor an FMS.

Supports furnished when the participant exercises budget authority:

- [x] **Maintain a separate account for each participant's participant-directed budget**
- [x] **Track and report participant funds, disbursements and the balance of participant funds**
- [ ] **Process and pay invoices for goods and services approved in the service plan**
- [x] **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- [x] **Other services and supports**

Specify:

Provide monthly statement of expenditures.

Maintain a participant portal that enables online access to current expenditures and participant directed budget status.

Additional functions/activities:

- [ ] **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- [ ] **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- [x] **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**

☐ **Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

a. Monitoring consists of an internal evaluation of FMS procedures, review of reports, review of complaint logs, re-examination of program data, on-site review, formal audit examinations, and/or any other reasonable procedures. Oversight of FMS entities is ensured by the Department through the establishment and oversight of a contractual agreement.
b. The contract is overseen by an administrator at the Department and performance is assessed quarterly.
c. An on-site review is conducted at least annually.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

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

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

As part of the Service Plan development process described in Appendix D-1.d of this application, case managers inform participants and/or legal guardians of all possible service alternatives, including opportunities for participant direction. The case manager assists with the completion of and reviews the required paperwork; Physician Attestation of Consumer Capacity form, Authorized Representative forms (if needed), Client or Authorized Representative Responsibilities form, and Attendant Support Management Plan (ASMP). The case manager then determines the level of care the client requires through the completion of an assessment including using the ULTC tool, Supports Intensity Scale, and other available assessments, and collaborates with the participant and/or Authorized Representative in the development of the Service Plan; coordinate with the Financial Management Services and Training and Operations contractors; and monitor participant-directed service effectiveness, quality, and expenditures.

Participants and/or legal guardians who choose the CDASS service delivery option are required to obtain a completed Physician Attestation of Consumer Capacity. If the physician indicates that the participant is unable to direct his/her care, the case manager must ensure that the participant or legal guardian designates an Authorized Representative as described in Appendix E-1.f of this application. If the Physician Attestation of Consumer Capacity indicates the participant is not in stable health, the participant is not eligible for the CDASS delivery option, and the case manager must provide the participant and/or legal guardian with his/her service options.

Case managers refer participants and/or Authorized Representatives to the Training and Operations contractor for the mandatory skills training. Following successful completion of that training, the participant and/or Authorized Representative must submit an Attendant Support Management Plan (ASMP) to the case manager for approval. The ASMP describes the following: how the participant will use attendant supports; a plan for recruiting and hiring attendants; an emergency backup plan; and a monthly budget worksheet. The case manager assists in the further development of the ASMP to address the participants assessed needs and any areas of concern and must approve the ASMP before services may begin under the CDASS delivery option. The case manager also coordinates the termination of existing agency-based services to ensure continuity of care and to eliminate potential duplication.

The FMS contractor monitors employment documentation provided by the participant and/or Authorized Representative to determine that it is complete, accurate, and timely. Case managers coordinate with the FMS and participants to ensure that all employment paperwork is submitted.

The participant’s allocation is determined as described in Appendix E-2.b.ii of this application. The FMS contractor provides monthly expenditure and utilization reports to the case manager and the participant and/or Authorized Representative for the purpose of financial and service reconciliation. The case manager monitors these reports for patterns of unusual spending, premature depletion of the participant’s allocation, and under and/or overutilization of services. The case manager works with the participant to determine if the participants assessed needs are being met through the CDASS service delivery option. When necessary expenditure safeguards described in Appendix E-2.b.v of this application will be implemented.

In order to assess the participant's and/or Authorized Representative's effectiveness and satisfaction with the participant-directed services; the case manager must contact the participant and/or the Authorized Representative at least monthly for the first three months and quarterly thereafter. Should the participant and/or Authorized Representative report a change in functioning which requires a modification to the participant’s ASMP or allocation, the case manager conducts a reassessment.

☒ **Waiver Service Coverage.**

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

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Benefits Planning	☐
Personal Emergency Response	☐
Respite	☐
Specialized	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Medical Equipment and Supplies	
Dental Services	☐
Hippotherapy	☐
Home Delivered Meals	☐
Assistive Technology	☐
Non-Medical Transportation	☐
Recreational Facility Fees/Passes	☐
Health Maintenance Activities	☒
Life Skills Training	☐
Remote Support Technology	☐
Prevocational Services	☐
Mentorship	☐
Day Habilitation	☐
Vision Services	☐
Peer Mentorship	☐
Behavioral Services	☐
Movement Therapy	☐
Personal Care	☒
Massage Therapy	☐
Transition Setup	☐
Supported Employment	☐
Home Accessibility Adaptations	☐
Homemaker	☒
Vehicle Modifications	☐

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

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

a. The Department contracts with a Training and Operations vendor to provide mandatory CDASS skills training to participants and/or Authorized Representatives, to provide training to case managers, and to provide customer service related to the CDASS delivery option.

b. The Training and Operations contractor is competitively procured in accordance with the State of Colorado Procurement C.R.S.25.5-6-12 et. seq. The Department pays a monthly fee for the participant and Authorized Representative training. The amount of the monthly payment was determined through a competitive bid process. The Department also pays a quarterly fee for case management training. The amount of this payment is a fixed contract amount and was determined through the competitive bid process.

c. The mandatory CDASS skills training provides the participant and/or the Authorized Representative with information about participant direction through the CDASS delivery option, participant rights, participant responsibilities, planning, and organizing attendant services, managing personnel issues, recognizing and recruiting quality attendant support, managing health and emergencies, using resources, and working with the FMS contractor. The Training and Operations contractor also maintains a call center and provides training and technical assistance to case managers and participants.

d. The contract manager monitors all activities conducted by the Training and Operations contractor pursuant to the terms of the contracts. Monitoring consists of an internal evaluation of procedures, review of reports, review of complaint logs, re-examination of program data, on-site review, formal audit examinations, and/or any other reasonable procedures.

e. Performance of these activities is assessed by a Department contract manager.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

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

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

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

CDASS is a voluntary service delivery option from which a participant may choose to terminate at anytime. Participants are informed of the process to voluntarily terminate when they receive CDASS training. Participants who choose to voluntarily terminate from the CDASS delivery option must contact their case manager. Case managers assist participants in transitioning to equivalent agency-based services in the community. A participant may choose to return to the CDASS delivery option as long as the participant remains eligible. Services may continue under the CDASS delivery option while the transition to agency-based services is in process.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

The Case Manager may involuntarily terminate the use of the CDASS delivery option under the following conditions:

1. The participant no longer meets CDASS criteria due to deterioration in physical or cognitive health and refuse to designate a new Authorized Representative to direct services;

2. The participant and/or Authorized Representative demonstrate a consistent pattern of overspending the monthly allocation leading to the premature depletion of funds, and the case manager has determined that attempts using the service utilization protocol to assist the participant/Authorized Representative to resolve the overspending have failed;

3. The participant and/or Authorized Representative exhibit Inappropriate Behavior toward Attendants, Case Managers, Training and Operations vendor, or the FMS vendor, and the Department has determined that the FMS vendor has made adequate attempts to assist the participant and/or Authorized Representative to resolve the Inappropriate Behavior, and those attempts have failed. Inappropriate Behavior as defined in 10 CCR 2505-10 Section 8.510.1 means offensive behavior which includes: documented verbal, sexual, and/or physical abuse. Verbal abuse may include threats, insults, or offensive language over a period of time;

4. There is documented misuse of the monthly allocation by the participant and/or Authorized Representative;

5. There has been intentional or consistent submission of fraudulent CDASS documents to case managers, the Department, Training and Operations vendor, or the FMS vendor;

6. Instances of convicted fraud and/or abuse; and/or

7. The client and/or authorized representative consistently fail to manage and meet EVV compliance requirements as outlined in the training materials located on the Participant Directed Program Website: https://hcpf.colorado.gov/participant-directed-programs.

Termination may be initiated immediately for participants being involuntarily terminated. Participants who are involuntarily terminated according to the above provisions, with the exception of EVV compliance, will not be re-enrolled in the CDASS delivery option. Clients and/or authorized representatives terminated due to EVV non-compliance are eligible to re-enroll in CDASS after 365 days from termination. The case manager must ensure choices for equivalent agency-based services are made available to ensure participant health and welfare.

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 Case Management Agency (CMA) 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 and 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 CMA anticipates an adverse action will be taken (i.e. when the CMA is denying enrollment, or taking action to suspend, reduce or terminate services).

Participants accessing services through the CDASS delivery option are required to provide a Physician Attestation of Consumer Capacity from the primary care physician attesting to a pattern of stable health that necessitates a predictable pattern of attendant support of CDASS services. Should the participant's physician indicate that the participant is not in stable health, the case manager must ensure choices for equivalent agency-based services are made available to ensure participant health and welfare. Should the participant be determined by his/her physician to return to stable health, the participant may re-enroll in the CDASS delivery option.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		522
Year 2		522
Year 3		522
Year 4		522
Year 5		522

Appendix E: Participant Direction of Services

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

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

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

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

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

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

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

☒ **Recruit staff**

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

☐ **Select staff from worker registry**

☒ **Hire staff common law employer**

☒ **Verify staff qualifications**

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

Specify how the costs of such investigations are compensated:

The FMS is compensated for the costs of the Colorado Bureau of Investigation (CBI) criminal history background checks at the time of a prospective attendant enrollment through the FMS administration fee.

If a member and/or authorized representative chooses to obtain a CBI criminal background check report for a working attendant or to obtain other types of reports, the member/authorized representative is responsible for the costs of the additional reports. The member and/or authorized representative will have access to information on how to request and pay for these reports along with resources to understand the information they entail. For CBI reports that have been updated to clarify charges as a stipulation of conditional employment, the FMS will request and pay for the report one additional time. It is the member/authorized representative and prospective attendant's responsibility to notify the FMS when the CBI report has been updated.

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

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

Prior to employment as a CDASS attendant, the Financial Management Service (FMS) vendor selected by the member and/or authorized representative will perform a background check which includes a Criminal Background Check through Colorado Bureau of Investigation (CBI). The Department maintains a list of crimes of high risk established by stakeholders. This list prohibits a potential attendant who has been convicted of any one of the crimes from employment as a CDASS attendant unless the member and/or authorized representative seek an exception to hire the individual through the Department established process. The process requires that the Department receive a written attestation that: the background check report was received and reviewed, that the reason for initial ineligibility is understood, that the member chooses to hire this person. The exception request must include a member and/or authorized representative developed safety plan containing specific safety elements.

The safety plan will be developed by the CDASS member and/or authorized representative and will be specific to the circumstances of the member, the member's needs and the attendant they choose to hire through the exception process. The safety plan must include the member's rationale for hiring this person despite the CBI Criminal Background Check report findings, oversight measures they will utilize, supports and resources they plan to access, and back up plans if the attendant must be terminated. The Training and Operations vendor staff walk members/authorized representatives through possible health and safety risk scenarios and encourage them to create plans that are comprehensive. The Department will inquire if the member/authorized representative needs to update the safety plan to reflect any additional support relative to the exception granted attendant. The CDASS member/authorized representative will be provided educational and training resources that can help them better understand the crimes, potential risks, and community resources if they need additional safety and health support.

Exception requests must be reviewed and granted by the Department.

The criteria that the unit will use to base its decision to grant exceptions is as follows:

1. Did the member/authorized representative receive the CBI Criminal Background Check report.
2. Did the member/authorized representative review the report.
3. Does the member/authorized representative understand the report and the results that have made the individual initially ineligible for hire as an attendant.
4. What is the severity of the results.
5. What is the age of the results.
6. Does the member/authorized representative have a complete safety plan that is unique to the hiring decision of this attendant.

a. A safety plan must have the following elements:

i. The rationale for the member/authorized representative choosing to hire the attendant despite the CBI Criminal Background Check report results.

ii. What monitoring will be used to ensure the attendant is meeting the member's needs.

iii. How the Department will provide oversight to attendants that receive exceptions.

iv. What entities and methods the member/authorized representative will use to report fraud and MANE concerns.

v. What specific resources the member/authorized representative will use to seek out support for fraud and MANE concerns.

vi. What will be the back up plan to ensure continuity of services if this attendant must be terminated or is not available.

Additional information located in Main B. Optional

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

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

☒ **Schedule staff**

☒ **Orient and instruct staff in duties**

☒ **Supervise staff**

☒ **Evaluate staff performance**

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

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

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

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

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

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

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

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

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

☒ **Substitute service providers**

☒ **Schedule the provision of services**

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

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

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

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

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

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

The needs considered in the determination of the participant's allocation must reflect the assessed needs identified by a comprehensive assessment using the ULTC 100.2, the Supports Intensity Scale (SIS), and documented in the Service Plan. The case manager calculates the participant's allocation which is determined using the Department prescribed method at the initial enrollment and at reassessment. Service authorization will align with the client's need for services and adhere to all service authorization requirements and limitations established by the client's waiver program. The established methods include the case manager's determination of the number of Personal Care Services, Homemaker Services, and Health Maintenance Activities hours needed on a weekly basis. A worksheet converts the service hours into an annual allocation amount. This is the amount of the participant-directed budget for waiver services over which the participant has authority.

The Department will ensure that the process to determine a participant's allocation is transparent to the participant and/or guardian. When a CDASS participant and/ or Authorized Representative participate in CDASS training, the Training and Operations contractor provides the participant and/or Authorized Representative with basic information about how the allocation is derived. If participants and/or Authorized Representatives request more detailed information, the Training and Operations contractor refers the participant to their case manager for an individualized explanation. In addition, the worksheets used to determine allocations are available to the public on the Department's website.

The training and operations vendor receives compensation monthly through a deliverables-based contract. This includes initial training and retraining of participants, answering support calls, and hosting call-in sessions regarding topics of interest to consumer direction.

Each Financial Management Services (FMS) vendor has a contracted rate for the F/EA model. The FMS vendor will continue billing using the contracted F/EA model reimbursement.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

Case managers and participant and/or Authorized Representative develop the allocation. The participant is provided written notification of the approved allocation available for services under the CDASS delivery option. If there is a change in participant condition or service needs, the participant and/or Authorized Representative may request the case manager to perform a reassessment. Should the reassessment indicate that a change in need for attendant support is justified, the participant and/or Authorized Representative must amend the Attendant Management Support Plan with the assistance of the case manager. The case manager will provide the participant with the updated allocation available for CDASS services.

In approving an increase in the allocation, the case manager will consider the following: any deterioration in the participant's functioning or change in the natural support condition, the appropriateness of attendant wages as determined by Department's established rate for equivalent services, and the appropriate use and application the CDASS allocation.

In approving a decrease in the allocation, the case manager will consider the following: any improvement of functional condition or changes in the available natural supports, inaccuracies or misrepresentation in previously reported condition or need for service, and the appropriate use and application of funds to CDASS services. The case manager notifies the participant or his/her legal representative when CDASS allocation is denied or reduced. Notice of participant appeal rights is mailed using the Department approved Notice of Action form which also includes the appeal rights and filing instructions.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

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

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

The Department maintains a services utilization and allocation management protocol for CDASS. The case manager reviews monthly reports provided by the FMS to monitor participant spending patterns and service utilization to assure appropriate management of funds available to meet assessed needs. If the case manager determines that the participant's spending patterns indicate a premature depletion of the budget, the case manager finds that a client has used 10% more than the monthly allocation they will contact the participant and/or Authorized Representative to determine the reason for overspending. If needed, the case manager will review the service plan to ensure that the participant's needs are adequately reflected in documentation. If the participant needs have changed the case manager will complete a reassessment to determine if an allocation increase is needed.

If the participant consistently overspends the monthly allocation, a retraining will be required. The case manager will refer the client and/or the Authorized Representative to the Training and Operations vendor for additional training.

If the participant and/or Authorized Representative completes training and continues to spend in a manner indicating premature depletion of funds, the client will be required to select another Authorized Representative.

If all efforts to determine the cause of and provide support to prevent premature spending fail, the participant will be involuntarily terminated from CDASS.

The current protocol is in place as a safeguard for underutilization. This includes the case manager conducting a quarterly review of the client expenditure statements provided by the FMS provider. Case manager will review the underutilization with the client and/or the Authorized Representative to review the allocation to ensure that services are meeting the clients support needs. The case manager may:

- Conduct a reassessment
- Explore other service delivery options and/or;
- Refer client/AR to training vendor if budgeting has been determined to be the problem.

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 and 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 Section 8.057.9 et seq and apply to all persons receiving services for Individuals with Intellectual Disabilities, including waiver participants.

Waiver participants are provided the right to appeal services when services set forth in the Service Plan are to be changed, reduced, or denied. This process begins as a dispute resolution process, where due process is afforded to all parties involved. If the dispute resolution process is exhausted or if this is waived by the parties, the objecting party may request that the Department review the decision. The Department's decision shall constitute final action on the dispute. Specific information on the dispute resolution process is as follows:

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 Section 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.

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.

The Department monitors the Dispute Resolution process at Program Approved Service Provider Agencies through its Inter Agency Agreement with the Colorado Department of Public Health and Environment (CDPHE). The CDPHE monitors to ensure clients/guardians are informed annually of their Dispute Resolution due process rights. The Department monitors all case management services provided by the Community Centered Boards (CCB), including dispute resolution processes. The Community Centered Boards, as the designated Case Management Agency, is responsible for PAR approvals or denials for all HCBS-SLS waiver services and therefore responsible for dispute resolutions related to PAR approval or denial. The Department monitors the dispute resolution at the CCBs. The Department requires that all Community Centered Boards and Service Agencies shall have procedures which comply with requirements as set forth in rules at 10 CCR 2505-10 Section 8.605.2 et seq and Section 25.5-10-212 C.R.S. The

types of disputes that can be addressed are:
• The applicant is not eligible for services or supports
• The client is no longer eligible for services or supports
• Services or supports are to be terminated, or
• Services set forth in the IP which are to be provided, are to be changed or reduced or denied

The process and timelines include:
• The opportunity for informal negotiation or mediation through a meeting of all parties or their representatives within 15 days of receipt of the complaint.
• After opportunities for informal negotiation have been attempted or mutually waived, either party may request the formal Dispute Resolution procedures be initiated
• Notification of the meeting must be provided at least 10 days prior to all parties unless waived by the objecting parties
• Written decision must be provided within 15 days of the meeting
• If the Dispute is not resolved, the objecting party may request that the Executive Director of the Department or designee review the decision

The Department shall render a decision within 10 working days of the submission of all relevant information and this decision shall constitute final agency action on the dispute.

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 and 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 Section 8.605.5 et seq and apply to all persons receiving services for Individuals with Intellectual and Developmental 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 and 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 email. 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 voicemail or e-mail are to be responded to within one business day. Primary involvement by the Department staff in resolving the complaint is generally only implemented when local efforts to resolve the complaint have failed, or if the complainant has a valid reason for not contacting the local agency (e.g., previous efforts to resolve similar complaints have failed, complaint involves a manager at the agency, fear of retaliation, etc.) Timelines for resolving the complaint are to be commensurate with the seriousness of the complaint (e.g., a complaint regarding a health and welfare issue shall be resolved immediately, complaints regarding agency meal menu selection procedures should be resolved promptly, etc.). The Department 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 (CCBs), and Case Management Agencies (CMAs) 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 Department Rules located at 10 CCR 2505-10 Section 8.608.8(2)(10).

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 (ANE), 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 operates a web-based critical incident reporting system and requires all CMAs to report a specific class of incidents, termed critical incidents, to the Department within 24 hours (business day) of notification of the incident. Critical incidents are reported to the Department via the web-based Critical Incident Reporting System (CIRS) through a secure web portal. CMAs and waiver service providers may also fax a critical incident report to the Department when necessary.

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 Incident Categories that must be reported include, but are not limited to: injury/illness; Mistreatment/abuse/neglect/exploitation; damage/theft of property; medication mismanagement; lost or missing person; criminal activity; unsafe housing/displacement; or death

Critical Incidents Types:

Death
-Unexpected or expected
Mistreatment/Abuse/Neglect/Exploitation

-Mistreatment means:
- o Abuse
- o Caretaker neglect
- o Exploitation
- o 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
- Unlawful sexual behavior as defined in Section 16-22-102(9), 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 that 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 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

Program Approved Service Agency (PASA) Reporting- The Department requires all service providers to report Critical Incidents of specific types of incidents to the Case Management Agency (CMA) immediately upon detection but no more than 24 hours after the incident occurrence.

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.

The Department's oversight for monitoring safeguards and standards is with the use of critical incident reports (CIRs) or complaint logs. The Department and the contract QIO review and track critical incident reports to ensure that a resolution is reached and the client's health and safety have been maintained.

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

In the event an individual must evacuate their current setting, the Department has developed processes that will ensure the health, safety, and welfare of the client while allowing for additional flexibility in the location and timeliness of the

critical incident reporting due to the emergent need. The member’s case manager will enter the member’s critical incident and any identified follow-up to the critical incident utilizing existing timelines identified by the Department and may request an extension in timelines for entry from the Department to the urgent nature of the evacuation.

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

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.

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 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 mistreatment, 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 mistreatment, 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 the 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 support 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 2505-10 806.8. All investigations completed by CCBs are to comply with the recommended standards of practice specified in the Conducting Serious Incident Investigations manual developed by Labor Relations Alternatives, Inc. The local Human Rights Committee (HRC) reviews all written investigation reports and, where appropriate, issues recommendations for follow-up actions by the provider agency and or the CCB and or the CMA.

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

Response to Critical Incidents by The Department-The Department contracts a Quality Improvement Organization (QIO) to review all Critical Incidents. The QIO monitors Critical Incidents for the completion of necessary follow-ups 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 the CMA contract, and termination of a service provider’s Colorado Provider Participation Agreement/Program Approval for the HCBS-SLS 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 (ANE). This is to ensure the investigation is thorough, conclusions are based upon evidence, and 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 support.

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 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-SLS 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-SLS 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 Plan to address behavior and individual's Safety Control Procedure). In addition, the PASA and CMA must have policies and procedures specific to the use of emergency control procedures (i.e., unanticipated use of restraint) and should include positive behavioral interventions in such procedures.

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 individual 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 person receiving services shall place excess pressure on the chest or back of that person or inhibit or impede the person's ability to breathe.

-During physical restraint, the person'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 person in mechanical restraint, except when the person is sleeping. A written record of relief periods must be maintained.

A person 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 service provider 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.R.S. chemical restraints may be used, only in an emergency and cannot be ordered or used on a PRN basis. Only a licensed physician that has directly observed the emergency can prescribe chemical restraints or he/she may order the use of the medication for an emergency via telephone if a licensed registered nurse has directly observed the 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.

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 PASAs and 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 Section 8.608.4(4) and 8.608.4(B) and that restraints are used only within the requirements specified in 10 CCR 2505-10 Section 8.608.3 et seq and 8.608.4 et seq 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-SLS 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: the use of seclusion is specifically prohibited by § 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.

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 Section 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 Section 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 § 25.2-10-118 C.R.S. and 10 CCR 2505-10 § 8.604.3. A suspension of rights is authorized under the two following processes:

-Imposition of Legal Disability: Pursuant to § 25.5-10-116 C.R.S. any individual, including a case manager for a waiver participant, may petition the district court to issue an imposition of legal disability to remove a participant's legal right. The statute provides specific requirements for when such an imposition may be granted and within six months after a legal disability has been imposed a review must occur. All actions to remove a legal right require a court order.

-Suspension of rights: Under the Statewide Transition Plan (STP), providers and case management agencies are moving toward compliance with the requirements of the HCBS Settings Final Rule, including that any rights suspension or restrictive procedure must comply with the HCBS Settings Final Rule requirements, pursuant to 79 Fed. Reg. 2948 and 42 C.F.R. § 441.301, § 25.5-10-118 C.R.S., and 10 CCR 2505-10 § 8.604.3. As of January 1, 2021, case managers were required to enter information about new and up-for-renewal rights modifications in the State's case management IT system. The Department is working with stakeholders to codify the federal settings criteria within state regulations, with the expectation that this codification will be effective by roughly Summer 2021. Under this codification, all rights suspensions and restrictive procedures will be treated as a rights modification under the Federal Rule, and thus 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 person-centered service plan. The following requirements must be documented in the person-centered service plan:

1. Identify a specific and individualized need.

2. Document the positive interventions and supports used prior to any modifications to the person-centered service plan.

3. Document less intrusive methods of meeting the need that have been tried but did not work.

4. Include a clear description of the condition that is directly proportionate to the specific assessed need.

5. Include regular collection and review of data to measure the ongoing effectiveness of the

modification.

6. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

7. Include the informed consent of the individual.

8. Interventions and supports will cause no harm to the individual.

State regulation and safeguards in place to protect participant's rights are included in 10 CCR 2505-10 Section 8.604.1et seq, 8.604.2 et seq, and 8.604.3 et seq and include 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 the 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 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 rules.

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 a functional analysis of the participant's challenging behavior,

c) Prepare a written ISSP with specific information defined in Department rule 10 CCR 2505-10 Section 8.608.1(B), 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 Service Plan or Service Plan addendum. Copies of the comprehensive life review, functional analysis assessment, written ISSP, and data documenting the use of the restrictive procedures must be maintained in the 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 in Department rule 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.

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-SLS service providers not licensed by CDHS. CDPHE conducts on-site recertification surveys of service agencies that include a review of the agency's incident management practices, compliance with standards for incident reporting, and review and data analysis practices. Such surveys include a specific review of written incident reports documenting the use of interventions to ensure such reports contain the information required by the Department. When non-compliant use of interventions is detected, deficiencies are cited, and the responsible agency is required to submit a plan of correction. Program Quality on-site surveys are completed at least every three years. CDPHE submits a report monthly to HCPF on the number and type of providers surveyed and the findings.

Critical Incident Reporting System (CIRS) Monitoring- The web-based CIRS system operated by the Department includes a specific data field for recording if any critical incident involved the use of restrictive interventions. Therefore, any use of a restrictive intervention in an allegation of serious abuse, medical crisis (i.e. needing emergency medical treatment), a crime against a person, or death is reported immediately to the Department. Such incidents receive additional scrutiny by the Department staff that includes a review of the original written incident report to ensure restrictive interventions were used in compliance with statutory and regulatory requirements. The CIRS monitoring operates on a daily/continuous basis.

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

Program Quality Surveys- The Department conducts regulatory surveys of CMAs that include a review of the agency's incident management practices, compliance with standards for incident reporting and review, and data analysis practices. Such surveys include a specific review of written incident reports documenting the use of restrictive interventions to ensure such reports contain the information required by 10 CCR 2505-10 § 8.608.4(A)(4) and 8.608.4(B) and that restrictive interventions are used only within the requirements specified in 10 CCR 2505-10 § 8.608.3 et seq. and 8.608.4 et seq. Additionally, surveys of CMAs include a specific review of the local HRC review activities, the composition of the participant's interdisciplinary team, and an investigation of allegations of abuse related to unreasonable restrictive interventions. When non-compliant use of restrictive procedures, restraints, or any use of seclusion is detected, deficiencies are cited and the responsible agency is required to submit a plan of correction.

The Critical Incident Reporting Team monitors data on a monthly and quarterly basis. Provider trends are relayed to the Department's Benefits Division to address and determine appropriate actions as needed.

CIRs data are tracked, trended, and analyzed by the Critical Incident Reporting Team on a monthly and quarterly basis. Specific provider trends are relayed to the Benefits division to address and determine what improvement strategies need to be implemented.

Appendix G: Participant Safeguards

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

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

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

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this

oversight is conducted and its frequency:

Seclusion: § 25.5-10-221 C.R.S. prohibits the use of seclusion. Monitoring by case managers, investigation of complaints made to Case Management Agencies (CMA) and the Department of Health Care & 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-SLS waiver service providers must complete on-site monitoring of the administration of medications to waiver participants including inspecting medications for labeling, safe storage, completing pill counts, and reviewing and reconciling the medication administration records, and interviews with staff and participants.

As part of the health inspection and survey process, CDPHE reviews medication administration procedures, storage of all medication, including controlled substances, medication audit and disposal practices, and reporting required for drug reactions and medication errors. If deficiencies are cited in any of these areas, CDPHE will follow-up with the provider to ensure compliance with the regulations.

Medication Management and Administration is a responsibility of the PASA and is monitored through CDPHE. The Department requires all PASA's to submit incidents of medication errors which result in a risk to the health of safety of an individual and meet Critical Incident reporting guidelines within 24 hours. The Department completes reviews of CIRs submitted to ensure compliance with requirements and completes follow up with PASA's for remediation/mitigation when necessary.

In addition, the Department monitors Critical Incident Reports submitted by providers for instances of a critical incident resulting from a medication management issue.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

The Department of Health Care Policy and Financing (the Department) is responsible for oversight as the single state Medicaid agency. The Department provides oversight through the following methods:

The Department maintains an Interagency Agreement with the Colorado Department of Public Health and Environment (CDPHE) to monitor medication administration for HCBS-SLS 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 Section 8.609(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 medications 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.

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).

(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 and +/-5% confidence interval
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
G.a.2 Number and percent of all critical incidents that were reported by the Case Management Agency (CMA) within required timeframe as specified in the approved waiver N: Number of all critical incidents reported by the CMA within the required timeframe as specified in the approved waiver D: Total number of all critical incidents reported by the CMA

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
G.a.3 Number and percent of all critical incidents that were remediated N: Number of all critical incidents that were remediated D: Total number of critical incidents

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

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

Data Aggregation and Analysis:

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

Performance Measure:
G.a.4 # and % of complaints against licensed waiver providers reported to CDPHE involving allegations of ANE that were resolved according to CDPHE regs N: # of complaints against licensed waiver providers reported to CDPHE involving allegations of ANE resolved according to CDPHE regs D: Total complaints against licensed waiver providers reported to CDPHE involving allegations of ANE.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Monthly Complaint Reports Submitted by CDPHE

Responsible Party for data collection/generation *(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**

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:

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

Performance Measures

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

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

Performance Measure:
G.b.3 Number and percent of annual reports provided to Case Management Agencies (CMAs) on identified trends in critical incidents N: Number of annual reports provided to the CMAs on identified trends in critical incidents D: Total number of annual reports required to be provided to CMAs

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:
State's case management IT System Data and/or CDPHE Reports; Record Reviews

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

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

Data Aggregation and Analysis:

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

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
State's case management IT System Data/Critical Incident Reports

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** 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 Numerator: Number of providers surveyed that met the requirements for use of training and support plans with restrictive procedures Denominator: Total number of providers surveyed

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

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

Data Aggregation and Analysis:

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

Performance Measure:
G.c.6 Number and percent of waiver participants with Restrictive Intervention Plans where proper procedures were followed in initially establishing the Restrictive Intervention Plan N:# of wvr participants w/ Restrictive Intervention Plan where proper procedures were followed in initially establishing the Restrictive Intervention Plan D:# of wvr participants w/ a Restrictive Intervention Plan

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

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

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

Data Aggregation and Analysis:

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

Performance Measure:
G.d.3 Number and percent of waiver participants who received care from a medical professional within the past 12 months Numerator: The number of participants who received care from a medical professional within the last 12 months Denominator: The total number of participants reviewed

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

The Dept. uses 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 critical incident reporting system (CIRS) and follow up on each Critical Incident Report (CIR) through the CIRS. Following the receipt of the initial critical incident report, the QIO reviews the documentation to determine if the instance was substantiated. If the documentation does not clearly state whether the 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 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 with 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
Critical incidents are reported to the Dept. via the web-based CIRS. CMAs and waiver service providers are required to report critical incidents within specific timeframes. The 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 an ombudsman, or additional follow-up with the participant. The CIR Administrator determines if adequate follow-up was conducted and if all appropriate actions were taken and may require additional follow-up or investigation if needed.

G.a.4
Critical incidents involving providers surveyed by CDPHE must be reported to the Dept. and CDPHE and are responded to by CDPHE. A hotline is set up for complaints about the quality of care, fraud, abuse, and misuse of personal property. CDPHE evaluates the complaint and initiates an investigation if warranted. The investigation begins within 24 hours or up to 3 days depending upon the nature of the complaint and risk to the participant’s health and welfare.

G.a.6
CMAs are required to attend preventative strategies training. Training records are maintained through webinars or in-person attendance of preventative strategies training provided 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 critical incident trend reports to be provided to all CMAs at least annually. Records of the reports and dates provided are maintained by the Dept.

G.b.4
The Dept. examines data in the CIRS to determine when critical incidents were preventable and whether resolutions were effective.

G.b.6
Root cause identified/trends reduced as a result of systemic intervention data are tracked and analyzed by the CIR

Team on a monthly and quarterly basis including through the mortality review committee.

G.c.1
Oversight and discovery of restrictive interventions where proper procedures were not followed are completed through the review of complaints regarding services and supports and conducting surveys of CMAs by Dept. staff and providers by CDPHE.

The Dept also monitors for the inappropriate/ineffective use of Restrictive Interventions (RI) through the CIRS. These incidents receive additional scrutiny by the Dept staff that includes a review of the original written incident report to ensure RI was used in compliance with 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 with RI.

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 with waiver service providers and/or CMAs when needed for deficient practice in following the proper procedures of RIs. This includes a formal request for response, technical assistance, Dept. investigation, the imposition of corrective action, termination of CMA contract, and termination of waiver service providers.

G.d.3
Service Plans must demonstrate that waiver participants identified health needs have been addressed through a waiver service and/or other support, i.e. natural supports, other state programs, private health insurance. The QIO reviewers use the BUS and/or Bridge to discover deficiencies for this performance measure and report in the QI Review Tool.

b. Methods for Remediation/Fixing Individual Problems

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

Issues or problems identified during annual program evaluations will be directed to the Case Management Agency (CMA) administrator or director and reported in the individual's annual report of findings. CMAs deficient in completing accurate and required critical incident reports will receive technical assistance and/or training by Dept. staff. CMAs are required to submit individual remediation action plans for all deficiencies identified within 30 days of notification. Following receipt of the CMA's remediation action plan, the Dept. reviews the plan and confirms the appropriate steps have been taken to correct the deficiencies.

In addition to annual data collection and analysis, Dept. contract managers and program administrators remediate problems as they arise based on the severity of the problem or by nature of the compliance issue. For issues or problems that arise at any other time throughout the year, technical assistance may be provided to the CMA case manager, supervisor, or administrator, and a confidential report will be documented in the waiver recipient care file when appropriate. The Dept. reviews and tracks the on-going referrals and complaints to ensure that a resolution is reached, and the participant's health and safety have been maintained.

G.a.1
The Dept. provides remediation training CMAs annually to assist with improving compliance with this measure. The remediation process includes a standardized template for individual CMA Corrective Action Plans (CAPs) to ensure all of the essential elements, including root-cause analysis, are addressed in the CAP. Time-limited CAPs are required for each performance measure below the 86% CMS compliance standard. The CAPS must also include a detailed account of actions to be taken, staff responsible for implementing the actions, and timeframes, and a date for completion. The Dept. reviews the CAPs, and either accepts or requires additional remedial action. The Dept. follows up with each individual CMA quarterly to monitor the progress of the action items outlined in their CAP.

G.a.2
The Dept. takes remedial action to address with waiver service providers and/or CMAs when needed for deficient practice in reporting and management of Critical Incidents. This includes a formal request for response, technical assistance, Dept. investigation, the imposition of corrective action, termination of CMA contract, and termination of waiver service providers.

G.a.3
CMAs deficient in completing accurate and required follow-ups will receive technical assistance and/or training by Dept. staff. CMAs are required to submit individual remediation action plans for all deficiencies identified within 30 days of notification. Following receipt of the CMA's remediation action plan, the Dept. reviews the plan and confirms the appropriate steps have been taken to correct the deficiencies.

G.a.4
In instances whereupon review of the complaint or occurrence report the Dept. identifies individual provider issues, the Dept. will address these issues directly with the provider and participant/guardian. If the Department identifies trends or patterns affecting multiple providers or participants, the Dept. will communicate a change or clarification of rules to all providers in monthly provider bulletins. If existing rules require an amendment the Dept. will develop rules or policies to resolve widespread issues.

G.a.6
The Dept. requires agencies who do not attend preventative strategies training as required to submit a corrective action plan. If remediation does not occur timely or appropriately, the Dept. issues a "Notice to Cure" the deficiency to the CMA/provider. This requires the agency to take specific action within a designated timeframe to achieve compliance.

G.b.3, G.b.4
The Dept. utilizes this information to develop statewide training, determine the need for individual agency technical assistance for case management and service provider agencies. In addition, the Dept. utilizes this information to identify problematic practices with individual CMAs and/or providers and to take additional action such as conducting an investigation, referring the agency to CDPHE for complaint investigation, or directing the agency to take corrective action. If problematic trends are identified by the Dept. in the reports, the Dept will require a written plan of action by the CMA and/or provider agency to mitigate future occurrences.

G.b.6
Specific provider trends are relayed to the Benefits division to address and determine what additional remediation/improvement strategies need to be implemented.

G.c.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 a formal request for response, technical assistance, Dept. investigation, the 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 agencies of deficiencies and determines the appropriate remedial actions: training, technical assistance, 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 SLS waiver. The waiver specific requirements and assurances are included in the appendices.

The Department draws from multiple sources when determining the need for and methods to accomplish system design changes. Using data gathered from Colorado Department of Public Health and Environment (CDPHE), Critical Incident Reporting System (CIRS), annual programmatic and administrative evaluations, and stakeholder input, the Department's Office of Community Living Benefits and Services Management Division, in partnership with the Case Management Quality and Performance unit and Office of Information Technology (OIT), uses an interdisciplinary approach to review and monitor the system to determine the need for design changes, including those to the state's case management IT system. Work groups form as necessary to discuss prioritization and selection of system design changes.

Discovery and Remediation Information:

The Department maintains oversight over the (specify waiver) waiver in its contracts/interagency agreements through tracking of contract deliverables on a monthly, quarterly, semi-annually, and yearly basis, depending on the details of each agreement. The Department has access to, and reviews all required reports, documentation and communications. Delegated responsibilities of these agencies/vendors are monitored, corrected, and remediated by the Department's Office of Community Living.

Colorado selects a representative random sample (unless otherwise noted in the waiver application) of waiver participants for annual review, with a confidence level of 95% margin of error +/-5%, from the total population of waiver participants. The results obtained reflect systemic performance to ensure the waiver is responsive to the needs of all individuals served. The Department trends, prioritizes, and implements system improvements (i.e., design changes) prompted as a result of an analysis of the discovery and remediation information obtained.

To ensure the quality review process is completed accurately, efficiently, and in accordance with federal standards, the Department contracts with an independent Quality Improvement Organization (QIO) to complete the QIS Review Tool for the annual Case Management Agency (CMA) program case evaluations. Additionally, the Department performs an inter-rater reliability study of results provided by the QIO to determine accuracy of QIO reviews.

The Department uses standardized tools for level of care (LOC) eligibility determinations, person centered support planning, and critical incident reporting for waiver populations. Through use of the state's case management system, the data generated from LOC eligibility determinations, Person Centered Support Plans, and critical incident reports, and concomitant follow-up are electronically available to CMAs and the Department, allowing effective access and use for clinical and administrative functions as well as for system improvement activities. This standardization and electronic availability provides comparability across CMAs, waiver programs, and allows on-going analysis. In addition, the Department is on track to implement a new case management system in the Spring of 2022 to streamline processes for identifying member needs and coordinating support. This new system will eliminate the need for case managers to complete documentation in multiple systems which will reduce the chance for errors and/or missing information.

Waiver providers that are required by Medical Assistance Program regulations to be surveyed by CDPHE, must complete the survey prior to certification to ensure compliance with licensing, qualification standards and training requirements. The Department is provided with monthly and annual reports detailing the number and types of agencies that have been surveyed, the number of agencies that have deficiencies and types of deficiencies cited, the date deficiencies were corrected, the number of complaints received, and complaints investigated, substantiated, and resolved. Providers who are not in compliance with CDPHE and other state standards receive deficient practice citations. Department staff review all provider surveys to ensure deficiencies have been remediated and to identify patterns and/or problems on a statewide basis by service area, and by program. The results of these reviews assist the Department in determining the need for technical assistance, training resources, and other needed interventions. The Department initiates termination of the provider agreement for any provider who is in violation of any applicable certification standard, licensure requirements, or provision of the provider agreement and does not adequately respond to a plan of correction within the prescribed period of time.

Following Medicaid provider certification, the fiscal agent enrolls all providers in accordance with program regulations and maintains provider enrollment information in Colorado Medicaid Management Information System (MMIS), the interChange. All provider qualifications are verified by the fiscal agent upon initial enrollment and in a revalidation cycle; at least every five years.

The MMIS, interChange, is designed to meet federal certification requirements for claims processing and submitted claims are adjudicated against interChange edits prior to payment. Claims are submitted through the Department's fiscal agent for reimbursement. The Department also engages in a post-payment review of claims to ensure the integrity of provider billings.

The information gathered from the Department's monitoring processes is used to determine areas that need additional training/technical assistance, system improvements, and quality improvement plans.
Trending:
The Department uses performance results to establish baseline data, and to trend and analyze over time. The Department's aggregation and root cause analysis of data is incorporated into annual reports that provide information to identify aspects of the system which require action or attention.
Prioritization:
The Department relies on a variety of resources to prioritize changes in the BUS. In addition to using information from annual reviews, analysis of performance measure data, and feedback from case managers, the Department factors in appropriation of funds, legislation and federal mandates.
For changes to the MMIS, interChange, the Department has developed a Priority and Change Board that convenes monthly to review and prioritize system modifications and enhancements. Change requests are presented to the Board, which discusses the merits and risks of each proposal, then ranks it according to several factors including implementation dates, level of effort, required resources, code contention, contracting requirements, and risk. Change requests are tabled, sent to the fiscal agent for an order of magnitude, or cancelled. If an order of magnitude is requested, it is reviewed at the next scheduled Board meeting. If selected for continuance, the Board decides where in the priority list the project is ranked.
The Department continually works to enhance coordination with CDPHE. The Department engages in quarterly meetings with CDPHE to maintain oversight of delegated responsibilities; report findings and analysis; provider licensure/certification and surveys; provider investigations, corrective actions and follow-up. Documentation of inter-agency meeting minutes, decisions and agreements will be maintained in accordance with state record maintenance protocol.
Quality improvement activities and results are reviewed and analyzed amongst benefit administrators, case management specialists, and critical incidents administrators.
Implementation:
Prior to implementation of a system-level improvement, the Department ensures the following are in place:
- o Process to address the identified need for the system-level improvement;
- o Policy and instructions to support the newly created process;
- o Method to measure progress and monitor compliance with the system-level improvement activities including identifying the responsible parties;
- o Communication plan;
- o Evaluation plan to measure the success of the system-level improvement activities post-implementation;
- o Implementation strategy.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Quality Improvement Committee**	☒ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system

design changes. If applicable, include the state's targeted standards for systems improvement.

Monitoring and Analyzing System Design Changes:
The process used to monitor the effectiveness of system design changes will include systematic reviews of baseline data, reviews of remediation efforts and analysis of results of performance measure data collected after remediation activities have been in place long enough to produce results. Targeted standards have not been identified but will be created on baseline data once the baseline data has been collected.
Roles and Responsibilities:
The Office of Community Living Benefit and Services Management Division and the Case Management and Quality Performance Division hold primary responsibility for monitoring and assessing the effectiveness of system design changes to determine if the desired effect has been achieved. This includes incorporation of feedback from waiver participants, advocates, CMAs, providers, and other stakeholders.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Office of Community Living's Waiver Administration and Compliance Unit will review the QIS and its deliverables with management on a quarterly basis and will provide updates to CMS when appropriate.
Evaluation of the QIS is the responsibility of the Benefit and Services Management Division, Waiver Administration and Compliance Unit and the Case Management and Quality Performance Division, Quality Performance Section. This evaluation will take into account the following elements:
1. Compliance with federal and state regulations and protocols.
2. Effectiveness of the strategy in improving care processes and outcomes.
3. Effectiveness of the performance measures used for discovery.
4. Effectiveness of the projects undertaken for remediation.
5. Relevance of the strategy with current practices.
6. Budgetary considerations.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ◉ **NCI Survey :**
- ○ **NCI AD Survey :**
- ○ **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the*

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

(a) Pursuant to 2 CFR Part 200 - Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards Subpart F – Audit Requirements §200.502 (i), Medicaid payments to a sub-recipient for providing patient care services to Medicaid eligible individuals are not considered federal awards expended under this part unless a State requires the funds to be treated as federal awards expended because reimbursement is on a cost-reimbursement basis. Therefore, the Department does not require an independent audit of waiver service providers.

Case Management Agencies (CMAs) are subject to the audit requirements within 2 CFR Part 200 for all Medicaid administrative payments. To ensure compliance with components detailed in the OMB Uniform Guidance, CMAs contract with external Certified Public Accountant (CPA) firms to conduct an independent audit of their annual financial statements and conduct the Single Audit when applicable. The Dept is responsible for overseeing the performance of the CMAs, reviewing the Single Audits of all CMAs who meet the $750,000 threshold, and issuing management decisions on any relevant audit findings.

(b) & (c) Title XIX of the Social Security Act, federal regulations, the Colorado Medicaid State Plan, state regulations, and contracts establish record maintenance and retention requirements for Medicaid services. A case record/medical record or file must be maintained for each waiver participant. Providers are required to retain records that document 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 Dept 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 Dept monitors the action of licensing boards to ensure Medicaid providers are in good standing.

Claims are submitted to the Dept'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 reviewed

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

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

Data Aggregation and Analysis:

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

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

The information gathered for the annual reporting of the performance measures serves as the Department's primary method of discovery.
The state ensures that claims are coded correctly through a number of mechanisms:
1. Rates are loaded with procedure code and modifier combinations, thus any use of incorrect coding results in a claim paid at $0.00 or a denied claim,
2. System edits exist to ensure that only specific (appropriate provider types) are able to bill for waiver services,
3. Finally, performing a review of claims in conjunction with the Department's published billing manual identifies any incorrect coding which resulted in a paid claim.

Duties of providers include a requirement of documentation of care, in/out times, and confirmation that care was provided per state rules and regulations. Additionally, there must be the completion of appropriate service notes regarding service provision for each visit. Documentation shall contain services provided, date and time in and out, and a confirmation that care was provided. Such confirmation shall be according to agency policy. This is then reviewed by 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 Supported Living Services (SLS) 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 SLS FFS rate schedules are published through the Dept's provider bulletin annually and posted on 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 conform to the program or service design and are in compliance with the Code of Colorado Regulations and statutes.

B. Denver City Minimum Wage Consideration:
As a result of House Bill 19-1210 and Denver Council Bill 1237 (CB-1237), Denver has enacted a citywide annual minimum wage increase for all workers effective January 1, 2020. The implementation of this minimum wage will result in the following changes to the 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 varies for facilities that are leased and facilities that are owned. Utility pricing includes gas and electricity which are determined annually through the Public Utility Commission which provides summer and winter rates and thermostat conversions for appropriate pricing. Finally, internet and phone services are determined through the use of the Build Your Own Bundle tool available through the Comcast Enterprise website.

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 the per-employee cost and multiplied by the total FTE required to provide services per Medicaid client. To ensure rates do not exceed funds appropriated by the Colorado State Legislature, a budget neutrality adjustment is applied to the final determined rate.

Following the development of the rate, stakeholder feedback is solicited, and appropriate, necessary changes may be made to the rate. HCBS SLS FFS rates utilizing the methodology described above include:

- *Personal Care*
  - *Personal Care Remote Supports*

- *Respite*
- *Mentorship*
- *Health Maintenance Activities*
- *Homemaker*
  - *Homemaker Remote Supports*
- *Supported Employment: Job Coaching (Individual)*
- *Supported Employment: Job Development (Group)*
  - *Supported Employment: Workplace Assistance (effective July 1, 2023)*
- *Non-Medical Transportation*
- *Behavioral Services: Behavioral Line Staff*
- *Behavioral Services: Behavioral Plan Assessment*
- *Behavioral Services: Behavioral Consultation*
- *Behavioral Services: Behavioral Counseling (Individual and Group)*
- *Massage Therapy*
- *Movement Therapy*
- *Hippotherapy*
- *Home Delivered Meals*
- *Peer Mentorship*
- *Peer Mentorship - Telehealth*
- *Life Skills Training*
- *Life Skills Training - Telehealth*
- *Transition Set-Up*
  - *Benefits Planning (effective July 1, 2023)*

The HCBS SLS waiver utilizes a negotiated market price methodology for services in which reimbursement will differ by client, product, and frequency of use. The services utilizing the negotiated market price methodology include:

- *Respite: Group or Overnight Group*
- *Supported Employment: Job Placement (Individual or Group)*
- *Recreational Facility Fees/Passes*
- *Specialized Medical Equipment and Supplies (Disposable Supplies or Equipment)*
- *Personal Emergency Response System*
- *Home Accessibility Adaptations*
- *Assistive Technology*
- *Vehicle Modifications*
  - *Remote Support Technology*

The HCBS SLS waiver utilizes a public pricing methodology for public services. Services with public pricing methodology are reimbursed at the price paid by the general public for the same service. The services utilizing the public pricing methodology include:

*1. Non-Medical Transportation-Public Transit will be reimbursed at the RTD discounted rates applied to seniors 65+, individuals with disabilities, and Medicare recipients. The RTD rates can be found at the following link: http://www.rtd-denver.com/Fares.shtml and the discounted rates reimbursed by Medicaid are denoted by a single *. RTD rates are updated annually in January. The Department will update the rates and fee schedules annually in January to align with annual changes.*

For the above services, case managers coordinate with providers and determine a market price that incorporates the client's needs, the product required, and the frequency of use. The Dept's HCBS SLS waiver administrator 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. HCBS SLS waiver rates are reviewed for appropriateness every five years with the waiver renewal. Rates were last reviewed in 2018. Rates are communicated via Departmental notice in provider bulletins, and tribal notices and are made available on the Dept's external website to be accessed by stakeholders and providers at any time.

Strctured rates are used in the Dept's rate-setting model to reimburse those services for which the level of provider effort and the intensity of service are variables based on the differing support needs of individuals. The difficulty of care factors

has 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 on those Support Levels and other underlying cost components.

With 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 six 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.

Participants may change Support Levels based on changing needs and/or circumstances, and Support Level determinations may be disputed. Participants may submit a request for Support Level re-determination to the CCB at any time. A Department-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 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.

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

- *Day Habilitation: Specialized Habilitation*
- *Day Habilitation: Supported Community Connections*
  - *Day Habilitation: Supported Community Connections 1:1*
  - *Day Habilitation: Supported Community Connections Tier 3*
- *Prevocational Services*
- *Supported Employment: Job Coaching (Group)*
- *Supported Employment: Job Development (Individual)*

Non-Medical Transportation (To/From Day Program) is reimbursed at a structured fee-for-service rate that varies based on the trip distance.
The following services are reimbursed on a standard, fee-for-service basis but were not determined by the rate-setting model described above Dental Services and Vision Services.

The Dept reviews IDD Dental rates regularly and utilizes the 2017 American Dental Association Survey of Dental Fees to ensure sufficiency in reimbursement rates.

Vision services are reimbursed according to the Colorado Medicaid Fee Schedule for State Plan and Early Periodic Screening, Diagnosis, and Treatment (EPSDT) vision services.

Further discussion on App I-2 may be found 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-SLS 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 Dept operates an Electronic Visit Verification (EVV) system to document that a variety of HCBS services are provided to members.

Electronic Visit Verification (EVV) is a technology used to verify that home or community based service visits occur. The purpose of EVV is to ensure that services are delivered to people needing those services and that providers only bill for services rendered. EVV typically verifies visit information through a mobile application on a smart phone or tablet, a toll-free telephone number, or a web-based portal.

EVV captures six points of data as required by the 21st Century Cures Act: individual receiving the service, attendant providing the service, type of service provided, location of service delivery, date of service, and time that service provision begins and ends.

The Department implemented a hybrid or open EVV model. The State contracts with an EVV vendor for a state-managed solution. This solution is available to providers at no cost. Providers may also choose to utilize an alternate EVV system procured and managed by the provider agency. The State's EVV Solution and Data Aggregator for alternate vendor data transfer are available for use.

Services which must be electronically verified: As of August 3, 2020, the Department implemented EVV for federally mandated and additional services that are similar in nature and service delivery. The Department mandates Electronic Visit Verification (EVV) per CCR 2505-10 Section 8.001. Required EVV waiver services include:
Behavioral Therapies
Consumer Directed Attendant Support Services (CDASS)
Consumer Directed Attendant Support Services (CDASS) SLS Health Maintenance
Homemaker
Independent Living Skills Training (ILST) and Life Skills Training (LST)
Personal Care
Respite

The Department also mandates EVV for the following State Plan Services:
Home Health
Hospice
Occupational Therapy
Pediatric Behavioral Therapies
Pediatric Personal Care
Physical Therapy
Private Duty Nursing
Speech Therapy

On February 1, 2022, the Department activated a pre-payment EVV claim edit. EVV-required services, excluding CDASS and hospice, require corresponding EVV records prior to payment. This has resulted in improved provider compliance and better oversight of service provision.

Provider agencies utilizing the State EVV Solution have access to a portal to view and modify visit activity, and in limited circumstances, create EVV records. All information entered via the provider portal is notated as manual entry or edit and is subject to Department audit.

In the event the caregiver is unable to collect EVV data at the time of service delivery, provider agencies will need to enter missing data. Within the State EVV Solution, an agency administrator may complete visit maintenance in the EVV Solution provider portal. The administrator will enter the missing data and select a reason code on why a manual entry was done. Manual entry may be entered on a case-by-case basis. Manual entries are subject to increased scrutiny by the Department and providers must maintain service records for these visits.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

- (●) ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***
- ( ) ***Payments for some, but not all, waiver services are made through an approved MMIS.***

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) ***Payments for waiver services are not made through an approved MMIS.***

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

  Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☒ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☐ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***

○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

- ◉ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- ○ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

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

- ○ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ○ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***
- ◉ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

(a) Each Community Centered Board (CCB) is designated as an OHCDS. Agencies must be approved to provide Targeted Case Management services for this designation.

(b) Providers may enroll directly with the Department by submitting an application. Included in the application is a Claims Submission Method Form. On this form, providers elect to enroll directly with the Department or to contract with an OHCDS. Additional information on provider enrollment is available on the Department's website.

(c) Department regulations require that case managers provide participants, guardians, and/or authorized representatives a listing of all qualified providers in the area. The Department's website also contains a statewide list of qualified providers for waiver services.

(d) The Department maintains documentation of qualifications for all providers. This documentation includes copies of the Medicaid Provider Agreement, copies of the Medicaid certification, verification of applicable State licenses, and any other documentation necessary to demonstrate compliance with the established provider qualification standards.

(e) The OHCDS agencies subcontract with providers certified by the Department to provide specific waiver services or with independent contractors which have been verified by the OHCDS to have met all applicable licensing and/or established provider qualification standards. The Department assures provider qualifications are met by OHCDS subcontractors through CCB contract compliance and administrative monitoring. These standards are defined at 10 CCR 2505-10 8.500.11.

(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:*

Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ○ ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing *(1 of 5)*

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- ◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ ***Nominal deductible***
- ☐ ***Coinsurance***
- ☐ ***Co-Payment***
- ☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing *(2 of 5)*

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- ◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	12344.52	11026.35	23370.87	252143.29	8816.64	260959.93	237589.06
2	13100.63	11351.63	24452.26	263187.17	8961.23	272148.40	247696.14
3	13699.16	15597.76	29296.92	274714.77	9108.19	283822.96	254526.04
4	15464.10	16927.07	32391.17	286747.28	9257.56	296004.84	263613.67
5	22883.53	16014.29	38897.82	299306.81	9409.38	308716.19	269818.37

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	5569	5569
Year 2	5713	5713
Year 3	5785	5785
Year 4	5881	5881
Year 5	5979	5979

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. The Department believes that the average length of stay is correlated with turnover in waiver enrollment and forecasts ALOS as a function of waiver growth. The magnitude of expected caseload growth or reduction is inversely correlated with expected ALOS. The Department has applied a 0.48% trend on ALOS for WYs 1-5 by selecting a proportion of the geometric average annual growth between the SFY 2015-16 and SFY 2017-18 actuals, as reported on the CMS 372 reports.

Updates for WY 4-5: The average length of stay is calculated based on the number of days individuals on average stay on a waiver in a year. The Department used CMS 372 (s) report data through SFY 2019-20 to estimate the averages. The magnitude of expected caseload growth or reduction is inversely correlated with expected ALOS.

Update for WY 5 for Amendment with the requested effective date of 7/1/2023:
The Department estimated the average length of stay (ALOS) on the waiver by reviewing historical data included in the annual 372 data report (specifically between SFY 2014-15 and SFY 2017-18). The Department believes that average length of stay is correlated with turnover in waiver enrollment, and forecasts ALOS as a function of waiver growth. The Average length of stay is calculated based on the number of days individuals stay on the waiver in a year on average. The Department used 25% of the average yearly growth rate between SFY 2014-15 and SFY 2017-18 to estimate future ALOS. The magnitude of expected caseload growth or reduction is inversely correlated with expected ALOS.

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 by utilizing 372 reports as its source of data to estimate the number of users, units per user and cost per unit. The most recent 372 used was from SFY 2019-20. The Department reviews 372 data from SFY 2007-08 through SFY 2019-20 but may only include certain fiscal years in the development of trends.

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

Certain years of data are not included because they are considered to be outliers based on out-of-date policy, sudden changes in utilization, new limits placed on services, or some other reason. By policy and procedure, these characteristics are used to determine when data is an outlier. The state will make available to CMS upon request, the specific characteristics of the data outlier of a specific service.

Historical growth rates: The source of data is 372 waiver reports. The Department reviews data from FY 2007-08 through FY 2019-20 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 2018-19 and FY 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 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.

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 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-Supported Community Connections Support Level 1*
- *Day Habilitation-Supported Community Connections Support Level 2*
- *Day Habilitation-Supported Community Connections Support Level 3*
- *Day Habilitation-Supported Community Connections Support Level 4*
- *Day Habilitation-Supported Community Connections Support Level 5*
- *Day Habilitation-Supported Community Connections Support Level 6*
- *Prevocational Services Support Level 1*
- *Prevocational Services Support Level 2*
- *Prevocational Services Support Level 3*
- *Prevocational Services Support Level 4*
- *Prevocational Services Support Level 5*
- *Prevocational Services Support Level 6*
- *Respite-Individual (15 min)*

- *Respite-Individual (Day)*
- *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 Consultation*
- *Behavioral Services-Behavioral Counseling – Individual*
- *Behavioral Services-Behavioral Counseling – Group*
- *Behavioral Services-Behavioral Line Staff Services*
- *Behavioral Services-Behavioral Plan Assessment*
- *HippoTherapy – Individual*
- *HippoTherapy – Group*
- *Home Delivered Meals*
- *Life Skills Training*
- *Massage Therapy*
- *Mentorship*
- *Movement Therapy – Bachelor*
- *Movement Therapy – Masters*
- *Non-Medical Transportation-To/From Day Program – Mileage Range 1-10*
- *Non-Medical Transportation-To/From Day Program – Mileage Range 11-20*
- *Non-Medical Transportation-To/From Day Program – Mileage Range >20*
- *Non-Medical Transportation-Not To/From Day Program*
- *Peer Mentorship*
- *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).

- *Homemaker Basic – (Standard): The Denver share of expenditure for this service is 23.71% with the Denver-only provider's wage of $5.68 for FY 2020-21 and $6.93 for FY 2021-22.*
- *Homemaker – Enhanced (Standard): The Denver share of expenditure for this service is 6.10% with the Denver-only provider's wage of $7.93 for FY 2020-21 and $9.34 for FY 2021-22.*
- *Personal Care (Standard): The Denver share of expenditure for this service is 14.06% with the Denver-only provider's wage of $5.68 for FY 2020-21 and $6.93 for FY 2021-22.*

The following service received the (B) 1% reduction to be implemented at the earliest on 9/01/2020 and (C) Denver minimum wage increase on 1/1/2021:
(Note: The rates listed below will not match the Department's Cost Neutrality Demonstration. In order to accurately project total expenditures for the service, the avg. cost/unit is adjusted to account for the rate being implemented for less than a 12-month period).

- *Homemaker Basic – (CDASS): The Denver share of expenditure for this service is 12.96% with the Denver-only provider wage of $4.52 for FY 2020-21 and $4.91 for FY 2021-22*
- *Homemaker – Enhanced (CDASS): The Denver share of expenditure for this service is 12.96% with the Denver-only provider wage of $7.35 for FY 2020-21 and $7.97 for FY 2021-22.*
- *Personal Care (CDASS): The Denver share of expenditure for this service is 12.96% with the Denver-only provider wage of $5.96 for FY 2020-21 and $6.42 for FY 2021-22.*
- *Health Maintenance Activities: The Denver share of expenditure for this service is 12.96% with the Denver-only provider's wage of $7.51 for FY 2020-21 and $7.64 for FY 2021-22.*

The following services did not receive a legislative rate decrease/increase as they are negotiated rates and were not adjusted in the Fall 2020 Amendments:

- *Respite-Group*
- *Respite-Group Overnight Camp*
- *Supported Employment – Job Placement – Individual*
- *Supported Employment – Job Placement – Group*
- *Dental Services-Preventative/Basic*
- *Dental Services-Major*
- *Vision Services*
- *Assistive Technology*
- *Home Accessibility Adaptations*
- *Non-Medical Transportation-Public Conveyance*
- *Personal Emergency Response*
- *Recreational Facility Fees/Passes*
- *Specialized Medical Equipment and Supplies-Equipment*
- *Specialized Medical Equipment and Supplies-Disposable Supplies*
- *Transition Setup Expense*
- *Vehicle Modifications*

The previous forecast in CO.0293.R05.03 for Personal Care (Standard), Homemaker – Basic (Standard), and Homemaker – Enhanced (Standard) included a preemptive estimated increase that was implemented during the 2019 Fall Amendments for increased provider cost due to Electronic Visit Verification (EVV) requirements and local municipalities raising the minimum wage. The Dept had put this higher rate into the previous forecast as an estimate. The actual rate in CO.0293.R05.09 turned out to be lower than the previous estimate which accounts for the slight decrease in rates during this forecast. The Dept received legislative approval to increase the rates for this service due to the Denver Minimum Wage increase. The percentage increases as it incorporates the multi-year rate increase.

The previous forecast in CO.0293.R05.03 for Homemaker-Enhanced (CDASS), Personal Care (CDASS), and Homemaker-Basic (CDASS) included a preemptive estimated increase that was implemented during the 2019 Fall Amendments for increased provider cost due to Electronic Visit Verification (EVV) requirements and local municipalities raising the minimum wage. Once the final policy was established, CDASS was removed from the services that received a rate increase due to EVV. The rate is lower in CO.0293.R05.09 because the 1% reduction and the Denver minimum wage were applied to a lower rate than previous forecasts.

The Department used 372 data available through SFY 2018-19 to develop the estimates for the number of users and units per user for the following services: Homemaker - Basic (Standard), Personal Care (Standard), 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, Supported Employment- Job Placement-Individual, and Supported Employment-Job Placement-Group. Most frequently, the Department will estimate the number of users by calculating the percent of the total unduplicated client count utilizing the specific service based on 372 data and will select the average of the previous two years to estimate the number of users in future years. In some cases, the Department will add a dampening factor in situations where the utilization of service is not expected to grow linearly with total enrollment. For CDASS services (Homemaker-Basic(CDASS) and Personal Care(CDASS)), the Department utilized a similar method by analyzing the proportion of the total unduplicated count utilizing CDASS services and applied that percentage towards future enrollment projections, dampened where appropriate for the same reasons mentioned earlier.

Further information pertaining to the Factor D Derivation can be found in Section Main B. - Optional

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

To calculate State Plan services costs associated with SLS Waiver clients, the Department analyzed historical D' values. D' has been increasing fairly steadily since FY 2007-08. The Department has chosen the average cost per client of all previous years' growth rate in forecast years FY 2019-20 - FY 2023-24 from the Department's bi-annual forecast for the state for Acute Care for disabled individuals age 59 and younger. To project WY1 for Factor D' the Department started with the FY 2016-17 value of $13,638.27 and applied a 4.72% trend in FY 2018-19 for the ACC 2.0 implementation. The Department arrived at $13,496.39 for WY1. The claims information used in the derivation of Factor D' does not contain costs for prescribed drugs for those dually eligible for Medicare and Medicaid as those claims are not tracked in the MMIS system. Therefore, the costs of those drugs are not included in the estimate of Factor D'

Update for WYs 4-5 for Amendment with a requested effective date of 07/01/2022:

To calculate State Plan services costs associated with SLS Waiver clients, the Department analyzed historical D' values. 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 2019-20 - FY 2023-24 based on a proportion of the average growth rate of previous years. The Department used actual cost per client for WY1 and applied half the average growth rate in cost per client from FY 2008-09 to FY 2019-20 for WY 2-5. The claims information used in the derivation of Factor D' does not contain costs for prescribed drugs for those dually eligible for Medicare and Medicaid as those claims are not tracked in the MMIS system. Therefore, the costs of those drugs are not included in the estimate of Factor D'.

Update for WY 5 for Amendment with the requested effective date of 7/1/2023:
To calculate State Plan services costs associated with SLS Waiver clients, the Department analyzed historical D' values. D' has been increasing fairly steadily since SFY 2007-08, with a slight decrease in SFY 2020-21. The Department has chosen the average cost per client growth rate in forecast years SFY 2021-22 - SFY 2023-24 based on a proportion of the average growth rate of previous years. The State trended forward using actuals from 372 reporting from SFY 2020-21 actuals using half the average yearly growth rate from SFY 2018-19 to SFY 2019-20 and SFY 2019-20 to SFY 2020-21. This is a 1.43% growth rate.

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/IDD costs, the Department examined utilization and average per user ICF/IDD costs. The Department utilized 372 reports from FY 2007-08 through FY 2016-17. The Department trended expenditure using the growth rate from FY 2016-17. To project WY 1 the Department started with FY 2016-17 value of $221,715.24 then applied a trend of 4.38% (the FY 2016-17 growth rate) for FY 2017-18 and FY 2018-19 to arrive at the FY 2019-20 value of $252,143.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

When determining the state plan costs for ICF/IID clients, the Department reviewed historical data and chose to trend these costs forward by the average growth rate of the previous 7 years. The current projections for Factor G' were calculated based actual state plan costs for services during the 372 report periods.
The growth rates for the previous seven years were:
FY 2008-09: 7.09%
FY 2009-10: -21.2%
FY 2010-11: -1.10%
FY 2011-12: -2.48%
FY 2012-13: 4.95%
FY 2013-14: -0.52%
FY 2014-15: 1.44%
FY 2015-16: -16.41%
FY 2016-17: 1.64%
FY 2016-17 growth rate was the selected trend for all future years except FY 2017-18 due to ACC 2.0.
To project WY 1 the Department started with FY 2016-17 value of $9457.46 then applied a -9.76% trend for ACC 2.0 then applied a 1.64% trend to get a $8,674.38.

The claims 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	
Homemaker	
Personal Care	
Prevocational Services	
Respite	
Supported Employment	
Dental Services	
Vision Services	
Assistive Technology	
Behavioral Services	
Benefits Planning	
Health Maintenance Activities	
Hippotherapy	
Home Accessibility Adaptations	
Home Delivered Meals	
Life Skills Training	
Massage Therapy	
Mentorship	
Movement Therapy	
Non-Medical Transportation	
Peer Mentorship	
Personal Emergency Response	
Recreational Facility Fees/Passes	

Waiver Services	
Remote Support Technology	
Specialized Medical Equipment and Supplies	
Transition Setup	
Vehicle Modifications	

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:						33342308.76
Specialized Habilitation Support Level 1	15min	547	1189.00	2.60	1690995.80	
Specialized Habilitation Support Level 2	15min	759	1482.00	2.86	3217036.68	
Specialized Habilitation Support Level 3	15min	271	1457.00	3.18	1255613.46	
Specialized Habilitation Support Level 4	15min	190	1508.00	3.75	1074450.00	
Specialized Habilitation Support Level 5	15min	204	1845.00	4.64	1746403.20	
Specialized Habilitation Support Level 6	15min	122	2026.00	6.66	1646165.52	
Supported Community Connections Support Level 1	15min	1323	1213.00	3.16	5071164.84	
Supported Community Connections Support Level 2	15min	1334	1587.00	3.45	7303850.10	
Supported Community Connections Support Level 3	15min	429	1810.00	3.91	3036075.90	
Supported Community Connections Support Level 4	15min	303	1644.00	4.48	2231631.36	
Supported					2761457.40	

GRAND TOTAL:		68746617.55
Total Estimated Unduplicated Participants:		5569
Factor D (Divide total by number of participants):		12344.52
Average Length of Stay on the Waiver:	333	

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Connections Support Level 5	15min	283	1807.00	5.40		
Supported Community Connections Support Level 6	15min	209	1555.00	7.10	2307464.50	
Supported Community Connections Tier 3	15min	0	0.00	0.01	0.00	
Supported Community Connections Tier 3	15min	0	0.00	0.01	0.00	
Homemaker Total:						4783677.90
Homemaker - Basic (Standard) (in person)	15min	641	660.00	4.32	1827619.20	
Homemaker - Basic (CDASS) (in person)	15min	124	561.00	4.32	300516.48	
Homemaker - Enhanced (Standard) (in person)	15min	1111	327.00	7.01	2546711.97	
Homemaker - Enhanced (CDASS) (in person)	15min	69	225.00	7.01	108830.25	
Homemaker Remote Supports	15min	0	0.00	0.01	0.00	
Personal Care Total:						7298982.84
Personal Care (Standard) (in person)	15min	2018	608.00	5.62	6895425.28	
Personal Care (CDASS) (in person)	15min	119	596.00	5.69	403557.56	
Personal Care Remote Supports	15min	0	0.00	0.01	0.00	
Prevocational Services Total:						1655706.84
Prevocational Services Support Level 1	15min	153	1596.00	2.60	634888.80	
Prevocational Services Support Level 2	15min	137	1572.00	2.86	615941.04	
Prevocational Services Support Level 3	15min	34	1747.00	3.18	188885.64	
Prevocational Services Support Level 4	15min	13	1536.00	3.75	74880.00	
Prevocational					66732.48	

GRAND TOTAL:	68746617.55
Total Estimated Unduplicated Participants:	5569
Factor D (Divide total by number of participants):	12344.52
Average Length of Stay on the Waiver:	333

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services Support Level 5	15min	9	1598.00	4.64		
Prevocational Services Support Level 6	15min	8	1396.00	6.66	74378.88	
Respite Total:						8940566.58
Individual (15 min)	15min	1147	994.00	5.55	6327654.90	
Individual (Day)	Day	447	16.00	221.93	1587243.36	
Group	Day	211	24.00	130.15	659079.60	
Group Overnight Camp	Day	207	2.00	885.48	366588.72	
Supported Employment Total:						5038188.83
Supported Employment - Job Coaching - Group Support Level 1	15min	250	1748.00	3.47	1516390.00	
Supported Employment - Job Coaching - Group Support Level 2	15min	174	1672.00	3.82	1111344.96	
Supported Employment - Job Coaching - Group Support Level 3	15min	38	1160.00	4.24	186899.20	
Supported Employment - Job Coaching - Group Support Level 4	15min	18	995.00	4.91	87938.10	
Supported Employment - Job Coaching - Group Support Level 5	15min	13	1575.00	5.85	119778.75	
Supported Employment - Job Coaching - Group Support Level 6	15min	2	821.00	7.65	12561.30	
Supported Employment - Job Coaching - Individual	15min	661	206.00	14.34	1952620.44	
Supported Employment - Job Development - Individual Support Level 1-2	15min	18	171.00	14.34	44138.52	
Supported Employment - Job Development - Individual Support Level 3-4	15min	2	43.00	14.34	1233.24	
Supported Employment - Job Development -	15min	2	73.00	14.34	2093.64	

GRAND TOTAL:	68746617.55
Total Estimated Unduplicated Participants:	5569
Factor D (Divide total by number of participants):	12344.52
Average Length of Stay on the Waiver:	333

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Individual Support Level 5-6						
Supported Employment - Job Development - Group	15min	4	174.00	4.58	3187.68	
Supported Employment - Job Placement - Individual	Session	1	1.00	1.00	1.00	
Supported Employment - Job Placement - Group	Session	2	1.00	1.00	2.00	
Supported Employment - Job Development - Individual	15min	0	0.00	0.01	0.00	
Workplace Assistance	15min	0	0.00	0.01	0.00	
Dental Services Total:						209971.62
Preventative/Basic	Session	152	1.00	615.42	93543.84	
Major	Session	126	1.00	924.03	116427.78	
Vision Services Total:						417384.00
Vision Services	Item	930	1.00	448.80	417384.00	
Assistive Technology Total:						140502.96
Assistive Technology	Per Purchase	78	1.00	1801.32	140502.96	
Behavioral Services Total:						1599908.34
Behavioral Consultation	15min	310	43.00	25.80	343914.00	
Behavioral Counseling - Individual	15min	447	88.00	25.80	1014868.80	
Behavioral Counseling - Group	15min	25	37.00	8.70	8047.50	
Behavioral Line Staff Services	15min	47	307.00	7.56	109083.24	
Behavioral Plan Assessment	15min	178	27.00	25.80	123994.80	
Benefits Planning Total:						0.00
Benefits Planning	1 hour	0	0.00	0.01	0.00	
Health Maintenance						371561.04

GRAND TOTAL:	68746617.55
Total Estimated Unduplicated Participants:	5569
Factor D (Divide total by number of participants):	12344.52
Average Length of Stay on the Waiver:	333

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Activities Total:						
Health Maintenance Activities	15min	93	537.00	7.44	371561.04	
Hippotherapy Total:						78117.83
HippoTherapy - Individual	15min	41	76.00	21.43	66775.88	
HippoTherapy - Group	15min	15	83.00	9.11	11341.95	
Home Accessibility Adaptations Total:						325181.36
Home Accessibility Adaptations	Per Purchase	56	1.00	5806.81	325181.36	
Home Delivered Meals Total:						1801.59
Home Delivered Meals	Per Meal	1	161.00	11.19	1801.59	
Life Skills Training Total:						13516.02
Life Skills Training	15min	2	631.00	10.71	13516.02	
Life Skills Training - Telehealth	15min	0	0.00	0.01	0.00	
Massage Therapy Total:						613884.96
Massage Therapy	15min	208	153.00	19.29	613884.96	
Mentorship Total:						1521024.48
Mentorship	15min	1278	108.00	11.02	1521024.48	
Movement Therapy Total:						603927.37
Movement Therapy - Bachelors	15min	103	143.00	16.09	236989.61	
Movement Therapy - Masters	15min	112	139.00	23.57	366937.76	
Non-Medical Transportation Total:						1528118.42
To/From Day Program - Mileage Range 0-10	Trip	111	1.00	434.04	48178.44	
To/From Day Program - Mileage Range 11-20	Trip	554	173.00	13.91	1333162.22	
To/From Day Program - Mileage Range	Trip	9	1.00	341.99	3077.91	

GRAND TOTAL:	68746617.55
Total Estimated Unduplicated Participants:	5569
Factor D (Divide total by number of participants):	12344.52
Average Length of Stay on the Waiver:	333

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
>20						
Not To/From Day Program	Trip	343	63.00	6.65	143699.85	
Public Conveyance	Item	0	0.00	0.01	0.00	
Peer Mentorship Total:						141.75
Peer Mentorship	15min	1	25.00	5.67	141.75	
Peer Mentorship - Telehealth	15min	0	0.00	0.01	0.00	
Personal Emergency Response Total:						48178.44
Personal Emergency Response	Item	111	1.00	434.04	48178.44	
Recreational Facility Fees/Passes Total:						43360.32
Recreational Facility Fees/Passes	Item	47	6.00	153.76	43360.32	
Remote Support Technology Total:						0.00
Remote Support Technology	Item	0	0.00	0.01	0.00	
Specialized Medical Equipment and Supplies Total:						64192.32
Equipment	Item	1	32.00	8.01	256.32	
Disposable Supplies	Item	225	4.00	71.04	63936.00	
Transition Setup Total:						1434.78
Transition Setup Expense	Per Transition	1	1.00	1178.46	1178.46	
Transition Setup Coordinator	15 min	1	32.00	8.01	256.32	
Vehicle Modifications Total:						104978.20
Vehicle Modifications	Modification	20	1.00	5248.91	104978.20	
				GRAND TOTAL:		68746617.55
				Total Estimated Unduplicated Participants:		5569
				Factor D (Divide total by number of participants):		12344.52
				Average Length of Stay on the Waiver:		333

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:						**34280161.99**
Specialized Habilitation Support Level 1	15min	562	1224.89	2.57	**1769157.62**	
Specialized Habilitation Support Level 2	15min	778	1528.41	2.83	**3365161.43**	
Specialized Habilitation Support Level 3	15min	278	1438.83	3.15	**1259983.43**	
Specialized Habilitation Support Level 4	15min	195	1458.07	3.71	**1054840.74**	
Specialized Habilitation Support Level 5	15min	209	1858.75	4.59	**1783117.46**	
Specialized Habilitation Support Level 6	15min	126	2029.51	6.59	**1685183.33**	
Supported Community Connections Support Level 1	15min	1357	1247.22	3.13	**5297454.70**	
Supported Community Connections Support Level 2	15min	1369	1593.78	3.42	**7462046.08**	
Supported Community Connections Support Level 3	15min	440	1854.47	3.87	**3157791.52**	
Supported Community Connections Support Level 4	15min	311	1643.57	4.44	**2269507.20**	
Supported Community Connections Support Level 5	15min	290	1827.94	5.35	**2836048.91**	
Supported Community Connections Support Level 6	15min	214	1555.33	7.03	**2339869.56**	
Supported Community Connections Tier 3	15min	0	0.00	0.01	**0.00**	
Supported Community Connections Tier 3	15min	0	0.00	0.01	**0.00**	
Homemaker Total:						**5294793.85**
Homemaker -					**1998293.36**	

GRAND TOTAL:	**74843909.88**
Total Estimated Unduplicated Participants:	**5713**
Factor D (Divide total by number of participants):	**13100.63**
Average Length of Stay on the Waiver:	333

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Basic (Standard) (in person)	15min	658	660.20	4.60		
Homemaker - Basic (CDASS) (in person)	15min	137	728.65	4.44	443223.22	
Homemaker - Enhanced (Standard) (in person)	15min	1140	326.76	7.23	2693221.27	
Homemaker - Enhanced (CDASS) (in person)	15min	76	292.50	7.20	160056.00	
Homemaker Remote Supports	15min	0	0.00	0.01	0.00	
Personal Care Total:						7936471.07
Personal Care (Standard) (in person)	15min	2070	613.38	5.78	7338846.35	
Personal Care (CDASS) (in person)	15min	132	775.25	5.84	597624.72	
Personal Care Remote Supports	15min	0	0.00	0.01	0.00	
Prevocational Services Total:						1687732.75
Prevocational Services Support Level 1	15min	157	1595.86	2.57	643913.55	
Prevocational Services Support Level 2	15min	141	1572.00	2.83	627275.16	
Prevocational Services Support Level 3	15min	35	1788.40	3.15	197171.10	
Prevocational Services Support Level 4	15min	14	1536.00	3.71	79779.84	
Prevocational Services Support Level 5	15min	9	1598.00	4.59	66013.38	
Prevocational Services Support Level 6	15min	8	1395.67	6.59	73579.72	
Respite Total:						9402507.67
Individual (15 min)	15min	1177	1006.42	5.64	6680897.76	
Individual (Day)	Day	458	16.03	225.72	1657177.55	
Group	Day	217	23.65	138.29	709711.19	
Group Overnight Camp	Day	213	1.77	940.88	354721.17	

GRAND TOTAL:		74843909.88
Total Estimated Unduplicated Participants:		5713
Factor D (Divide total by number of participants):		13100.63
Average Length of Stay on the Waiver:	333	

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Employment Total:						**5259746.85**
Supported Employment - Job Coaching - Group Support Level 1	15min	256	1784.86	3.44	**1571819.11**	
Supported Employment - Job Coaching - Group Support Level 2	15min	179	1689.50	3.78	**1143149.49**	
Supported Employment - Job Coaching - Group Support Level 3	15min	39	1159.51	4.20	**189927.74**	
Supported Employment - Job Coaching - Group Support Level 4	15min	18	1017.96	4.86	**89051.14**	
Supported Employment - Job Coaching - Group Support Level 5	15min	14	1601.92	5.79	**129851.64**	
Supported Employment - Job Coaching - Group Support Level 6	15min	2	855.00	7.57	**12944.70**	
Supported Employment - Job Coaching - Individual	15min	678	215.02	14.20	**2070126.55**	
Supported Employment - Job Development - Individual Support Level 1-2	15min	19	171.39	14.20	**46241.02**	
Supported Employment - Job Development - Individual Support Level 3-4	15min	2	48.23	14.20	**1369.73**	
Supported Employment - Job Development - Individual Support Level 5-6	15min	2	74.45	14.20	**2114.38**	
Supported Employment - Job Development - Group	15min	4	173.75	4.53	**3148.35**	
Supported Employment - Job Placement - Individual	Session	1	1.00	1.00	**1.00**	
Supported Employment - Job Placement - Group	Session	2	1.00	1.00	**2.00**	
Supported Employment - Job Development - Individual	15min	0	0.00	0.01	**0.00**	

GRAND TOTAL:	**74843909.88**
Total Estimated Unduplicated Participants:	**5713**
Factor D (Divide total by number of participants):	**13100.63**
Average Length of Stay on the Waiver:	333

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Workplace Assistance	15min	0	0.00	0.01	0.00	
Dental Services Total:						215205.39
Preventative/Basic	Session	156	1.00	615.42	96005.52	
Major	Session	129	1.00	924.03	119199.87	
Vision Services Total:						442884.96
Vision Services	Item	954	1.00	464.24	442884.96	
Assistive Technology Total:						169207.38
Assistive Technology	Per Purchase	81	1.00	2088.98	169207.38	
Behavioral Services Total:						1652040.52
Behavioral Consultation	15min	318	46.48	25.54	377497.55	
Behavioral Counseling - Individual	15min	458	87.93	25.54	1028545.35	
Behavioral Counseling - Group	15min	26	36.40	8.61	8148.50	
Behavioral Line Staff Services	15min	48	306.52	7.56	111229.98	
Behavioral Plan Assessment	15min	182	27.24	25.54	126619.15	
Benefits Planning Total:						0.00
Benefits Planning	1 hour	0	0.00	0.01	0.00	
Health Maintenance Activities Total:						426298.14
Health Maintenance Activities	15min	107	536.94	7.42	426298.14	
Hippotherapy Total:						77569.36
HippoTherapy - Individual	15min	41	75.63	21.22	65799.61	
HippoTherapy - Group	15min	15	86.99	9.02	11769.75	
Home Accessibility Adaptations Total:						337400.67
Home Accessibility Adaptations	Per Purchase	57	1.00	5919.31	337400.67	
Home Delivered						1843.45

GRAND TOTAL:	74843909.88
Total Estimated Unduplicated Participants:	5713
Factor D (Divide total by number of participants):	13100.63
Average Length of Stay on the Waiver:	333

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Meals Total:						
Home Delivered Meals	Per Meal	1	161.00	11.45	1843.45	
Life Skills Training Total:						15030.42
Life Skills Training	15min	2	631.00	11.91	15030.42	
Life Skills Training - Telehealth	15min	0	0.00	0.01	0.00	
Massage Therapy Total:						620903.95
Massage Therapy	15min	213	152.62	19.10	620903.95	
Mentorship Total:						1590065.62
Mentorship	15min	1311	111.17	10.91	1590065.62	
Movement Therapy Total:						621957.46
Movement Therapy - Bachelors	15min	105	143.30	15.93	239690.74	
Movement Therapy - Masters	15min	115	142.48	23.33	382266.72	
Non-Medical Transportation Total:						4557456.60
To/From Day Program - Mileage Range 0-10	Trip	1234	180.57	6.39	1423841.40	
To/From Day Program - Mileage Range 11-20	Trip	568	172.80	13.77	1351531.01	
To/From Day Program - Mileage Range >20	Trip	174	154.22	20.97	562714.85	
Not To/From Day Program	Trip	351	62.71	6.58	144833.76	
Public Conveyance	Item	1669	1.00	643.82	1074535.58	
Peer Mentorship Total:						148.00
Peer Mentorship	15min	1	25.00	5.92	148.00	
Peer Mentorship - Telehealth	15min	0	0.00	0.01	0.00	
Personal Emergency Response Total:						25333.34
Personal Emergency					25333.34	

GRAND TOTAL:	74843909.88
Total Estimated Unduplicated Participants:	5713
Factor D (Divide total by number of participants):	13100.63
Average Length of Stay on the Waiver:	333

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Response	Item	114	0.51	435.73		
Recreational Facility Fees/Passes Total:						**3089.88**
Recreational Facility Fees/Passes	Item	9	1.00	343.32	**3089.88**	
Remote Support Technology Total:						**0.00**
Remote Support Technology	Item	0	0.00	0.01	**0.00**	
Specialized Medical Equipment and Supplies Total:						**119020.33**
Equipment	Item	48	6.14	154.36	**45492.98**	
Disposable Supplies	Item	261	3.95	71.32	**73527.35**	
Transition Setup Total:						**1434.78**
Transition Setup Expense	Per Transition	1	1.00	1178.46	**1178.46**	
Transition Setup Coordinator	15min	1	32.00	8.01	**256.32**	
Vehicle Modifications Total:						**105605.43**
Vehicle Modifications	Modification	21	1.00	5028.83	**105605.43**	

GRAND TOTAL:	**74843909.88**
Total Estimated Unduplicated Participants:	**5713**
Factor D (Divide total by number of participants):	**13100.63**
Average Length of Stay on the Waiver:	333

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:						**31360027.30**
Specialized Habilitation	15min		1072.57	2.63	**1605068.83**	

GRAND TOTAL:	**79249620.00**
Total Estimated Unduplicated Participants:	**5785**
Factor D (Divide total by number of participants):	**13699.16**
Average Length of Stay on the Waiver:	308

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Support Level 1		569				
Specialized Habilitation Support Level 2	15min	789	1340.01	2.90	3066076.88	
Specialized Habilitation Support Level 3	15min	281	1207.81	3.23	1096244.59	
Specialized Habilitation Support Level 4	15min	198	1198.13	3.80	901473.01	
Specialized Habilitation Support Level 5	15min	212	1591.90	4.70	1586169.16	
Specialized Habilitation Support Level 6	15min	127	1728.39	6.75	1481662.33	
Supported Community Connections Support Level 1	15min	1375	1128.61	3.21	4981402.39	
Supported Community Connections Support Level 2	15min	1386	1408.52	3.51	6852252.61	
Supported Community Connections Support Level 3	15min	445	1671.71	3.97	2953326.47	
Supported Community Connections Support Level 4	15min	315	1446.34	4.55	2072966.80	
Supported Community Connections Support Level 5	15min	294	1627.17	5.48	2621566.13	
Supported Community Connections Support Level 6	15min	217	1368.95	7.21	2141818.10	
Supported Community Connections Tier 3	15min	0	0.00	0.01	0.00	
Supported Community Connections Tier 3	15min	0	0.00	0.01	0.00	
Homemaker Total:						6292990.79
Homemaker - Basic (Standard) (in person)	15min	595	718.13	5.26	2247531.46	
Homemaker - Basic (CDASS) (in person)	15min	171	840.75	4.70	675710.78	
Homemaker - Enhanced (Standard) (in	15min	1190	339.25	7.69	3104510.68	

GRAND TOTAL:	79249620.00
Total Estimated Unduplicated Participants:	5785
Factor D (Divide total by number of participants):	13699.16
Average Length of Stay on the Waiver:	308

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
person)						
Homemaker - Enhanced (CDASS) (in person)	15min	103	337.50	7.63	265237.88	
Homemaker Remote Supports	15min	0	0.00	0.01	0.00	
Personal Care Total:						8341993.34
Personal Care (Standard) (in person)	15min	1933	622.20	6.15	7396682.49	
Personal Care (CDASS) (in person)	15min	171	894.52	6.18	945310.85	
Personal Care Remote Supports	15min	0	0.00	0.01	0.00	
Prevocational Services Total:						1521196.39
Prevocational Services Support Level 1	15min	145	1520.02	2.63	579659.63	
Prevocational Services Support Level 2	15min	125	1572.00	2.90	569850.00	
Prevocational Services Support Level 3	15min	34	1506.35	3.23	165427.36	
Prevocational Services Support Level 4	15min	14	1295.08	3.80	68898.26	
Prevocational Services Support Level 5	15min	7	1598.00	4.70	52574.20	
Prevocational Services Support Level 6	15min	9	1395.67	6.75	84786.95	
Respite Total:						8522617.64
Individual (15 min)	15min	1097	952.40	5.78	6038844.58	
Individual (Day)	Day	438	15.35	231.36	1555502.69	
Group	Day	222	18.44	146.94	601525.34	
Group Overnight Camp	Day	203	1.61	999.74	326745.02	
Supported Employment Total:						4882177.41
Supported Employment - Job Coaching - Group Support Level 1	15min	240	1517.90	3.53	1285964.88	
Supported Employment - Job	15min		1477.17	3.87	983263.44	

GRAND TOTAL:	79249620.00
Total Estimated Unduplicated Participants:	5785
Factor D (Divide total by number of participants):	13699.16
Average Length of Stay on the Waiver:	308

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Coaching - Group Support Level 2		172				
Supported Employment - Job Coaching - Group Support Level 3	15min	40	1205.09	4.31	207757.52	
Supported Employment - Job Coaching - Group Support Level 4	15min	21	983.14	4.98	102816.78	
Supported Employment - Job Coaching - Group Support Level 5	15min	15	1581.16	5.93	140644.18	
Supported Employment - Job Coaching - Group Support Level 6	15min	2	820.64	7.76	12736.33	
Supported Employment - Job Coaching - Individual	15min	750	192.31	14.56	2100025.20	
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	4	240.50	4.64	4463.68	
Supported Employment - Job Placement - Individual	Item	1	250.00	1.00	250.00	
Supported Employment - Job Placement - Group	Item	2	406.00	1.00	812.00	
Supported Employment - Job Development - Individual	15min	35	85.25	14.56	43443.40	
Workplace Assistance	15min	0	0.00	0.01	0.00	
Dental Services Total:						124381.44
Preventative/Basic	Session	91	1.00	615.42	56003.22	

GRAND TOTAL:	79249620.00
Total Estimated Unduplicated Participants:	5785
Factor D (Divide total by number of participants):	13699.16
Average Length of Stay on the Waiver:	308

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Major	Session	74	1.00	924.03	68378.22	
Vision Services Total:						410074.28
Vision Services	Item	844	1.00	485.87	410074.28	
Assistive Technology Total:						192067.78
Assistive Technology	Per Purchase	82	1.00	2342.29	192067.78	
Behavioral Services Total:						1592184.70
Behavioral Consultation	15min	312	43.19	26.18	352782.83	
Behavioral Counseling - Individual	15min	441	85.12	26.18	982742.75	
Behavioral Counseling - Group	15min	23	51.30	8.83	10418.52	
Behavioral Line Staff Services	15min	48	313.71	7.41	111580.37	
Behavioral Plan Assessment	15min	191	26.93	26.18	134660.23	
Benefits Planning Total:						0.00
Benefits Planning	1 hour	0	0.00	0.01	0.00	
Health Maintenance Activities Total:						505209.60
Health Maintenance Activities	15min	120	537.00	7.84	505209.60	
Hippotherapy Total:						46995.07
HippoTherapy - Individual	15min	26	79.83	21.75	45143.86	
HippoTherapy - Group	15min	3	66.71	9.25	1851.20	
Home Accessibility Adaptations Total:						404277.33
Home Accessibility Adaptations	Per Purchase	67	1.00	6033.99	404277.33	
Home Delivered Meals Total:						11.74
Home Delivered Meals	Per Meal	1	1.00	11.74	11.74	
Life Skills Training Total:						18923.69
Life Skills Training					15409.02	

GRAND TOTAL:	79249620.00
Total Estimated Unduplicated Participants:	5785
Factor D (Divide total by number of participants):	13699.16
Average Length of Stay on the Waiver:	308

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	15min	2	631.00	12.21		
Life Skills Training - Telehealth	15min	2	157.75	11.14	3514.67	
Massage Therapy Total:						791543.04
Massage Therapy	15min	257	157.30	19.58	791543.04	
Mentorship Total:						1610878.57
Mentorship	15min	1303	110.58	11.18	1610878.57	
Movement Therapy Total:						747625.26
Movement Therapy - Bachelors	15min	115	143.16	16.33	268847.32	
Movement Therapy - Masters	15min	140	142.97	23.92	478777.94	
Non-Medical Transportation Total:						11505723.35
To/From Day Program - Mileage Range 0-10	Trip	373	140.59	6.74	353446.07	
To/From Day Program - Mileage Range 11-20	Trip	2341	167.03	14.11	5517253.12	
To/From Day Program - Mileage Range >20	Trip	1224	166.21	21.49	4371947.95	
Not To/From Day Program	Trip	334	74.34	6.74	167351.23	
Public Conveyance	Item	1719	1.00	637.42	1095724.98	
Peer Mentorship Total:						13851.04
Peer Mentorship	15min	1	2281.00	6.07	13845.67	
Peer Mentorship - Telehealth	15min	1	1.00	5.37	5.37	
Personal Emergency Response Total:						48553.62
Personal Emergency Response	Item	111	1.00	437.42	48553.62	
Recreational Facility Fees/Passes Total:						7279.01
Recreational Facility Fees/Passes	Item	8	2.64	344.65	7279.01	

GRAND TOTAL:	79249620.00
Total Estimated Unduplicated Participants:	5785
Factor D (Divide total by number of participants):	13699.16
Average Length of Stay on the Waiver:	308

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Remote Support Technology Total:						**0.00**
Remote Support Technology	Item	0	0.00	0.01	**0.00**	
Specialized Medical Equipment and Supplies Total:						**194963.56**
Equipment	Item	57	4.35	154.96	**38422.33**	
Disposable Supplies	Item	311	7.03	71.60	**156541.23**	
Transition Setup Total:						**1429.66**
Transition Setup Expense	Per Transition	1	1.00	1178.46	**1178.46**	
Transition Setup Coordinator	15 min	1	32.00	7.85	**251.20**	
Vehicle Modifications Total:						**112644.40**
Vehicle Modifications	Modification	22	1.00	5120.20	**112644.40**	

GRAND TOTAL:	**79249620.00**
Total Estimated Unduplicated Participants:	**5785**
Factor D (Divide total by number of participants):	**13699.16**
Average Length of Stay on the Waiver:	308

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:						**35230483.62**
Specialized Habilitation Support Level 1	15min	573	1104.94	3.41	**2158975.41**	
Specialized Habilitation Support Level 2	15min	790	1382.15	3.68	**4018186.48**	
Specialized Habilitation Support Level 3	15min	272	1192.80	4.03	**1307499.65**	

GRAND TOTAL:	**90944346.83**
Total Estimated Unduplicated Participants:	**5881**
Factor D (Divide total by number of participants):	**15464.10**
Average Length of Stay on the Waiver:	312

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Habilitation Support Level 4	15min	180	1158.28	4.62	963225.65	
Specialized Habilitation Support Level 5	15min	200	1603.94	5.56	1783581.28	
Specialized Habilitation Support Level 6	15min	123	1731.71	7.69	1637972.54	
Supported Community Connections Support Level 1	15min	1189	1160.54	4.01	5533327.06	
Supported Community Connections Support Level 2	15min	1225	1414.54	4.31	7468417.56	
Supported Community Connections Support Level 3	15min	417	1712.45	4.79	3420499.00	
Supported Community Connections Support Level 4	15min	272	1446.34	5.40	2124384.19	
Supported Community Connections Support Level 5	15min	265	1645.98	6.37	2778496.54	
Supported Community Connections Support Level 6	15min	182	1369.20	8.17	2035918.25	
Supported Community Connections Tier 3	15min	0	0.00	0.01	0.00	
Supported Community Connections Tier 3	15min	0	0.00	0.01	0.00	
Homemaker Total:						6866241.63
Homemaker - Basic (Standard) (in person)	15min	538	736.77	6.40	2536846.46	
Homemaker - Basic (CDASS) (in person)	15min	20	896.80	5.31	95240.16	
Homemaker - Enhanced (Standard) (in person)	15min	1136	385.77	8.93	3913436.05	
Homemaker - Enhanced (CDASS) (in person)	15min	103	360.00	8.37	310359.60	
Homemaker Remote Supports	15min	33	144.00	2.18	10359.36	

GRAND TOTAL:		90944346.83
Total Estimated Unduplicated Participants:		5881
Factor D (Divide total by number of participants):		15464.10
Average Length of Stay on the Waiver:	312	

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Care Total:						**9527332.39**
Personal Care (Standard) (in person)	15min	1787	651.19	7.30	**8494838.67**	
Personal Care (CDASS) (in person)	15min	158	954.16	6.78	**1022134.36**	
Personal Care Remote Supports	15min	33	144.00	2.18	**10359.36**	
Prevocational Services Total:						**3564092.58**
Prevocational Services Support Level 1	15min	171	1520.02	3.35	**870743.46**	
Prevocational Services Support Level 2	15min	112	1572.00	3.62	**637351.68**	
Prevocational Services Support Level 3	15min	148	1461.20	3.96	**856380.10**	
Prevocational Services Support Level 4	15min	127	1295.08	4.54	**746717.23**	
Prevocational Services Support Level 5	15min	35	1598.00	5.46	**305377.80**	
Prevocational Services Support Level 6	15min	14	1395.67	7.55	**147522.32**	
Respite Total:						**8239796.57**
Individual (15 min)	15min	1025	908.67	6.44	**5998130.67**	
Individual (Day)	Day	361	15.35	263.74	**1461475.65**	
Group	Day	189	18.44	156.14	**544172.88**	
Group Overnight Camp	Day	138	1.61	1062.28	**236017.37**	
Supported Employment Total:						**4592089.36**
Supported Employment - Job Coaching - Group Support Level 1	15min	192	1425.72	4.26	**1166124.90**	
Supported Employment - Job Coaching - Group Support Level 2	15min	143	1432.23	4.61	**944168.98**	
Supported Employment - Job Coaching - Group Support Level 3	15min	30	1170.74	5.06	**177718.33**	
Supported Employment - Job	15min		942.00	5.74	**91920.36**	

GRAND TOTAL:	**90944346.83**
Total Estimated Unduplicated Participants:	**5881**
Factor D (Divide total by number of participants):	**15464.10**
Average Length of Stay on the Waiver:	312

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Coaching - Group Support Level 4		17				
Supported Employment - Job Coaching - Group Support Level 5	15min	9	1537.23	6.71	92833.32	
Supported Employment - Job Coaching - Group Support Level 6	15min	2	756.00	8.58	12972.96	
Supported Employment - Job Coaching - Individual	15min	745	173.04	15.51	1999468.55	
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	3	424.88	5.40	6883.06	
Supported Employment - Job Placement - Individual	Item	4	1.00	1.00	4.00	
Supported Employment - Job Placement - Group	Item	1	1.00	1.00	1.00	
Supported Employment - Job Development - Individual	15min	54	119.39	15.51	99993.90	
Workplace Assistance	15min	0	0.00	0.01	0.00	
Dental Services Total:						60650.37
Preventative/Basic	Session	46	1.00	615.42	28309.32	
Major	Session	35	1.00	924.03	32341.05	
Vision Services Total:						358940.50
Vision Services	Item	710	1.00	505.55	358940.50	

GRAND TOTAL:		90944346.83
Total Estimated Unduplicated Participants:		5881
Factor D (Divide total by number of participants):		15464.10
Average Length of Stay on the Waiver:	312	

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assistive Technology Total:						**363300.88**
Assistive Technology	Per Purchase	136	1.00	2671.33	**363300.88**	
Behavioral Services Total:						**1485182.77**
Behavioral Consultation	15min	280	34.85	26.70	**260538.60**	
Behavioral Counseling - Individual	15min	395	90.28	26.70	**952138.02**	
Behavioral Counseling - Group	15min	15	44.65	9.01	**6034.45**	
Behavioral Line Staff Services	15min	51	313.71	7.56	**120954.03**	
Behavioral Plan Assessment	15min	185	29.46	26.70	**145517.67**	
Benefits Planning Total:						**0.00**
Benefits Planning	1 hour	0	0.00	0.01	**0.00**	
Health Maintenance Activities Total:						**4378133.99**
Health Maintenance Activities	15min	120	4327.93	8.43	**4378133.99**	
Hippotherapy Total:						**26441.42**
HippoTherapy - Individual	15min	18	62.67	22.19	**25031.65**	
HippoTherapy - Group	15min	2	74.67	9.44	**1409.77**	
Home Accessibility Adaptations Total:						**811917.48**
Home Accessibility Adaptations	Per Purchase	66	2.00	6150.89	**811917.48**	
Home Delivered Meals Total:						**4021.92**
Home Delivered Meals	Per Meal	2	168.00	11.97	**4021.92**	
Life Skills Training Total:						**19295.98**
Life Skills Training	15min	2	631.00	12.45	**15711.90**	
Life Skills Training - Telehealth	15min	2	157.75	11.36	**3584.08**	
Massage Therapy Total:						**799942.28**
Massage Therapy					**799942.28**	

GRAND TOTAL:	**90944346.83**
Total Estimated Unduplicated Participants:	**5881**
Factor D (Divide total by number of participants):	**15464.10**
Average Length of Stay on the Waiver:	312

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	15min	270	148.36	19.97		
Mentorship Total:						**1520799.84**
Mentorship	15min	1189	105.97	12.07	**1520799.84**	
Movement Therapy Total:						**768935.70**
Movement Therapy - Bachelors	15min	118	125.53	16.66	**246776.92**	
Movement Therapy - Masters	15min	143	149.65	24.40	**522158.78**	
Non-Medical Transportation Total:						**11893844.36**
To/From Day Program - Mileage Range 0-10	Trip	380	140.59	6.87	**367024.25**	
To/From Day Program - Mileage Range 11-20	Trip	2380	167.03	14.38	**5716501.53**	
To/From Day Program - Mileage Range >20	Trip	1245	166.21	21.91	**4533868.07**	
Not To/From Day Program	Trip	339	74.34	6.87	**173132.66**	
Public Conveyance	Item	1747	1.00	631.55	**1103317.85**	
Peer Mentorship Total:						**14124.76**
Peer Mentorship	15min	1	2281.00	6.19	**14119.39**	
Peer Mentorship - Telehealth	15min	1	1.00	5.37	**5.37**	
Personal Emergency Response Total:						**132614.24**
Personal Emergency Response	Item	302	1.00	439.12	**132614.24**	
Recreational Facility Fees/Passes Total:						**15528.03**
Recreational Facility Fees/Passes	Item	17	2.64	345.99	**15528.03**	
Remote Support Technology Total:						**7767.20**
Remote Support Technology	Item	133	1.00	58.40	**7767.20**	
Specialized Medical Equipment and Supplies Total:						**178563.24**

GRAND TOTAL:	**90944346.83**
Total Estimated Unduplicated Participants:	**5881**
Factor D (Divide total by number of participants):	**15464.10**
Average Length of Stay on the Waiver:	312

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Equipment	Item	50	4.35	155.56	33834.30	
Disposable Supplies	Item	329	6.12	71.88	144728.94	
Transition Setup Total:						5226.48
Transition Setup Expense	Per Transition	2	2.00	1178.46	4713.84	
Transition Setup Coordinator	15 min	2	32.00	8.01	512.64	
Vehicle Modifications Total:						79079.24
Vehicle Modifications	modification	15	0.95	5549.42	79079.24	
				GRAND TOTAL:		90944346.83
				Total Estimated Unduplicated Participants:		5881
				Factor D (Divide total by number of participants):		15464.10
				Average Length of Stay on the Waiver:		312

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:						38405500.59
Specialized Habilitation Support Level 1	15min	579	1138.29	3.66	2412195.87	
Specialized Habilitation Support Level 2	15min	798	1425.62	3.95	4493696.80	
Specialized Habilitation Support Level 3	15min	275	1177.97	4.29	1389710.11	
Specialized Habilitation Support Level 4	15min	182	1119.75	4.89	996555.10	
Specialized Habilitation Support Level 5	15min	202	1616.08	5.84	1906457.25	
Specialized Habilitation	15min				1721149.76	
				GRAND TOTAL:		136820650.06
				Total Estimated Unduplicated Participants:		5979
				Factor D (Divide total by number of participants):		22883.53
				Average Length of Stay on the Waiver:		310

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Support Level 6		124	1735.03	8.00		
Supported Community Connections Support Level 1	15min	1202	1193.39	4.30	6168155.55	
Supported Community Connections Support Level 2	15min	1239	1420.58	4.61	8114054.64	
Supported Community Connections Support Level 3	15min	422	1754.19	5.07	3753159.67	
Supported Community Connections Support Level 4	15min	275	1446.34	5.71	2271115.38	
Supported Community Connections Support Level 5	15min	268	1665.00	6.66	2971825.20	
Supported Community Connections Support Level 6	15min	184	1382.37	8.48	2156939.56	
Supported Community Connections Tier 3	15min	21	159.00	7.56	25242.84	
Supported Community Connections Tier 3	15min	21	159.00	7.56	25242.84	
Homemaker Total:						13494610.96
Homemaker - Basic (Standard) (in person)	15min	759	829.02	5.95	3743895.77	
Homemaker - Basic (CDASS) (in person)	15min	107	952.85	5.75	586240.96	
Homemaker - Enhanced (Standard) (in person)	15min	1285	783.08	8.75	8804755.75	
Homemaker - Enhanced (CDASS) (in person)	15min	103	382.50	8.80	346698.00	
Homemaker Remote Supports	15min	33	144.00	2.74	13020.48	
Personal Care Total:						14301255.06
Personal Care (Standard) (in person)	15min	1871	978.07	7.17	13120877.51	
Personal Care (CDASS) (in person)	15min	158	1013.79	7.30	1169305.39	

GRAND TOTAL:	136820650.06
Total Estimated Unduplicated Participants:	5979
Factor D (Divide total by number of participants):	22883.53
Average Length of Stay on the Waiver:	310

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Care Remote Supports	15min	33	144.00	2.33	11072.16	
Prevocational Services Total:						4215015.06
Prevocational Services Support Level 1	15min	171	1520.02	3.64	946121.25	
Prevocational Services Support Level 2	15min	114	1572.00	3.95	707871.60	
Prevocational Services Support Level 3	15min	150	1506.35	4.27	964817.18	
Prevocational Services Support Level 4	15min	129	1775.66	4.87	1115522.88	
Prevocational Services Support Level 5	15min	35	1598.00	5.81	324953.30	
Prevocational Services Support Level 6	15min	14	1395.67	7.97	155728.86	
Respite Total:						18141185.89
Individual (15 min)	15min	1036	1725.99	6.86	12266541.89	
Individual (Day)	Day	365	45.67	287.97	4800330.31	
Group	Day	191	18.44	232.79	819895.69	
Group Overnight Camp	Day	140	1.61	1128.74	254418.00	
Supported Employment Total:						12967251.30
Supported Employment - Job Coaching - Group Support Level 1	15min	194	1425.72	4.61	1275078.42	
Supported Employment - Job Coaching - Group Support Level 2	15min	144	1432.23	4.99	1029143.19	
Supported Employment - Job Coaching - Group Support Level 3	15min	31	1170.74	5.47	198522.38	
Supported Employment - Job Coaching - Group Support Level 4	15min	18	942.00	6.29	106653.24	
Supported Employment - Job Coaching - Group Support Level 5	15min	10	1537.23	7.47	114831.08	
Supported Employment - Job	15min	2	756.00	9.17	13865.04	

GRAND TOTAL:	136820650.06
Total Estimated Unduplicated Participants:	5979
Factor D (Divide total by number of participants):	22883.53
Average Length of Stay on the Waiver:	310

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Coaching - Group Support Level 6						
Supported Employment - Job Coaching - Individual	15min	754	177.28	16.22	2168113.13	
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	8	459.76	5.75	21148.96	
Supported Employment - Job Placement - Individual	Item	4	1.00	1.00	4.00	
Supported Employment - Job Placement - Group	Item	1	1.00	1.00	1.00	
Supported Employment - Job Development - Individual	15min	90	993.90	16.22	1450895.22	
Workplace Assistance	15min	200	2247.27	14.66	6588995.64	
Dental Services Total:						67026.14
Preventative/Basic	Session	50	1.00	638.26	31913.00	
Major	Session	38	1.00	924.03	35113.14	
Vision Services Total:						378267.69
Vision Services	Item	717	1.00	527.57	378267.69	
Assistive Technology Total:						679707.00
Assistive Technology	Per Purchase	225	1.00	3020.92	679707.00	
Behavioral Services Total:						2068892.37
Behavioral Consultation					296137.88	

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	15min	309	34.85	27.50		
Behavioral Counseling - Individual	15min	420	117.55	27.50	1357702.50	
Behavioral Counseling - Group	15min	16	765.40	9.28	113646.59	
Behavioral Line Staff Services	15min	54	313.71	7.79	131965.25	
Behavioral Plan Assessment	15min	206	29.91	27.50	169440.15	
Benefits Planning Total:						104888.50
Benefits Planning	1 hour	101	10.00	103.85	104888.50	
Health Maintenance Activities Total:						5103387.58
Health Maintenance Activities	15min	120	4709.66	9.03	5103387.58	
Hippotherapy Total:						43973.93
HippoTherapy - Individual	15min	18	103.34	22.86	42522.34	
HippoTherapy - Group	15min	2	74.67	9.72	1451.58	
Home Accessibility Adaptations Total:						865268.28
Home Accessibility Adaptations	Per Purchase	69	2.00	6270.06	865268.28	
Home Delivered Meals Total:						4142.88
Home Delivered Meals	Per Meal	2	168.00	12.33	4142.88	
Life Skills Training Total:						20223.55
Life Skills Training	15 min	2	631.00	12.82	16178.84	
Life Skills Training - Telehealth	15min	2	157.75	12.82	4044.71	
Massage Therapy Total:						869757.20
Massage Therapy	15min	280	151.01	20.57	869757.20	
Mentorship Total:						1777317.81
Mentorship	15min	1281	109.42	12.68	1777317.81	
Movement Therapy Total:						1500062.18

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Movement Therapy - Bachelors	15min	135	202.98	17.16	470223.47	
Movement Therapy - Masters	15min	155	264.39	25.13	1029838.71	
Non-Medical Transportation Total:						21193725.54
To/From Day Program - Mileage Range 0-10	Trip	1756	140.59	12.54	3095825.54	
To/From Day Program - Mileage Range 11-20	Trip	2420	167.03	23.46	9482827.60	
To/From Day Program - Mileage Range >20	Trip	1265	166.21	31.84	6694539.90	
Not To/From Day Program	Trip	346	142.42	14.38	708607.86	
Public Conveyance	Item	1776	1.00	682.39	1211924.64	
Peer Mentorship Total:						14559.16
Peer Mentorship	15min	1	2281.00	6.38	14552.78	
Peer Mentorship - Telehealth	15min	1	1.00	6.38	6.38	
Personal Emergency Response Total:						152255.46
Personal Emergency Response	Item	314	1.00	484.89	152255.46	
Recreational Facility Fees/Passes Total:						44520.04
Recreational Facility Fees/Passes	Item	19	4.00	585.79	44520.04	
Remote Support Technology Total:						7767.20
Remote Support Technology	Item	133	1.00	58.40	7767.20	
Specialized Medical Equipment and Supplies Total:						269262.55
Equipment	Item	51	5.80	191.34	56598.37	
Disposable Supplies	Item	394	7.48	72.16	212664.18	
Transition Setup Total:						8528.00
Transition Setup					8000.00	

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Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Expense	Per Transition	2	2.00	2000.00		
Transition Setup Coordinator	15 min	2	32.00	8.25	528.00	
Vehicle Modifications Total:						122298.15
Vehicle Modifications	Modification	15	1.00	8153.21	122298.15	

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