

OFFICIAL

TITLE XIX OF THE SOCIAL SECURITY ACT MEDICAL ASSISTANCE PROGRAM

Attachment 3.1-C

State of Colorado

METHODS AND STANDARDS OF ASSURING HIGH QUALITY CARE

1. The following is a description of the methods that will be used to assure that the medical and remedial care and services are of high quality, and a description of the standards established by the State to assure high quality care:
 - a. Practitioners will be licensed or otherwise authorized to practice under State law. This means persons who are authorized to practice medicine as licensed physicians, or physicians in approved training programs supervised by licensed physicians;
 - b. Medical institutions will be licensed by the State;
 - c. Independent clinical laboratories will be certified according to Medicare Standards;
 - d. Patients can obtain needed medical services from the facility or practitioner which in the judgment of competent medical authority is best able to meet their medical needs whether the facility or practitioner is in or outside the state;
 - e. The scope of care and services offered includes the use of specialist and consultative services;
 - f. The medical unit will continuously review and evaluate the utilization of the quality of medical care and services;
 - g. The Medical Care Advisory Committee at frequent intervals will review reports of care and services provided and make indicated suggestions to the Department and to the disciplines involved concerning the quality and utilization of the care and services offered or needed.
 - h. X-ray units will be certified according to Medicare standards.

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 HEALTH CARE
 FINANCING
 ADMINISTRATION

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1915(i) HCBS State Plan Services

Administration and Operation

1. **Program Title** (optional):

State Plan HCBS

2. **State-wideness.** (Select one):

<input checked="" type="radio"/>	The State implements this supplemental benefit package statewide, per §1902(a)(1) of the Act.
<input type="radio"/>	The State implements this benefit without regard to the statewideness requirements in §1902(a)(1) of the Act. (Check each that applies):
<input type="checkbox"/>	Geographic Limitation. HCBS state plan services will only be available to individuals who reside in the following geographic areas or political subdivisions of the State. (Specify the areas to which this option applies):
<input type="checkbox"/>	Limited Implementation of Participant-Direction. HCBS state plan services will be implemented without regard to state-wideness requirements to allow for the limited implementation of participant-direction. Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the State. Individuals 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 option):

3. **State Medicaid Agency (SMA) Line of Authority for Operating the HCBS State Plan Supplemental Benefit Package.** (Select one):

<input checked="" type="radio"/>	The HCBS state plan supplemental benefit package is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program (select one):	
<input checked="" type="radio"/>	The Medical Assistance Unit (name of unit):	Medical Assistance & CHP+ Program Administration Office/Long Term Benefits Division/Community Based Long Term Care Section
<input type="radio"/>	Another division/unit within the SMA that is separate from the Medical Assistance Unit (name of division/unit)	
<input type="radio"/>	The HCBS state plan supplemental benefit package is operated by (name of agency)	
	a separate agency of the State that is not a division/unit of the Medicaid agency. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.	

4. Distribution of State Plan HCBS Operational and Administrative Functions.

X The State assures that in accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration or supervision of the state plan. When a function is performed by other than the Medicaid agency, the entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities.

(Check all agencies and/or entities that perform each function):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Disseminate information concerning the state plan HCBS to potential enrollees	X		X	X
2 Assist individuals in state plan HCBS enrollment	X		X	X
3 Manage state plan HCBS enrollment against approved limits, if any	X		X	X
4 Review participant service plans to ensure that state plan HCBS requirements are met	X		X	X
5 Recommend the prior authorization of state plan HCBS	X		X	X
6 Conduct utilization management functions	X		X	X
7 Recruit providers	X			
8 Execute the Medicaid provider agreement	X			
9 Conduct training and technical assistance concerning state plan HCBS requirements	X		X	X
10 Conduct quality monitoring of individual health and welfare and State plan HCBS program performance.	X		X	X

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

The Department of Health Care Policy and Financing, the Department, which is the State Medicaid Agency (SMA) contracts with 43 local and non-state entities referred to as Single Entry Point agencies that operate statewide and perform the functions identified in 1, 2, 3, 4, 5, 6, 9, and 10. The contract, which is renewed annually, contains Conflict of Interest standards.

The Department (SMA) also contracts with a Fiscal Management Services (FMS) to serve as the employer of record of participant-hired attendants while delegating authority to clients and/or authorized representatives for hiring, firing, training, setting wages and supervising the day-to-day activities of his or her attendants. (Function 9). The FMS will be the holder of the mandatory Medicaid provider agreement, which is executed between Medicaid and the attendant providing State Plan HCBS services. The FMS will also provide mandatory skills training to client and/or authorized representatives prior to enrolling in State Plan HCBS Services. (Function 9)

The Department has set forth regulations based on state statute prohibiting the authorized representative from providing services. The Department will utilize an Authorized Representative Screening Questionnaire and Authorized Representative Designation and Affidavit forms to assure that the following authorized representative requirements are met as defined in statute:

- Must be at 18 years of age;
- Know the client for at least 2 years;
- Have not been convicted of any crime involving exploitation, abuse, or assault on another person; and
- Do not have a mental, emotional, or physical condition that could result in harm to the client
- Shall not be reimbursed for providing authorized representative services and;
- Shall not serve as a provider of State Plan HCBS services.

The FMS will provide training to clients and/or their authorized representatives to assure that authorized representatives understand the requirements and limitations of the designated position. In addition, the FMS contractor is required to have an edit in place in the payroll system that will prohibit an authorized representative from being paid to provide HCBS State Plan Services.

SEPs will also coordinate with the FMS contractor to ensure that clients received appropriate skills training and attendants are adequately processed before the delivery of State Plan HCBS service.

5. **X Conflict of Interest Standards.** The State assures it has written conflict of interest standards that, at a minimum, address the conduct of individual assessments and eligibility determinations.
6. **X Appeals.** The State allows for appeals in accordance with 42 CFR 431 Subpart E.
7. **X No FFP for Room and Board.** The State has methodology to prevent claims for Federal financial participation for room and board in HCBS state plan services.

Number Served

1. Projected Number of Unduplicated Individuals To Be Served Annually. (Specify):

Annual Period	From	To	Projected Number of Participants
Year 1	1/1/2008	12/31/2008	50
Year 2	1/1/2009	12/31/2009	300
Year 3	1/1/2010	12/31/2010	4,000
Year 4	1/1/2011	12/31/2011	4,000
Year 5	1/1/2012	12/31/2012	4,000

2. Optional Annual Limit on Number Served. (Select one):

<input checked="" type="checkbox"/>	The State does not limit the number of individuals served during the Year.																								
<input type="checkbox"/>	The State chooses to limit the number of individuals served during the Year. (Specify):																								
	<table border="1" style="width: 100%;"> <thead> <tr> <th>Annual Period</th> <th>From</th> <th>To</th> <th>Annual Maximum Number of Participants</th> </tr> </thead> <tbody> <tr> <td>Year 1</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Year 2</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Year 3</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Year 4</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Year 5</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	Annual Period	From	To	Annual Maximum Number of Participants	Year 1				Year 2				Year 3				Year 4				Year 5			
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Year 1																									
Year 2																									
Year 3																									
Year 4																									
Year 5																									
<input type="checkbox"/>	The State chooses to further schedule limits within the above annual period(s). (Specify):																								

3. Waiting List. (Select one):

<input checked="" type="checkbox"/>	The State will not maintain a waiting list.
<input type="checkbox"/>	The State will maintain a single list for entrance to the HCBS state plan supplemental benefit package. State-established selection policies: are based on objective criteria; meet requirements of the Americans with Disabilities Act and all Medicaid regulations; ensure that otherwise eligible individuals have comparable access to all services offered in the package.

Financial Eligibility

1. X Income Limits. The State assures that individuals receiving state plan HCBS are in an eligibility group covered under the State's Medicaid state plan, and who have income that does not exceed 150% of the Federal Poverty Level (FPL).

2. Medically Needy. (Select one):

<input checked="" type="checkbox"/>	The State does not provide HCBS state plan services to the medically needy.
<input type="checkbox"/>	The State provides HCBS state plan services to the medically needy (select one):
<input type="checkbox"/>	The State elects to waive the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy.
<input type="checkbox"/>	The State does not elect to waive the requirements at section 1902(a)(10)(C)(i)(III).

Needs-Based Evaluation/Reevaluation

1. **Responsibility for Performing Evaluations / Reevaluations.** Independent evaluations/reevaluations to determine whether applicants are eligible for HCBS are performed (*select one*):

<input type="radio"/>	Directly by the Medicaid agency
<input checked="" type="radio"/>	By Other (<i>specify</i>):
	Single Entry Point agencies.

2. **Qualifications of Individuals Performing Evaluation/Reevaluation.** There are qualifications (that are reasonably related to performing evaluations) for persons responsible for evaluation/reevaluation for eligibility. (*Specify qualifications*):

Case managers are employed by the SEP agency. At minimum case managers are required to have a bachelor's degree in a human behavioral science field such as human services, nursing, social work, or psychology. The majority of case managers have a bachelor's degree in sociology or psychology and some have a master's degree in social work.

3. **X Independence of Evaluators and Assessors.** The State assures that evaluators of eligibility for HCBS state plan services and assessors of the need for services are independent. They are not:
- related by blood or marriage to the individual, or any paid caregiver of the individual
 - financially responsible for the individual
 - empowered to make financial or health-related decisions on behalf of the individual
 - service providers, or individuals or corporations with financial relationships with any service provider.
4. **Needs-based HCBS Eligibility Criteria.** Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for HCBS state plan services. The criteria take into account the individual's support needs and capabilities and may take into account the individual's ability to perform two or more ADLs, the need for assistance, and other risk factors: (*Specify the needs-based criteria*):

An individual whose health is at risk without appropriate supports due to a chronic condition and/or progressive disease as documented by a physician, requires significant assistance with transferring, mobility or supervision and assistance with at least one of the following Activities of Daily Living: bathing, dressing, eating or toileting will be determined eligible for State Plan HCBS Services. The SEP case manager determines eligibility by completing a comprehensive assessment utilizing the Universal Long Term Care Assessment 100.2 (ULTC 100.2) instrument. The ULTC 100.2 includes a functional assessment and Professional Medical Instrument Page (PMIP). The functional assessment measures 6 defined Activities of Daily Living: bathing, dressing, eating, mobility, toileting, and transferring, as well as the need for Supervision due to issues of behavior or memory/cognition. The ULTC 100.2 is currently used to determine institutional level of care for nursing facility and waiver participation. However, the SEP case managers will utilize the ULTC 100.2 differently when assessing a client for the State Plan HCBS Services by applying a different and less stringent scoring mechanism.

The ULTC 100.2 instrument allows for scores “0”, “1”, “2”, or “3” to quantify an individual’s need for assistance with the defined Activities of Daily Living or Supervision.

The SEP case manager will apply the ULTC 100.2 differently in assessing an individual for State Plan HCBS services by quantifying the individual’s need for assistance based on at least one score of a “2” or above and a second score of a least “1” across the Defined Activities of Living or a score of “1” or above in Supervision.

In contrast, the SEP case manager will apply the ULTC 100.2 in determining institutional level of care for nursing facility and waiver participation by quantifying the individual’s need for assistance based on at least two scores of “2” or above across the Defined Activities of Daily Living (2 + 2); or a score of “2” or above in Supervision.

The ULTC 100.2 will be revised to include the following instructions: To qualify for State Plan HCBS Services, the recipient/applicant must have a score of “2” or above across the Defined Activities of Living and a second score of at least 1 in another Activity of Daily Living (2 + 1) or a score of “1” or above in Supervision.

5. **X Needs-based Institutional and Waiver Criteria.** There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of HCBS state plan services. Individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Include copies of the State’s official documentation of the need-based criteria for each of the following):*

- *Applicable Hospital*
- *NF*
- *ICF/MR*

State plan HCBS needs-based eligibility criteria	NF (& NF LOC waivers)	ICF/MR (& ICF/MR LOC waivers)	Applicable Hospital* LOC (& Hospital LOC waivers)
<p>The ULTC 100.2 instrument allows for scores "0", "1", "2", or "3" to quantify an individual's need for assistance with the defined Activities of Daily Living or Supervision.</p> <p>Individuals must have at least one score of a "2" or above and a second score of at least "1" across the Defined Activities of Daily Living (2 + 1) or a score of at least "1" in Supervision.</p> <p>The needs based criteria is less stringent and will allow individuals who do not meet institutional level of care to access services.</p> <p>Activities of Daily Living: bathing, dressing, toileting, eating, mobility, transferring.</p>	<p>Criteria for receipt of institutional and waiver services requires individuals to score at least a 2 in 2 Activities of Daily Living (2 +2) or require a 2 or above score in Behaviors or Memory Cognition under Supervision.</p> <p>Activities of Daily Living: bathing, dressing, toileting, eating, mobility, transferring.</p>	<p>Criteria for receipt of institutional and waiver services requires individuals to score at least a 2 in 2 Activities of Daily Living (2 +2) or require a 2 or above score in Behaviors or Memory Cognition under Supervision.</p> <p>Activities of Daily Living: bathing, dressing, toileting, eating, mobility, transferring.</p>	<p>Criteria for receipt of institutional and waiver services requires individuals to score at least a 2 in 2 Activities of Daily Living (2 +2) or require a 2 or above score in Behaviors or Memory Cognition under Supervision.</p> <p>Activities of Daily Living: bathing, dressing, toileting, eating, mobility, transferring.</p>

6. **X Reevaluation Schedule.** The State assures that needs-based reevaluations are conducted at least annually.
7. **X Adjustment Authority.** The State will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).
8. **X Residence in home or community.** The State plan HCBS benefit will be furnished to individuals who reside in their home or in the community, not in an institution. (Specify any residential settings, other than an individual's home or apartment, in which residents will be furnished State plan HCSS, if applicable. Describe the criteria by which the State determines that these settings are not institutional in character such as privacy and unscheduled access to food, activities, visitors, and community pursuits outside the facility):

Person-Centered Planning & Service Delivery

1. X The State assures that there is an independent assessment of individuals determined to be eligible for HCBS. The assessment is based on:
 - An objective face-to-face evaluation by a trained independent agent;
 - Consultation with the individual and others as appropriate;
 - An examination of the individual's relevant history, medical records, care and support needs, and preferences;
 - Objective evaluation of the inability to perform, or need for significant assistance to perform 2 or more ADLs (as defined in § 7702B(c)(2)(B) of the Internal Revenue Code of 1986); and
 - Where applicable, an evaluation of the support needs of the individual (or the individual's representative) to participant-direct.
2. X The State assures that, based on the independent assessment, the individualized plan of care:
 - Is developed by a person-centered process in consultation with the individual, the individual's: treating physician, health care or supporting professional, or other appropriate individuals, as defined by the State, and where appropriate the individual's family, caregiver, or representative;
 - Identifies the necessary HCBS to be furnished to the individual, (or, funded for the individual, if the individual elects to participant-direct the purchase of such services);
 - Takes into account the extent of, and need for, any family or other supports for the individual;
 - Prevents the provision of unnecessary or inappropriate care;
 - Is guided by best practices and research on effective strategies for improved health and quality of life outcomes; and
 - Is reviewed at least annually and as needed when there is significant change in the individual's circumstances.
3. **Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities.** There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with physical and mental needs for HCBS. (*Specify qualifications*):

At minimum SEP case managers are required to have a bachelor's degree in a human behavioral science field such as human services, nursing, social work, or psychology. The majority of case managers have a bachelor's degree in sociology or psychology and some have a master's degree in social work.

4. **Responsibility for Service Plan Development.** There are qualifications (that are reasonably related to developing plans of care) for persons responsible for the development of the individualized, person-centered plan of care. (*Specify qualifications*):

In addition to the above mentioned educational/professional qualifications, SEP case managers are required to complete training specifically related to a person-centered approach in the development of individualized plans that focus on an individual's strengths, supports, and needs. SEP agencies are required to train new case managers on the person-centered approach to service plan development within the first three months of employment. New case managers also shadow veteran case managers to assure a thorough and comprehensive understanding of the process before independently developing a service plan. The Department (SMA) completed a statewide training in June 2007 on service plan development prior to the implementation of an automated service plan that is maintained by the Department (SMA) in the Benefits Utilization System (BUS), which is a computer program utilized by every SEP to enter data including Level of Care Assessments, service plan, case notes and timeframes for evaluation and reevaluation.

- 5. Supporting the Participant in Service Plan Development.** Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the service plan development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

Clients may choose among qualified providers and services. The case manager will advise the client or authorized representative of the range of services and supports for which the client is eligible in advance of service plan development. The choice of services and providers for HCBS State Plan Services is assured by facilitating a client centered process and providing the client with a list of all providers from which to choose.

When scheduling to meet with the client the case manager makes reasonable attempts to schedule the meeting at a time convenient for the client. In addition, a client and/or authorized representative have the authority to select and invite individuals of their choice to actively participate in the service planning process. SEP case managers develop emergency back-up plans with the client and/or authorized representative during the service planning process and document the plan on the service plan.

- 6. Informed Choice of Providers.** *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the service plan):*

Clients electing the State Plan HCBS Services will have the flexibility of hiring his or her attendants. The FMS is required to maintain and make available to clients a list of attendants for possible recruitment and hiring.

Services

1. HCBS State Plan Services. (Complete the following table for each service. Copy table as needed):

Service Specifications (Specify a service title from the options for HCBS State plan services in Attachment 4.19-B):			
Service Title:		Home Health Aide	
Service Definition (Scope):			
<p>Services that assist an individual in accomplishing health maintenance activities. Health maintenance activities are those routine and repetitive activities of daily living which require skilled assistance for health and normal bodily functioning, and which would be carried out by an individual with a disability if he or she were physically/cognitively able. Skilled assistance refers to assistance to accomplish activities such as bowel/bladder care, wound care, administration of medication, ventilator care and monitoring, skilled feeding and range of motion. The client, or the authorized representative, is responsible for hiring, training, recruiting, setting wages, scheduling, and in other ways managing the attendant. The client, or authorized representative certifies that the attendant is qualified to provide skilled assistance.</p> <p>Home Health Aide Services offered under the State Plan HCBS are limited based on the client's assessed need for services. SEP case managers will not authorize HCBS State Plan Home Health Aide services for clients currently receiving state plan Home Health Aide or In Home Support Health Maintenance Services under the HCBS-Elderly, Blind, and Disabled and Children's waivers.</p> <p>The Colorado Nurse Practice Act has been amended to allow individuals employed through a consumer directed service option to provide delegated nursing tasks and without the supervision of an R.N.</p>			
Additional needs-based criteria for receiving the service, if applicable (specify):			
Specify limits (if any) on the amount, duration, or scope of this service for (chose each that applies):			
X	Categorically needy (specify limits):		
□	Medically needy (specify limits):		
Specify whether the service may be provided by a (check each that applies):		X	Relative
		X	Legal Guardian
		X	Legally Responsible Person
Provider Qualifications (For each type of provider. Copy rows as needed):			
Provider Type (Specify):	License (Specify):	Certification (Specify):	Other Standard (Specify):
Attendant	N/A	N/A	At minimum, attendants must be at least 16 years of age, successfully complete training provided by the client/authorized representative and meet the qualifications

			set forth by the client/authorized representative in order to provide skilled assistance. Attendants are required to meet Core Competency Standards and meet training requirements set forth by the Department. Attendants must demonstrate proficiency in the skills needed to serve the individual including documentation that the attendant has met the Core Competency Standards and training requirements prior to providing home health aide services. This certification will be reviewed and verified by the FMS and kept on file.

Verification of Provider Qualifications (For each provider type listed above. Copy rows as needed):

Provider Type (Specify):	Entity Responsible for Verification (Specify):	Frequency of Verification (Specify):
Attendant	FMS, The Department of Health Care Policy and Financing, Community Based Long Term Care Section,	Annually

Service Delivery Method. (Check each that applies):

<input checked="" type="checkbox"/>	Participant-directed	<input type="checkbox"/>	Provider managed
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Service Specifications (Specify a service title from the options for HCBS State plan services in Attachment 4.19-B):

Service Title:	Personal Care
Service Definition (Scope):	
Services that assist an individual in accomplishing activities of daily living such assistance with eating, bathing, dressing, personal hygiene and other activities of daily living. Personal Care includes	

accompanying the client outside of the home when associated with the delivery of the personal care task. The client or authorized representative is responsible for hiring, training, recruiting, setting wages, scheduling, and in other ways managing the attendant.

Personal Care Services offered under the State Plan HCBS are limited based on the client's assessed need for services and prior authorization by the SEP case manager to ensure there are no duplication of personal care services through an HCBS waiver.

Additional needs-based criteria for receiving the service, if applicable (*specify*):

Specify limits (if any) on the amount, duration, or scope of this service for (*choose each that applies*):

Categorically needy (*specify limits*):

Medically needy (*specify limits*):

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

- Relative
- Legal Guardian
- Legally Responsible Person

Provider Qualifications (*For each type of provider. Copy rows as needed*):

Provider Type (<i>Specify</i>):	License (<i>Specify</i>):	Certification (<i>Specify</i>):	Other Standard (<i>Specify</i>):
Attendant	N/A	N/A	At minimum, attendants must be at least 16 years of age, trained to perform appropriate tasks to meet the client's needs, and demonstrate the ability to provide support to the client as defined in the client's State Plan HCBS Services Management Plan and Hiring Agreement.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type (<i>Specify</i>):	Entity Responsible for Verification (<i>Specify</i>):	Frequency of Verification (<i>Specify</i>):

Attendant	FMS, The Department of Health Care Policy and Financing, Community Based Long Term Care Section	Annually
Service Delivery Method. (Check each that applies):		
<input checked="" type="checkbox"/>	Participant-directed	<input type="checkbox"/> Provider managed

Service Specifications (Specify a service title from the options for HCBS State plan services in Attachment 4.19-B):			
Service Title:	Homemaker		
Service Definition (Scope):			
Services consisting of general household activities (meal preparation and routine household care) provided in the home of an eligible client to maintain a healthy and safe environment for a client when the individual regularly responsible for these activities is temporarily absent or unable to manage these tasks.			
Homemaker Services offered under the State Plan HCBS are limited based on the client's assessed need for services and prior authorization by the SEP case manager to ensure no duplication of Homemaker Services through an HCBS waiver			
Additional needs-based criteria for receiving the service, if applicable (specify):			
Specify limits (if any) on the amount, duration, or scope of this service for (chase each that applies):			
<input checked="" type="checkbox"/>	Categorically needy (specify limits):		
<input type="checkbox"/>	Medically needy (specify limits):		
Specify whether the service may be provided by a (check each that applies):		<input checked="" type="checkbox"/>	Relative
		<input checked="" type="checkbox"/>	Legal Guardian
		<input checked="" type="checkbox"/>	Legally Responsible Person
Provider Qualifications (For each type of provider. Copy rows as needed):			
Provider Type (Specify):	License (Specify):	Certification (Specify):	Other Standard (Specify):
Attendant	N/A	N/A	At minimum, attendants must be at least 16 years of age, trained to perform appropriate tasks to meet the client's needs, and demonstrate the ability to provide support to the client as defined in the client's State Plan HCBS Services Management Plan and Hiring Agreement.

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Verification of Provider Qualifications (For each provider type listed above. Copy rows as needed):

Provider Type (Specify):	Entity Responsible for Verification (Specify):	Frequency of Verification (Specify):
Attendant	FMS, The Department of Health Care Policy and Financing, Community Based Long Term Care Section (SMA)	Annually

Service Delivery Method. (Check each that applies):

<input checked="" type="checkbox"/> Participant-directed	<input type="checkbox"/> Provider managed
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2. **Policies Concerning Payment for State Plan HCBS Furnished by Legally Responsible Individuals, Other Relatives and Legal Guardians.** *(Select one):*

<input type="radio"/>	The State does not make payment to legally responsible individuals, other relatives or legal guardians for furnishing state plan HCBS.
<input checked="" type="radio"/>	The State makes payment to <i>(check each that applies):</i>
<input checked="" type="checkbox"/>	Legally Responsible Individuals. The State makes payment to legally responsible individuals under specific circumstances and only when the relative is qualified to furnish services. <i>(Specify (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) in cases where legally responsible individuals are permitted to furnish personal care or similar services, the State must assure and describe its policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual); (c) how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; (d) the State's strategies for ongoing monitoring of the provision of services by legally responsible individuals; and, (e) the controls that are employed to ensure that payments are made only for services rendered):</i>

For the purpose of this section family shall be defined as all persons related to the client by virtue of blood, marriage, adoption, or common law and legal guardians as court appointed

The family member providing State Plan HCBS shall meet requirements for employment by:

- a. Being employed by the FMS and supervised by the client and/or authorized representative if providing HCBS State Plan services.
- b. A family member who is an individual's authorized representative may not be reimbursed for the provision of HCBS State Plan Services.

The family member employed by the FMS may be reimbursed up to 40 hours of State Plan HCBS Services in a seven day period. The family member must meet the following requirements: At minimum, family members serving as attendants must be at least 16 years of age, trained to perform appropriate tasks to meet the client's needs, and demonstrate the ability to provide support to the client as defined in the client's State Plan HCBS Services Management Plan and Hiring Agreement. Legally responsible individuals and relatives must meet the same qualifications as the providers as specified in the service qualifications.

The SEP case manager will determine the tasks that are typically provided by a legally responsible individual and determine if the care is extraordinary care based on the State's guidelines because it is above and beyond what a legally responsible individual would typically provide. The SEP case manager will determine if care is extraordinary care by assessing whether an individual who is the same age without a disability needs the requested level of care, the activity is one that a legally responsible individual would not normally provide as part of a normal household routine. Examples include excessive laundry due to incontinence or health condition and/or specialized diet that requires more time and preparation.

A client and/or authorized representative must provide a planned work schedule to the FMS a minimum of two weeks in advance of receiving State Plan HCBS Services and variations to the schedule must be noted and supplied to the FMS agent when billing. The FMS will review the time sheets submitted by a relative and/or legally responsible individual who is serving as an attendant to ensure that no more than a total of 40 hours of home health aide, personal care, and homemaker services have been reported for a seven day time period. The FMS will not reimburse for hours submitted in excess of 40 hours for all of these services in a seven day time period.

An authorized representative cannot serve as the client's attendant.

	<p>An individual must be offered a choice of providers. Clients and/or authorized representatives who choose to hire a family member as a care provider in State Plan HCBS Services must document their choice on the HCBS State Plan Services Management Plan.</p> <p>The following additional requirements are employed when a family member is paid as a care provider for clients receiving the State Plan HCBS Services.</p> <p>a. At least quarterly reviews by the SEP case manager of expenditures, and health, safety and welfare status of the client.</p> <p>b. Monthly reviews by the fiscal agent of hours billed for family member provided care.</p>
<input type="checkbox"/>	Other policy. (Specify):

Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

1. Election of Participant-Direction. (Select one):

○	The State does not offer opportunity for participant-direction of state plan HCBS.
	Every participant in HCBS state plan services (or the participant’s representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
X	Participants in HCBS state plan services (or the participant’s representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the State. <i>(Specify criteria):</i>

	<ul style="list-style-type: none"> • Demonstrate a current need for attendant support • Provide a statement from his or her primary care physician that indicates the client has sound judgment and the ability to direct his or her own care or requires an Authorized Representative to direct the care on the client's behalf and has a pattern of stable health based on the client's health condition and disability. • Complete Attendant Support Management Training and the Post Training Assessment to demonstrate the ability to handle the financial aspects, health management aspects and supervision of attendants or have an authorized representative complete the Attendant Support Management Training and Post Training Assessment.
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2. Description of Participant-Direction. *(Provide an overview of the opportunities for participant-direction under the HCBS State Plan option, including: (a) the nature of the opportunities afforded; (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 approach to participant-direction):*

State Plan HCBS provides clients the opportunity for participant direction of home health aide, personal care, and homemaker services. The SEP case manager will provide an informational packet including service description, eligibility criteria, and required paperwork to all long term care clients.

The client and/or legal guardian who are interested in State Plan HCBS Services will obtain a completed Physician Statement of Consumer Capability indicating that the client is of sound judgment and has the ability to direct his or her care or requires the assistance of an authorized representative to direct care on his or her behalf. The Physician Statement of Consumer Capability is a Department (SMA) approved form that includes definitions of stable health, ability to manage the health aspects of his/her life, ability to direct his/her own care, and authorized representative for the treating physician to ensure that the physician's judgment can be consistently applied. If the physician indicates that the client is not able to direct his/her care, the client or legal guardian will designate an authorized representative.

The authorized representative may not be the client's attendant. The authorized representative must submit an affidavit stating that he or she is at least 18 years of age, has known the client 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 client. The client and/or authorized representative works with the case manager who determines eligibility based on the needs criteria through the completion of a ULTC 100.2. The case manager authorizes the services by completing a PAR and refers the State Plan HCBS client and/or authorized representative to the FMS.

This option offers flexibility to clients who choose to direct his/her own care or have an authorized representative direct the care. If a client and/or legal guardian choose State Plan HCBS Services the client and/or authorized representative will have the ability to recruit, hire, train, schedule, set wages, and in other ways manage his/her attendants. The attendant will be employed through a FMS, but will be supervised in all other ways by the client and/or authorized representative. The case manager will calculate the client's individual monthly allocation based on the number of hours of personal care, homemaker, and home health services defined in the client's service plan and provide this information to the client. The case manager will then refer the client and/or authorized representative to the FMS for skills training.

The FMS will provide skills training to the client and/or authorized representative to assure that clients and/or authorized representatives understand the philosophy of consumer direction and the tasks involved to successfully manage their services. Skills training will include an overview of the program, client and/or authorized representative rights and responsibilities, planning and organizing attendant services, managing personnel issues, recognizing and recruiting quality attendant support, managing health, managing emergencies, using resources and working with the FMS. The FMS will also be required to monitor the client's and/or authorized representative's submittal of required information to determine that it is complete, accurate and timely, work with the case manager to address client performance problems, and provide monthly reports to the client and/or authorized representative. The FMS will also provide personnel and financial management services for State Plan HCBS Services clients and/ or authorized representatives. Information regarding the Nurse Advice Help Line will also be made available to clients/authorized representatives during the training process. This information will be referenced in the training manual to assure that each client/authorized representative understands that he or she can call for advice if the client is sick, hurt, or needs health care advice including help in decisions about whether to go to the emergency room or not and about when to see a doctor.

After the client and/or authorized representative complete skills training they will have to develop a State Plan HCBS Services Management Plan and submit the plan to the case manager for approval. The State Plan HCBS Services Management Plan will describe the following: the client's current health status, the client's consumer directed attendant support needs, the client's plans for securing consumer attendant support services, the clients plans for utilizing the monthly allocation and the client's plan for handling emergencies. If areas of concern are identified upon the case manager's review of the State Plan HCBS Services Management Plan, the case manager will assist the participant to further develop the plan. The client will not be able to begin State Plan HCBS Services until the Plan is approved by the SEP case manager.

After the client has started State Plan HCBS, the case manager will contact the client and/or the authorized representative twice a month for the first three months to assess their effectiveness in managing State Plan HCBS and the client's and/or authorized representative's satisfaction with attendants and the quality of services being provided. If the client and/or authorized representative report a change in functioning which requires a modification to the client's State Plan HCBS Management Plan, a home visit will be made. After the first three months, the case manager will contact the client and or authorized representative quarterly to assess the implementation of the State Plan HCBS Management Plan, attendant management issues, quality of care, attendant support expenditures and general satisfaction with State Plan HCBS. After six months in the program the case manager will conduct a face-to face reassessment with the client and/or authorized representative to determine level of functioning and review the State Plan HCBS Management Plan determine if services meet the client's level of care needs. An adjustment in the monthly allocation can be made if it is determined that there has been a change in the client's condition that necessitates more or less State Plan HCBS.

3. **Participant-Directed Services.** (Indicate the HCBS that may be participant-directed and the authority offered for each. Add lines as required):

Participant-Directed Service	Employer Authority	Budget Authority
Home Health Aide	X	X
Personal Care	X	X
Homemaker	X	X

4. **Financial Management.** (Select one):

<input type="radio"/>	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
<input checked="" type="radio"/>	Financial Management is furnished as an administrative function.

5. **X Participant-Directed Service Plan.** The State assures that, based on the independent assessment, a person-centered process produces an individualized plan of care for participant-directed services that:

- Is directed by the individual or authorized representative and builds upon the individual's preferences and capacity to engage in activities that promote community life;
- Specifies the services to be participant-directed, and the role of family members or others whose participation is sought by the individual or representative;
- For employer authority, specifies the methods to be used to select, manage, and dismiss providers;
- For budget authority, specifies the method for determining and adjusting the budget amount, and a procedure to evaluate expenditures; and
- Includes appropriate risk management techniques.

6. **Voluntary and Involuntary Termination of Participant-Direction.** (Describe how the State facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):

State Plan HCBS Services is a voluntary service. A client may choose to withdraw at anytime. If a client chooses to withdraw he/she must contact his/her SEP case manager, who will assist the client in obtaining other home care services, if applicable and the client remains eligible for care.

Circumstances that may result in an involuntary termination of State Plan HCBS in which a participant and/or their authorized representative:

- fails to comply with HCBS state plan option services requirements; and/or
- demonstrates an inability to manage attendant support; and/or
- a participant's physical or cognitive condition deteriorates to the point that he or she no longer meets admission criteria and the client refuses to designate an authorized representative to direct services on his/her behalf; and/or
- exhibits inappropriate behavior toward the attendant and the Department (SMA) has determined that the FMS has made adequate attempts to resolve the behavior and resolution has failed.

Inappropriate behavior includes, but is not limited to, documented verbal, sexual, or physical abuse.

The SEP case manager shall notify the client and/or Authorized Representative in writing at least twenty (20) calendar days prior to termination that he or she is no longer eligible for State Plan HCBS, The client and/or Authorized Representative should contact his or her SEP case manager for assistance in obtaining other home care services. The SEP case manager will use the Department's prescribed Notice of Action form that will provide the client and/or Authorized Representative with the reasons for termination including definition of verbal, sexual, or physical abuse if applicable to the termination and with information about the client's rights to fair hearing and appeal procedures, in accordance with 10 C.C.R. 2505-10,§ 8.057. The Notice of Action form will provide information regarding the continuation of benefits, if the client chooses to file an appeal before the effective date of the action along with information regarding the client's responsibility for costs incurred during the appeal process in the event the client loses the appeal. Exceptions may be made to the twenty (20) day advance notice requirement when the Department (SMA) has documented that there is a danger to the client or to the attendant(s). The SEP case manager shall notify the FMS of the date on which the client is being terminated from State Plan HCBS.

7. **Opportunities for Participant-Direction**

a. **Participant-Employer Authority** (individual can hire and supervise staff). (Select one):

<input type="radio"/>	The State does not offer opportunity for participant-employer authority.
<input checked="" type="radio"/>	Participants may elect participant-employer Authority (Check each that applies):
<input checked="" type="checkbox"/>	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.
<input type="checkbox"/>	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.

b. Participant–Budget Authority (individual directs a budget). *(Select one):*

<input type="radio"/>	The State does not offer opportunity for participants to direct a budget.
<input checked="" type="radio"/>	<p>Participants may elect Participant–Budget Authority.</p> <p>Participant-Directed Budget. <i>(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including how the method makes use of reliable cost estimating information, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the plan of care):</i></p> <p>SEP case managers will establish a monthly allocation for the client by calculating the number of personal care, homemaker, and home health services needed on a monthly basis as defined in the client’s long-term service plan and multiply by the Department (SMA)’s established rates for personal care, homemaker, and home health aide services. The SEP case manager will compare the historical utilization expenditures to the current service plan when applicable to assure that the long term service plan reflects the current level of services and the allocation is calculated appropriately.</p> <p>The cost of providing the services included in the service plan is calculated based on the expected reimbursement for such services and is adjusted to account for the self-directed service delivery model. Based on the historical utilization patterns and differences in set-up and oversight, the Department will adjust the state plan service reimbursement by 10%.</p> <p>The Department will develop a protocol on the budget methodology, which will be made available to SEP case managers and will also provide training prior to implementation to assure that the methodology is applied in a consistent manner for each client that accesses State Plan HCBS services.</p> <p>The budget methodology will be made publicly available in the training manual distributed to clients prior to receiving State Plan HCBS services, posted on the Department’s website and will be reflected in state regulations.</p> <p>The case manager will review and approve the State Plan HCBS Services Management Plan completed by the client and/or authorized representative during training to ensure that the client and/or authorized representative understand the requirements, risks, and responsibilities of consumer direction. If case managers identify areas of concern, they will assist the participant and/or authorized representative with further development of the State Plan HCBS Services Management Plan before the client begins receiving State Plan HCBS.</p> <p>Expenditure Safeguards. <i>(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):</i></p>

The SEP case manager will review monthly reports provided by the FMS to monitor client spending patterns and service utilization to assure appropriate budgeting and follow up with the client and/or authorized representative when discrepancies occur. The SEP case manager will also contact the FMS quarterly to determine the status of each client's financial management activities. If the SEP case manager determines that the client's spending patterns indicate a premature depletion of the budget, the SEP case manager will contact the client and/or authorized representative to determine the reason for overspending. If the client requires an allocation increase the SEP case manager will complete a reassessment. If the client requires further skills training the SEP case manager will refer the client and/or the authorized representative to the FMS for additional training. The SEP case manager will also review monthly reports and identify clients who are underutilizing the monthly allocation and appropriate follow up will be made with the client and/or authorized representative to the SEP case manager.

If the client 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 he/she refuses, the client will be terminated from State Plan HCBS Services and the case manager will assist the client in transitioning to agency services, if appropriate.

The SEP case manager will also review monthly reports to identify clients who are underutilizing the monthly allocation and will conduct appropriate follow up with the client and or authorized representative to ensure that the client is receiving appropriate services and assist the client and/or authorized representative in addressing underlying issues if the level of services is not adequate.

Quality Management Strategy

(Describe the State's quality management strategy in the table below): *The Department is working on a comprehensive/global quality strategy.*

Requirement	Monitoring Activity (What)	Monitoring Responsibilities (Who)	Evidence (Data Elements)	Management Reports (Yes/No)	Frequency (Mos/Yrs)
Service plans address assessed needs of enrolled participants, are updated annually, and document choice of services and providers.	Ongoing provider reviews by SEP agency and Annual Department (SMA) SEP agency site review	SEP agency and Community Based Long Term Care Section – (SMA)	Client records and SEP agency site review tool	Onsite Review Results	Annually The SEP agency reviews the service plan and contacts providers at least every six months.
	Client Satisfaction Surveys	Community Based Long Term Care Section – (SMA)	Aggregate data from surveys		Annually
Providers meet required qualifications	Ongoing review of certificate indicating that the attendant has completed training and is qualified to provide services.	FMS, SEP agency	Client records- Certificate	Onsite Review Results	Annually
		Community Based Long Term Care Section –(SMA)		FMS –Verification Report	Quarterly
The SMA retains authority and responsibility for program operations and oversight.	SEP Review	Community Based Long Term Care Section –(SMA)	Client records, SEP agency site review tool including administrative component. BUS log notes Customer service records, examples of expenditure reports, client statements, and web based time entry	Onsite Review Results, Administrative Review Results	Annually
	FMS Contract Monitoring Review of policies, procedures for each function required by the contract. prior to	Community Based Long Term Care Section – (SMA) Program Staff		Readiness Review Findings	Prior to the Operational Start Date of the service.

	<p>the operational start date of the contract. On-site review of policies and procedures for each contractual function. Review of all required systems including key information systems and financial software programs. Review of key features of customer service, record security, skills training, and disaster recovery systems. Review of examples of all necessary materials and forms.</p> <p>On-going review</p>		<p>reports.</p> <p>Expenditure reports, Customer service records, complaint logs, web based time entry reports</p>	<p>Expenditure Reports, Complaint Log Summary Report</p> <p>On-site review results</p>	<p>Monthly</p> <p>Annually</p>
<p>The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to enrolled participants by qualified providers.</p>	<p>On-gong Monitoring of Claims for services rendered to assure payment made is in accordance with the approved service plan and prior authorized units.</p>	<p>Program Integrity –</p>	<p>MMIS reports and Business Objects of America (BOA) reports</p>	<p>Case Summary Reports</p>	<p>Weekly</p> <p>Monthly</p>
<p>The State identifies, addresses and seeks to prevent incidents of abuse,</p>	<p>On going complaint monitoring utilizing</p>	<p>Community Based Long Term Care</p>	<p>Critical Incident Reporting System –</p>	<p>Critical Incident Summary Reports</p>	<p>Monthly</p>

neglect, and exploitation, including the use of restraints.	the Department of Public Health and Environment reporting system	Program Staff (SMA)	BUS Occurrence reports complaint investigation reports Aggregate data from surveys	Occurrence report summary data	Quarterly and Annually Annually
Describe the process (es) for remediation and systems improvement.	<p>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 data collected after remediation activities have been in place long enough to produce results.</p> <p>The (SMA) Community Based Long Term Care staff will address negative findings and non-compliance issues by identifying and prioritizing the issues through the systematic review. Staff will determine the appropriate remediation necessary dependent on the negative finding. A critical incident reported without appropriate documentation or resolution will require immediate follow up to the SEP case manager, other negative findings may result in the need for revised protocols, additional training or improvement in reporting systems. Non-compliance issues will result in a required Corrective Action Plan to assure that necessary changes are made to meet compliance standards.</p> <p>The Long Term Care Benefits Division and the Community Based Long Term Care and Quality Improvement Sections SMA hold primary responsibility for monitoring and assessing the effectiveness of system design changes. Results of quality improvement activities are discussed during SMA Long Term Care Benefits Division and CBLTC Section monthly meetings, as well as at specially convened meetings around specific findings to plan for implementation. The SMA Long Term Care Benefits Division and CBLTC Section are responsible for implementing the system improvements. Timelines, resource allocation and project planning will accompany each system improvement so that its progress towards implementation can be tracked and measured for impact.</p> <p>The Department will include in its annual report to CMS information on the required on-going case management monitoring of clients and/or authorized representatives to assess the implementation of the HCBS State Plan Services and assure that the client and or authorized representative is effectively managing the services, receiving quality care, budgeting appropriately for their needs. The on-going monitoring will also include the case manager's assessment of level of functioning and review of the Attendant Support Management Plan to assure that HCBS State Plan services continues to meet the client's current level of care needs.</p>				