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 waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

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

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

1. Request Information

A. The **State** of **Colorado** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.
B. **Program Title:**
Children's Home and Community Based Services (CHCBS) waiver
C. **Waiver Number:CO.4157**
Original Base Waiver Number: CO.4157.
D. **Amendment Number:CO.4157.R05.02**
E. **Proposed Effective Date:** *(mm/dd/yy)*
11/21/15
Approved Effective Date of Waiver being Amended: 07/01/13

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
The purpose of this amendment is to modify language surrounding the Children's Home and Community Based Services (CHCBS) waiver's In Home Support Services (IHSS) service and to update all of the waiver's Quality Performance Measures. These changes will go into effect on November 21st, 2015.

Summary of the IHSS programming changes that affect the CHCBS waiver:
1) Allowing IHSS to be provided in the community
2) Clarifying that the client or the client's authorized representative is responsible for directing their care, including scheduling, managing, and supervising attendants
3) Allowing clients or the client's authorized representative to work with the IHSS agency to determine the amount of nurse oversight

The Quality Improvement Performance Measures are being updated to incorporate CMS' new sub-assurances and to allow the state to report meaningful, measureable data as evidence of meeting those sub-assurances.

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	3, QIS
☑ Appendix B – Participant Access and Eligibility	QIS
☑ Appendix C – Participant Services	1,5,QIS
☑ Appendix D – Participant Centered Service Planning and Delivery	1, QIS
☑ Appendix E – Participant Direction of Services	1
☐ Appendix F – Participant Rights	
☑ Appendix G – Participant Safeguards	2, QIS
☑ Appendix H	1
☑ Appendix I – Financial Accountability	2, QIS
☑ Appendix J – Cost-Neutrality Demonstration	2

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

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

Specify:

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

1. Request Information (1 of 3)

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

B. **Program Title** (*optional - this title will be used to locate this waiver in the finder*):
Children's Home and Community Based Services (CHCBS) waiver

C. **Type of Request: amendment**

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: CO.4157
Waiver Number:CO.4157.R05.02
Draft ID: CO.005.05.02

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/13
Approved Effective Date of Waiver being Amended: 07/01/13

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*):

- [x] **Hospital**

  Select applicable level of care

  - (●) **Hospital as defined in 42 CFR §440.10**
    If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:
    The CHCBS Waiver is limited to an acute care hospital level of care.
  - ( ) **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

- [x] **Nursing Facility**

  Select applicable level of care

  - (●) **Nursing Facility as defined in 42 CFR □□440.40 and 42 CFR □□440.155**
    If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
    The CHCBS waiver is limited to skilled nursing facilities 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 Children's Home and Community Based Services (CHCBS) waiver assists children who require long term supports and services in order for them to remain in their family residence, or in the community. Eligibility is limited to children, age - birth up to their eighteenth (18th) birthday who require long-term supports at a level typically provided in a Skilled Nursing Facility or Acute Hospital, as specified in this application.

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

The Department currently has twenty-seven (27) agencies that provide case management and review of waiver services, Case Management and In Home Support Services (IHSS). The Department has three (3) different types of Case Management Agencies that provide intake and subsequent case management services for the CHCBS program: Single Entry Point (SEP) Agencies, Community Centered Boards (CCB's) and private Case Management Agencies. These agencies ensure a statewide network of availability of Case Management Agencies to perform case management functions for individuals enrolled in the CHCBS waiver. Functions of case management include intake/screening/referral, assessment of the child's needs, functional eligibility determination through the ULTC-100.2, service plan development, ongoing case management and monitoring to assure participant protections and quality assurance.

3. Components of the Waiver Request

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

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

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

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

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

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

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

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

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

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

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

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

4. Waiver(s) Requested

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

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

- ( ) **Not Applicable**
- (●) **No**
- ( ) **Yes**

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

- (●) **No**
- ( ) **Yes**

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

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

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

5. Assurances

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

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

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

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

I. **Public Input.** Describe how the State secures public input into the development of the waiver:
The Department will afford the opportunity for all stakeholders to provide input for this waiver amendment by posting a full copy of the waiver, summary of changes, and a copy of the transition plan to the Department website. These documents are also available by fax, mail, or in-person. The Department also published notices in 10 newspapers, meeting population requirement guidelines, throughout the state of Colorado. These notices will be running weekly for the entire period of public notice. The public comment period will run from July 15, 2015 through August 14th, 2015. A defined stakeholder input process was communicated to stakeholder groups via email. This email will then be sent out via a variety of additional stakeholder and advocate distribution lists. Additionally, the Department will post all information on the Department website with directions on how to submit comments or questions during the public notice period. The Department will also present these changes to the Medical Advisory Committee on August 27th, 2015 in person and email to all Committee members on 7/15. Lastly, these changes were part of Tribal Government notifications made on July 10th, 2015. Feedback will be accepted via US mail, e-mail, and fax. All comments are maintained in a listening log kept on the Department's website.

The Department followed all, at a minimum, all items indicated in the letter addressed to the Regional Centers for Medicare and Medicaid Services Director from The Department's legal Attorney General counsel dated June 15th, 2015.

The items are summarized as follows: The Department will send, via electronic mail, a summary of all proposed changes to all stakeholders. Stakeholders include clients, contractors, families, providers, advocates, and other interested parties. Non-Web-Based Notice: The Department will also post notice in the newspaper of widest circulation in each city with a population of 50,000 or more. The Department will employ 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 recently given by the CMS Regional Office. The Department will post on its website the full waiver and a summary of any proposed changes to that waiver. The Department will also make available paper copies of the summary of proposed changes and paper copies of the full waiver. These paper copies will be available at the request of individuals. The Department understands that, by posting both the full waiver and a summary of the proposed amendments on its website, as well as by providing paper copies as requested, it will have met the regulatory requirements and CMS Technical Guidance. The Department will allow at least 30 days for public comment, and will specify these dates in the waiver amendment submission. The Department will comply 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. The Department will also have the waiver amendments 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. In addition to the specific action steps described above, the Department will also ensure that all waiver amendments' documentation includes instructions about obtaining a paper copy. All documentation will contain language stating: "You may obtain a paper copy of the waiver and the proposed changes by calling (303) 866-2993 or by visiting the Department at 1570 Grant Street, Denver, Colorado 80203." Newspaper notices about waiver amendments will also include instructions on how to obtain an electronic copy or paper. At stakeholder meetings that announce proposed waiver amendments, the attendees will be offered a paper copy, which can be provided at the meeting or can be mailed to them after the meeting. Attendees both in person and on the telephone will also be instructed that they may call or visit the Department for a paper copy.

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: Roy

First Name: Dennis

Title: CHCBS Administrator

Agency: Colorado Department of Health Care Policy and Financing

Address: 1570 Grant Street

Address 2:

City: Denver

State: **Colorado**

Zip: 80203

Phone: (303) 866-4828 **Ext:** ☐ **TTY**

Fax: (303) 866-2786

E-mail: dennis.royjr@state.co.us

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City: Denver

State: **Colorado**

Zip:

Phone:

Ext: ☐ **TTY**

Fax:

E-mail:

8. Authorizing Signature

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

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name: Hammer

First Name: Gretchen

Title: State Medicaid Director

Agency: Colorado Department of Health Care Policy & Financing

Address: 1570 Grant St.

Address 2:

City: Denver

State: **Colorado**

Zip: 80203

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

Fax:
(303) 866-4411

E-mail:
gretchen.hammer@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:

Not applicable.

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.

All CHCBS waiver participants live in the private home of their parent and/or guardian. Children residing in foster homes or facilities are not eligible for the waiver as the state has established rules that prohibit a child from being otherwise eligible for Medicaid. This waiver does not have active participants residing in facilities.

The Colorado Department of Health Care Policy & Financing oversees the provider certification processes and ongoing oversight of provider compliance with all state standards. The Department assesses providers for ongoing compliance with the HCB Settings through two processes. First, provider certification visits and surveys, delegated to the Colorado Department of Public Health and Environment through an interagency agreement, document the interaction between providers and participants to monitor potential changes in provider-specific policies and service delivery processes. Secondly, the ongoing incident and complaint management systems described in Appendix G of the approved waiver ensure that the Department is notified of any potential changes to participants' reception of services through waiver benefits.

The CHCBS waiver does not have any institutional like community settings and therefore does not need to implement any changes or transitions.

Colorado assures that the settings transition plan included with this waiver amendment or renewal will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. Colorado will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

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:
       Long Term Services and Supports Division, HCBS Operations Unit
       (Do not complete item A-2)

     - ( ) **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

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

       (Complete item A-2-a).

   - ( ) **The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

     Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

   a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver

operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

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

Appendix A: Waiver Administration and Operation

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

- **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
  Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
  The Department currently has provider agreements with twenty-seven (27) Case Management Agencies throughout the state of Colorado that are responsible for providing utilization review; developing service plans and prior authorizations. Of the twenty-seven (27) Case Management Agencies, fourteen (14) are Single Entry Points (SEPs), ten (10) are Community Centered Boards (CCBs) and three (3) are private case management agencies.

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

  The Department of Health Care Policy and Financing (the Department) maintains an Interagency Agreement with the state Survey Agency, the Department of Public Health and Environment (DPHE), to license, survey, and investigate complaints against IHSS agencies. DPHE has purview for health facilities and survey and certification related activities. The Department monitors the survey schedule activities through monthly reports required through the interagency agreement. Once an IHSS provider has been surveyed and licensed by DPHE, they are referred to the Department to obtain Medicaid Certification. IHSS providers are surveyed annually for continued licensing or more frequently to investigate complaints or follow up on survey deficiencies in accordance with the CMS state operations manual.
- **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 has twenty-seven (27) Case Management Agencies, fourteen (14) are Single Entry Points (SEPs), ten (10) are Community Centered Boards (CCBs) and three (3) are private case management agencies. Of the twenty-seven (27) agencies, fifteen (12) are Local/Regional non-state public agencies.

   One of the services for the CHCBS waiver is case management, this service includes utilization reviews, development of service plans and prior authorization of waiver services.

   All CHCBS case management agencies are held to the same standards and requirements. All CHCBS case management agencies must complete the state approved provider agreement (contract) and be approved by the Department.

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

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

   The Department has provider agreements with twenty seven (27) Case Management Agencies, fourteen (14) are SEPs agencies, ten (10) are CCBs and three (3) are private case management agencies that are located throughout the state of Colorado. Of the twenty-seven (27) agencies, fifteen (15) are Local/Regional non-governmental non-state entities. These agencies are responsible to perform Home and Community Based waiver operational and administrative services, case management, development of service plans, utilization review, and prior authorization of waiver services. All CHCBS case management agencies are held to the same standards and requirements.

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.**Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
   Colorado Department of Health Care Policy and Financing, Long Term Services and Supports Division.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
   The Department provides 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 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 DPHE requires that all complaints be investigated and reported to the Department. By gathering this information the Department is able to develop strategies to resolve issues that have been identified. For the CHCBS waiver, DPHE is responsible for monitoring In Home Support Services providers. Further information about the relationship between CDPHE and the Department is provided in Appendix G of the waiver application.

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

The administrative evaluation is used to monitor compliance with agency operations and functions as outlined in waiver and department contract requirements. The Department reviews documents used by the CMAs during the administrative evaluation. These documents include: job descriptions (to assure appropriateness of qualifications), release of information forms, prior authorization forms, complaint logs and procedures, service provider choice forms, tracking worksheets and/or databases, agency case review tool, professional medical information (to assure licensed medical professional completion) and all other pertinent client signature pages including intake forms and service plan agreements. The administrative review also evaluates agency specific resource development plans, community advisory activity, and provider or other community service coordination. Should the monitors 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 in person or via phone and e-mail. The Department conducts follow-up monitoring to assure corrective action implementation and ongoing compliance. If a compliance issue extends to multiple CMAs the Department provides clarification through Dear Administrator Letters (DALs), formal training, or both.

The programmatic evaluation consists of a desk audit using a standardized tool in conjunction with the Benefits Utilization System (BUS) to audit client files and assure that all components of the CMA contract have been performed according to necessary waiver requirements. The BUS is an electronic record used by each CMA to maintain client specific data. Data includes: client referrals, screening, Level of Care (LOC) assessments, individualized service plans, case notes, reassessment documentation and all other case management activities. Additionally, the BUS is used to track and evaluate timelines for assessments, reassessments and 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 accuracy of documentation and track appropriateness of services based upon the LOC determination. Additionally, the sample is used to evaluate compliance with the aforementioned case management functions.

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	☑	☑	☑

Function	Medicaid Agency	Contracted Entity	Local Non-State Entity
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 State's quality improvement strategy, provide information in the following fields to detail the State's 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:
Number and percent of CMAs that performed delegated functions as identified in the Administrative Tool. Numerator = Number of CMAs that performed delegated functions as identified in the Administrative Tool Denominator = Total number of CMAs serving waiver participants

Data Source (Select one):
Other
If 'Other' is selected, specify:
Administrative 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:	☑ **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:
Number and percent of data reports as specified in the Interagency Agreement (IA) between CDPHE and the Department that were submitted on time and in the correct format. Numerator =Number of data reports, as specified in the IA, that were submitted on time and in the correct format. Denominator =Number of data reports specified in the IA.

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

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Performance Measure:

 # and % of CMAs in a representative sample determined to have met all contractual obligations by desk review and/or on-site monitoring visits by the Department during the performance period, based on a four-year cycle. Numerator = # of CMAs in a sample determined to have met all provider obligations. Denominator = # of CMAs reviewed during the performance period, based on a 4-year cycle

Data Source (Select one):
Operating agency performance monitoring
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**

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: On-site monitoring occurs annually, CMA's are visited on a four year cycle.

Performance Measure:
Number and percentage of quarterly meetings convened to ensure that CHCBS Waiver providers & agencies with delegated functions work in collaboration & coordination with one another to serve participants on the CHCBS Waiver. Numerator = Number of quarterly meetings held for which agendas and minutes are available Denominator = 4 expected number of meetings per year

Data Source (Select one):
Other
If 'Other' is selected, specify:
Meeting notes and agendas

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

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The Department uses the information gathered from annual Case Management Agencies' evaluation as a primary method for discovery. The administrative tool used to evaluate Case Management Agency operative functions provides for reportable data to be used in Department discovery as a data source.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's 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.
The Department contracts with the Department of Public Health and Environment to manage aspects of provider licensure requirements, qualifications, survey, and complaints/critical incidents; and with Case Management Agencies to perform operational services, case management, utilization review, and prior authorization. Delegated responsibilities of these contracted entities is monitored, corrected and remediated by the Department's Long Term Services and Supports Division.

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

If issues or problems are identified during the course of a Case Management Agency audit, the Department Monitors will communicate findings directly with the Case Management Agency administrator, as well as document findings within the agency's annual report of audit findings, and where needed, require corrective action. If issues or problems arise at any other time during the non-certification period, the Department will work with the responsible parties (case manager, case management supervisor, Case Management Agency Administrator) to ensure appropriate remediation has occurred.

The Department will maintain administrative authority over the CHCBS waiver program in its contract with sister agencies. The Department will have access and will review all required documentation and communications regarding this authority.

The Department will monitor the reports generated by its Fiscal Agent. The Long Term Services and Supports Division will review and coordinate with the Program Integrity section to track and trend payment (claims) reviews.

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

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

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

◉ **No**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☑ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☑	Medically Fragile	0	17	☐
	☐	Technology Dependent			☐
☐ Intellectual Disability or Developmental Disability, or Both					
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Intellectual Disability			☐
☐ Mental Illness					
	☐	Mental Illness			
	☐	Serious Emotional Disturbance			

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

Determination of a disability which would require long term care at a skilled nursing facility or an acute hospital level of care or put the child at risk of institutionalization, through the use of the Uniform Long Term Care Assessment form (ULTC-100.2). A disability determination will be conducted prior to approval to the CHCBS waiver to assure that the federal SSI definition of disability is met.

c. **Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

- ○ **Not applicable. There is no maximum age limit**
- ◉ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

  Specify the percentage:

- **Other**

  Specify:

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

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

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

- **The following dollar amount:**

  Specify dollar amount:

  The dollar amount *(select one)*

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

    Specify the formula:

  - **May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**
- **The following percentage that is less than 100% of the institutional average:**

  Specify percent:

- **Other:**

  Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

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

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	1522
Year 2	1522
Year 3	1522
Year 4	1522
Year 5	1522

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	1308
Year 2	1308
Year 3	1308
Year 4	1308
Year 5	1308

Appendix B: Participant Access and Eligibility

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

e. **Allocation of Waiver Capacity.**

Select one:

- ◉ **Waiver capacity is allocated/managed on a statewide basis.**
- ○ **Waiver capacity is allocated to local/regional non-state entities.**

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

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

Children from birth up to their 18 birthday, whose disability meets the established minimum criteria for a skilled nursing facility or an acute hospital level of care and have been determined to meet the SSI definition of disability but have been denied SSI due to the child's parents and/or legal guardian income being over the SSI income limit criteria.

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)**
- [x] **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 spenddown 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 five-year period beginning January 1, 2014, 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 December 31, 2018.*

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

Select one:

○ **SSI standard**

- **Optional State supplement standard**
- **Medically needy income standard**
- **The special income level for institutionalized persons**

(*select one*):

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

Specify the percentage:

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

Specify dollar amount:

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

Specify percentage:

- **Other standard included under the State Plan**

Specify:

- **The following dollar amount**

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

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

Specify:

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

- **Other**

Specify:

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

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

Specify:

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

- **SSI standard**
- **Optional State supplement standard**
- **Medically needy income standard**
- **The following dollar amount:**

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

The amount is determined using the following formula:

Specify:

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

Not Applicable (see instructions)

AFDC need standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

Other

Specify:

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

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

Select one:

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

The State does not establish reasonable limits.

The State establishes the following reasonable limits

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

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

  Specify percentage:

- ○ **The following dollar amount:**

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

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

  Specify formula:

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

- ○ **Other**

  Specify:

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

Select one:

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

Explanation of difference:

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

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

Select one:

- (selected) **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 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 (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-5-a 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 that you do not need to complete this section and therefore this section is not visible.

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):

   - (selected) **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**
   - (selected) **By an entity under contract with the Medicaid agency.**

   Specify the entity:

   Case Management Agencies that have provider agreements with the state.

   - ( ) **Other**

   Specify:

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

   At Minimum, Case Management Agency employees that perform level of care evaluations are required to have a bachelor's degree in a human behavioral sciences field such as human services, nursing, social work or psychology. The majority of case managers have a bachelor's of sociology or psychology. Some case managers have a master's of social work.

   In addition to the educational requirements, the case manager is required to demonstrate competency in all of the following areas:
   • Knowledge of and ability to relate to populations served by the CMA;
   • Client interviewing and assessment skills;
   • Knowledge of the policies and procedures regarding public assistance programs;
   • Ability to develop care plans and service agreements;
   • Knowledge of long term care community resources; and

• Negotiation, intervention, and interpersonal communication skills.

The CMA supervisor(s) must meet all qualifications for case managers and have a minimum of two years of experience in the field of long term care services and supports.

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 a comprehensive assessment utilizing the Uniform Long Term Care (ULTC) 100.2 assesment. The ULTC 100.2 includes a functional assessment and Professional Medical Information Page (PMIP). The functional assessment measures 6 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. The case manager sends the PMIP to the child's medical professional for completion. The medical professional verifies the child's need for institutional level of care.

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

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

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

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

A child is referred to the Case Management Agency (CMA)for an Home and Community Bases Services eligibility assessment. The CMA screens the referrals to determine if an assessment is appropriate.

Should the CMA determine that an assessment is not appropriate; the CMA provides information and referral to other agencies as needed. The child's parents or legal guardian are informed of the right to request an assessment if the they disagree with the CMA's determination.

Should the CMA determine that an assessment is appropriate, the CMA:
• Verifies the applicant's current financial eligibility status,
• Refers the applicant to the county department of social services of the child's county of residence for application, or
• Provides the applicant with financial eligibility application form(s) for submission, with required attachments, to the county department of social services for the county in which the child resides, and document follow-up on return of forms.
The determination of the applicant's financial eligibility is completed by the county department of social services for the county in which the applicant resides.

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

Case managers are required to complete a reassessment of the child within twelve months of the initial client

assessment or the previous Continued Stay Review (CSR) assessment. A reassessment may be completed sooner if the child's condition changes or if required by program criteria, i.e., the child's condition improves and the waiver is no longer needed or the child's condition deteriorates and more services are needed to keep the child in the home.

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

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

  Specify the other schedule:

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

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

  Specify the qualifications:

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

Case Management Agencies (CMAs) are required to maintain a tracking system to assure that re-evaluations are completed on a timely basis. The Department monitors CMA's annually to ensure compliance through record reviews and reports electronically generated by the Benefits Utilization System (BUS). The BUS contains electronic client records and the timeframes for evaluation and re-evaluation. All CMA'a are required to use the BUS. The annual program evaluation includes review of a random sample to ensure assessments are being completed correctly and timely.

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

Case Management Agencies (CMAs) are required to keep documentation electronically in the Benefits Utilization System (BUS). The BUS database is located at the Department and the documentation is accessible electronically to monitoring staff and program administrators. CMAs are monitored annually for compliance with appropriate record maintenance.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's 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:
Number and percent of new waiver enrollees with a level of care assessment indicating a need for institutional care prior to receipt of services. Numerator = Number of new waiver enrollees who received an Level of Care assessment indicating a need for institutional level of care prior to the receipt of waiver services Denominator = Total number of new waiver enrollees.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Benefits Utilization System (BUS) 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 =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

Performance Measures

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

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

Performance Measure:
Number and percentage of new waiver participants assessed with the ULTC assessment tool prior to receiving waiver services. Numerator = Number of wavier participants assessed with the ULTC assessment tool prior to receiving waiver services Denominator = Total number of new waiver participants certified to receive waiver services

Data Source (Select one):
Other
If 'Other' is selected, specify:
Benefits Utilization System (BUS) Data/Super Aggregate Report/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 =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
 # and % of participants in a rep. sample for whom a Professional Medical Information Page was completed according to Department regulation for initial determinations. Numerator = # of participants in the sample for whom an initial PMIP was completed as required. Denominator = Total # of initial determinations in the sample certified to receive waiver services.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Benefits Utilization System (BUS) 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% 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:
Number and percent of cases in a representative sample in which the ULTC assessment tool was applied appropriately for the initial assessment. Numerator = Number of cases in a represetnative sample in which the ULTC assessment tool was applied appropriately for the initial assessment. Denominator = Total number of clients reviewed in the sample

Data Source (Select one):
Other
If 'Other' is selected, specify:
Business Utilization System (BUS) 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% 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:

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 uses information gathered by the CMA annual program evaluations as the primary method for discovery. The Program Review Tool is used to evaluate a statistically valid sample of waiver applicants and recipients. The sample evaluates level of care determinations and service planning. It provides reportable data to use to identify waiver program trends.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's 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.
Department contract managers and program administrators remediate problems as they arise based on the severity of the problem or by nature of the compliance issues in addition to annual data collection and analysis.

The Department delegates responsibility to CMAs to perform waiver operative functions including case management, utilization review and prior authorization.

Issues or problems identified during annual program evaluations will be directed to the CMA administrator or director and reported in the individual agency's annual report of findings. In some cases, a plan of correction may be required. Technical assistance may be provided to the CMA case managers, supervisors or administrators for other issues or problems that arise at any other time of the year. A confidential report will be documented in the client case file where appropriate.

If complaints are raised by the client about the service planning process, case manager, or other CMA functions; case managers are required to document the complaint on the CMA complaint log and assist the client to resolve the complaint. This complaint log comes to the Department on a semi-annual basis. The Department is then able to review the log and note trends to discern if a certain case manager or agency is receiving an increase in complaints.

In addition to being available to the client as needed, case managers contact clients quarterly and inquire about the quality of services clients are receiving. If on-going or system wide issues are identified by a CMA, the CMA administrator will bring the issue to the Department's attention for resolution. The client may also contact the case manager's supervisor or the Department if they do not feel comfortable contacting the case manager directly. The contact information for the case manager's supervisor, the CMA administrator, and the Department is included on the copy of the service plan that is provided to the client. The client also has the option of lodging an anonymous complaint to case manager, CMA, or the Department.

ii. **Remediation Data Aggregation**

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

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

c. **Timelines**

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

a. **Procedures.**Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver

services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The child's parents and/or legal guardian are informed of any feasible alternatives under the waiver and given choice of either institutional or home and community based services during the initial assessment and service planning process, and at time of reassessment.

Case managers identify the child's needs and supports through completion of a functional assessment using the ULTC 100.2 and through the service planning process with the client and/or legal representative. Based on this assessment and discussion with the child's parents and/or legal guardian, a long term service plan is developed.

Case managers complete a long term service plan that is reviewed with the child's parents and/or legal guardian. The case manager also provides the child's parents and/or legal guardian with a choice of providers as well as choice of whether these services will be provided in the community or in a skilled nursing facility or an acute hospital.

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

Both written and electronically retrievable facsimiles of freedom of choice documentation are maintained at the Case Management Agency and in the Benefits Utilization system (BUS) at the Departments.

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):
Case Management Agencies employ several methods to assure meaningful access to waiver services by Limited English Proficiency persons. The Case Management Agencies employ Spanish and other language speaking case management staff to provide translation to clients. Documents include a written statement in Spanish instructing clients how to obtain assistance with translation. Documents are orally translated for child's parents and/or legal guardian who speak other languages by the appropriate language translator. For languages where there are no staff who can translate on site, translation occurs by offering the client the choice 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	Case Management		
Other Service	In Home Support Services		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service:
Case Management
Alternate Service Title (if any):

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope)*:
Case management service is assistance provided by a Case Management Agency on behalf of an eligible child, which includes referral of needed Medicaid services and supports, including In Home Support Services (IHSS), that enable the child to remain in his/her community based setting.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Case Management services must be provided at least monthly.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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	Private Case Management Agency
Agency	Single Entry Point Agency
Agency	Community Centered Board

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Agency

Provider Type:
Private Case Management Agency
Provider Qualifications
License *(specify):*

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

Verification of Provider Qualifications
Entity Responsible for Verification:
The Department of Health Care Policy and Financing
Frequency of Verification:
Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:
Agency

Provider Type:
Single Entry Point Agency
Provider Qualifications
License *(specify):*

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

Verification of Provider Qualifications
Entity Responsible for Verification:
The Department of Health Care Policy and Financing
Frequency of Verification:
Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:
Agency
Provider Type:
Community Centered Board
Provider Qualifications
License *(specify)*:

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

Case management agencies operated by Community Centered Boards shall also meet the General Provisions set forth in the Community Centered Boards Section of the Department of Human Services, Developmental Disabilities Services, Rules and Regulations, Chapter 2 (2 CCR 503-1).

Case management agencies operated by Community Centered Boards shall also meet all standards in the Case Management Services Section of the Department of Human Services, Developmental Disabilities Services, Rules and Regulations, Chapter 5 (2 CCR 503-1).D. Case management agencies are required to apply specifically for certification as a Children's HCBS Waiver Program provider and have a Provider Agreement with the State.
Other Standard *(specify)*:

Verification of Provider Qualifications
Entity Responsible for Verification:
The Department of Health Care Policy and Financing
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
In Home Support Services

HCBS Taxonomy:

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

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

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

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

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

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

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

An IHSS Plan means a written and signed plan between the child's parent and/or legal guardian and the IHSS agency. The Plan shall include a detailed listing of the amount, scope and duration of the health maintenance service provided to the child and who will be responsible for providing the service.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
IHSS services are offered in this waiver and are limited based on the clients assessed need for services and prior authorization by case managers, IHSS will be limited to children who can be determined that they will be served safely in the home. The child's parents and/or legal guardian may not provide more than 40 hours of In Home Support Services in a seven-day period.

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

For a child with an unstable medical condition, the physician's statement shall include a recommendation regarding whether additional in-home monitoring is necessary and if so, the amount and scope of the in-home monitoring and that the child is served safely in their home.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency

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

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Home Health Agency
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:
Certified to provide IHSS. Certification as a Medicaid provider of In Home Support Services. 10 C.C.R. 2505-10, 8.552.7
Other Standard *(specify)*:

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

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

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Personal Care Agency
Provider Qualifications
License *(specify)*:

Certificate *(specify):*
Certified to provide IHSS. Certification as a Medicaid provider of In Home Support Services. 10 C.C.R. 2505-10,8.552.7
Other Standard *(specify):*

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

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

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
In Home Support Services Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Certified as an IHSS agency. Certification as a Medicaid provider of In Home Support Services. 10 C.C.R. 2505-10,8.552.7
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Public Health and Environment, Health Facilities and Emergency Section Division.
Frequency of Verification:
IHSS providers are surveyed on a 9 to 36 month risk based survey cycle. Providers that have deficiencies in areas of staff training/ supervision, or client care are surveyed every 9-15 months according to the number and severity of the deficiencies. Providers that have administrative deficiencies due to errors in paperwork are surveyed every 15 to 24 months. Providers that have no deficiencies are surveyed every 24 to 36 months. In addition, if DPHE receives a complaint involving client care, the findings of the investigation may be grounds for DPHE to initiate a full survey of the provider agency regardless of the date of their last survey.

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.*

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

CHCBS Case Management agencies are providers responsible for the case management services, the agencies that provide this service are the Single Entry Point (SEP) Agencies, Community Centered Boards (CCB) and Private Case Management Agencies.

Appendix C: Participant Services

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

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

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

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

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

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

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

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

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

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

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

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

Appendix C: Participant Services

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

c. **Services in Facilities Subject to §1616(e) of the Social Security Act.** *Select one:*

- (●) **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- ( ) **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

Appendix C: Participant Services

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

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

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

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

care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.

The child's parents and/or legal guardian may be paid to furnish health maintenance activities through In Home Support Services so long as the care is determined to be extraordinary. Extraordinary care is determined by assessing whether a child who is the same age without a disability needs the requested level of care, the activity is one that a parent would not normally provide as part of a normal household routine and the activity is one that a parent is not legally responsible to provide.

The child's parents and/or legal guardian may not provide more than 40 hours of In Home Support Services (IHSS) in a seven day period. A parent and/or guardian of who is the child's authorized representative may not be reimbursed for the provision of IHSS.

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

- ○ **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- ◉ **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

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

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

  Family members may be employed by an In Home Support Services (IHSS) agency to provide Health Maintenance Activities to the child under CHCBS waiver subject to the conditions below:

  1. The family member employed by the IHSS agency may provide up to 40 hours of IHSS in a seven day period.

  2. The family member who is an individual's authorized representative may not be reimbursed for the provision of IHSS.
- ○ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

  Specify the controls that are employed to ensure that payments are made only for services rendered.

- ○ **Other policy.**

  Specify:

f. **Open Enrollment of Providers.**Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

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

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

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

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

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's 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:
Number and percent of waiver providers enrolled within the performance period, by type, that have the required license or certification prior to serving waiver participants. Numerator = Number of newly enrolled waiver providers, by type, that have the required license or certification prior to serving waiver participants Denominator = Total number of newly enrolled waiver providers, by type

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

Performance Measure:
 # and % of waiver providers that continue to be licensed or certified at time of regularly scheduled or periodic recertification survey Numerator = # of licensed/certified waiver providers who had no deficiencies or made the required correction to deficiencies as a identified in their survey within the prescribed timelines Denominator = Total # of licensed/certified waiver providers surveyed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
CDPHE Reports/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 Source (Select one):
Other
If 'Other' is selected, specify:
Provider database

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:
Number and percent of non-licensed/non-surveyed waiver providers enrolled during the performance period, by type, that meet the initial waiver provider qualifications Numerator = Number of newly enrolled non-licensed/non-surveyed waiver providers that meet the initial waiver provider qualifications Denominator = Total number of newly enrolled non-licensed/non-surveyed 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):*

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:
Number and percent of non-licensed/non-surveyed waiver providers, by type, that continually meet waiver provider qualifications Numerator = Number of non-licensed/non-surveyed waiver providers that continually meet waiver provider qualifications Denominator = Total number of enrolled non-licensed/non-surveyed waiver providers

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:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

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

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

Performance Measure:
Number and percentage of HCBS providers surveyed in the performance period, by type, trained in accordance with Department regulations Numerator = Number of HCBS providers surveyed in the performance period, trained in accordance with Department regulations Denominator = Total number of HCBS providers surveyed in the performance period that require training by Department regulations

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:	☑ **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 contracts with the Department of Public Health and Environment (DPHE) to manage provider licensure requirements, qualifications, survey, and complaints/critical incidents. DPHE surveys providers interested in providing Home and Community Services that are required by Medical Assistance Program regulations to be surveyed prior to certification. Providers who have obtained a satisfactory survey are referred to the Department for certification as a Medicaid provider. Each certified provider who is required by Medical Assistance Program regulations to be surveyed is re-surveyed according to the DPHE schedule to ensure ongoing compliance.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's 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.
Providers who are not in compliance with DPHE 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 DPHE. Providers that are unable to correct deficient practices are recommended for termination by DPHE and are terminated by the Department. When required or deemed appropriate, DPHE 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 DPHE are assessed for immediate jeopardy or life threatening situations and are investigated in accordance with applicable federal requirements and time frames.

Currently, the Department relies on two methods for discovering individual problems with providers that are not surveyed by DPHE. First, case managers are required to assist clients in coordination and monitoring of care. Included in coordination and monitoring is the expectation that case managers will assist clients to remediate/fix problems with providers if they occur. Clients are provided with this information during the initial and annual service planning process using the "Client Roles and Responsibilities" and the Case Mangers' "Roles and Responsibilities" form.

In addition to being available to the client as needed, case managers contact clients quarterly and inquire about the quality of services clients are receiving. If an issue is reported the case manager assists the client in resolving it. This may include changing providers or assisting the client in resolving the issue with the provider. If on-going or system-wide issues are identified by a Case Management Agency, the agency administrator will bring the issue to the Department's attention for resolution.

The second method the Department uses to remediate/fix problem with providers that are not surveyed by DPHE is an informal complaint/grievance process that includes direct contact with clients. Clients, family members and/or advocates who have concerns or complaints about providers may contact the Department directly. If the Department receives a complaint, the program administrator or HCBS provider manager investigates the complaint and remediates the issue.

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

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

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

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

◉ **No**

○ **Yes**
Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. **Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

○ **Not applicable**- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

◉ **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☑ **Other Type of Limit.** The State employs another type of limit.
Describe the limit and furnish the information specified above.

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

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

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

Services are most often provided in the child's private residence. Services may be provided in the community. Clients and families have a choice on where they would like to receive services. All service settings in this waiver meet the HCB Settings requirements. The Department will ensure the settings remain compliant with ongoing case management and provider monitoring.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:
Case Management Agencies Service plan

a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*
   - ☐ **Registered nurse, licensed to practice in the State**
   - ☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**
   - ☐ **Licensed physician (M.D. or D.O)**
   - ☑ **Case Manager** (qualifications specified in Appendix C-1/C-3)
   - ☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
     Specify qualifications:

☐ **Social Worker**

Specify qualifications:

☐ **Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

◉ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

When scheduling to meet with the child's parents and/or legal guardian the case manager makes reasonable attempts to schedule the meeting at a time convenient for the child, the child's parents and/or legal guardian to complete a comprehensive assessment of the child's needs. The child's parents and/or legal guardian have the authority to select and invite individuals of their choice to actively participate in the assessment process. The child's parents and/or legal guardian provide the case manager with information about the child's needs, preferences, and goals. In addition, the case manager obtains diagnostic and health status information from the child's medical provider, and determines the child's functional capacity using the Uniform Long Term Care (ULTC 100.2) assessment tool. The case manager also determines if services provided by a caregiver living in the home are beyond the workload of a normal family/household routine. The case manager works with the child's parents and/or legal guardian to identify risk factors and addresses risk factors with appropriate parties.

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

The child's parents and/or legal guardian may contact the case manager for on-going case management such as assistance in coordinating services, conflict resolution or crisis intervention, as needed.

The case manager reviews the ULTC 100.2 form and service plan with the child's parents and/or legal guardian every six months. The review is conducted over the telephone or at the child's place of residence, place of service or other appropriate setting as determined by the child's needs. This review includes obtaining information concerning the child's parents and/or legal guardian satisfaction with the services provided, informal assessment of changes in child's function, service effectiveness, service appropriateness, and service cost effectiveness. If complaints are raised by the child's parents and/or legal guardian the case manager will document the complaint on the Case Management Agencies complaint log and assist the child's parent and/or guardian to resolve the complaint.

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

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

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

The client may also contact the case manager's supervisor or the Department if they do not feel comfortable

contacting the case manager directly. The contact information for the case manager, case manager's supervisor, the CMA administrator, and the Department is included on the copy of the service plan that is provided to the client. The client also has the option of lodging an anonymous complaint to case manager, CMA, or the Department.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

The service provider is informed of the potential risks of providing services to the child's prior to services beginning by obtaining a copy of the service plan.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. **Informed Choice of Providers.**Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

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

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

In an effort to better monitor case management agencies (CMA), compliance with this requirement the Department has developed a client survey/questionnaire that is administered to clients as specified in the Quality Improvement Strategy. The survey identifies client satisfaction with waiver services, case management services, Medicaid and other medical services, etc. The survey also inquires whether clients were provided choices, including but not limited to: a choice in waiver services, LTC service delivery (HCBS or NF/hospital),
participation in service planning, etc. Clients are also asked if they have received a list of client rights and responsibilities, complaint procedures, critical incident reporting guidelines and contingency options.

Survey results are analyzed, tracked and trended each year according to program area and CMA.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. **Process for Making Service Plan Subject to the Approval of the Medicaid Agency.**Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

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

The service plans must include the client's assessed needs; goals; specific services; amount, duration, and frequency of services; documentation of choice between waiver services and institutional care; and documentation of choice of providers. CMA monitoring by the Department includes a statistical sample of service plan reviews. During the review, service plans and prior authorizations are compared with the documented level of care for appropriateness and adequacy. A targeted review of service plan documentation and authorization review is part of the overall administrative and programmatic evaluation by the Department.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Specify the other schedule:

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

- ☐ **Medicaid agency**
- ☐ **Operating agency**
- ☑ **Case manager**
- ☑ **Other**

Specify:

The service plan is also available electronically on the BUS and can viewed by the child's Case Management Agency and the Department.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

Case Management Agencies are responsible for service plan development, implementation, and monitoring. Case managers are required to meet the child's parents and/or legal guardian (and anyone else the child's parents and/or legal guardian chooses) annually, face to face, in the child's parents and/or legal guardian home for service plan development. Once the service plan is implemented case managers are required to contact the child's parents and/or legal guardian(at minimum by phone) quarterly to ensure the service plan continues to meet the child's needs. Case managers are also required to contact the child's parents and/or legal guardian when significant changes occur in the child's physical or mental condition.

Participant's exercise of free choice of providers:

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

The child's parents and/or legal guardian are provided with this information during the initial and annual service planning process using the "Client Roles and Responsibilities" and the Case Mangers "Roles and Responsibilities" form. The form provides information to the child's parents and/or legal guardian about the following, but not limited to, case management responsibilities:
• Assists with coordination of needed services.
• Communicate with the service providers and regarding service delivery and concerns
• Review and revise services, as necessary
• Notifying clients regarding a change in services

The form also states that child's parents and/or legal guardian are responsible for notifying their case manager of any changes in the child's care needs and/or problems with services. If a case, manger is notified about an issue that requires prompt follow up and/or remediation the case manger is required to assist the child's parents and/or legal guardian. Case managers document the issue and the follow- up in the Benefits Utilization System (BUS).

In an effort to better monitor CMA compliance with this requirement the Department has developed a client survey/questionnaire that is administered to clients as specified in the Quality Improvement Strategy (QIS). Freedom of choice will be included in the client/parent or legal guardian surveys that will be administered annually. The surveys will identify client satisfaction with waiver services, case management services, Medicaid and other medical services, etc. The survey will also inquire whether clients were provided choices, including but not limited to: a choice in waiver services, LTC service delivery (HCBS or Institutionalization), qualified providers, participation in service planning, etc. The child's parents and/or legal guardian will also be asked whether they received a list of client rights and responsibilities, complaint procedures, critical incident reporting guidelines and contingency options. Survey results will be analyzed, tracked and trended each year and appropriate improvements will be implemented.

CMAs are obligated to conduct annual internal programmatic reviews. As specified in the QIS, the Department will require the CMA to conduct their 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. The Department requires that each CMA complete a specified number of client reviews as determined by the sampling methodology detailed in the QIS.

Evidentiary information supporting the CMAs internal programmatic reviews is submitted to the Department. Department staff then reviews a portion of each CMA's internal programmatic reviews using the sampling methodology described in the QIS. The Department staff compare information submitted by the CMA to BUS documentation and Prior Authorization Request (PAR) submissions, client signature pages including but not limited to; intake; service planning; release of information or HIPAA; and the Professional Medical Information Page (PMIP). If the Department discovers error outside the allowable margin, the agency may be subject to a full audit.

In addition, the Department audits each CMA for administrative functions including: qualifications of the individuals performing the assessment and service planning, process regarding evaluation of need, service planning, 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 on-going review of sample cases to reconcile services rendered compared to costs. Cases under review are those referred through various sources such as the Department staff, DPHE and child's parents and/or legal guardian complaints. The policies and procedures Program Integrity employs in this review are available from the Department.

Cost are also monitored by the Department staff reviewing the 372 reports and expenditures.

b. Monitoring Safeguards. *Select one:*

- (●) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's 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:
 # and % of waiver participants in a representative sample whose Service Plans (SPs) address the needs identified in the ULTC assessment, through waiver and other non-waiver services. Numerator= # of participants in the sample whose SPs address the needs identified in the ULTC assessment, through waiver and other non- waiver services. Denominator= Total # of waiver participants in the sample.

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% 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:
Number and percent of waiver participants in a representative sample whose SP adequately address the waiver participant's desired goals as identified in the Personal Goals. Numerator= Number of waiver participants in the sample whose SPs address the waiver participant's personal goals. Denominator=Total number of waiver participants in the sample.

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% 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:

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

Performance Measure:
Number and percent of waiver participants in a representative sample whose SPs address identified health and safety risks through a contingency plan. Numerator=number of waiver participants in the sample who's SPs address health and safety risks through a contingency plan. Denominator=total number of waiver participants in the sample.

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

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:

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 participant's 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:
Number and percent of waiver participants in a representative sample whose SPs were revised, as needed, to address changing needs. Numerator = Number of waiver participants in the sample whose SPs were revised, as needed, to address changing needs. Denominator = Total number of waiver participants in the sample who needed a revision to their SP to address changing needs.

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% 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**

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

Performance Measure:
Number and percent of waiver participants in a representative sample with a prior Service Plan that was updated with one year Numerator = Number of waiver participants in the sample with a prior SP and whose SP start date is within one year of the prior SP start date Denominator = Total number of waiver participants in the sample with a prior SP

Data Source (Select one):
Other
If 'Other' is selected, specify:
Benefits Utilization System (BUS) 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% 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:

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:
Number and percent of waiver services, by type, in a representative sample of waiver participants which were delivered in accordance with the service plan. Numerator = Number of waiver services, by type, in the smaple where the paid claims equal those services authorized by the service plan. Denominator = Total number of waiver services, by type, in the sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS Data/Benefits Utilization System (BUS) 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% 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:

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and 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:
Number and percent of waiver participants in a representative sample whose SPs document a choice between/among HCBS waiver services and qualified waiver service providers. Numerator = Number of waiver participants in the sample whos SPs document these choices Denominator = Total number of waiver participants in the sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Benefits Utilization System (BUS) 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% 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):*

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:
 # and % of waiver participants in a representative sample who are provided a fact sheet with general information about HCBS and specific information about the range of services, types of providers, and contact information. Numerator= # of waiver participants in the smaple whose Service Plans indicate a fact sheet was provided. Denominator= Total # of waiver participants in the sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Benefits Utilization System (BUS) 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% 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:

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 uses information from the annual Program Review Tool and data pulled from the Benefit Utilization System as the two primary methods for discovery during the annual program evaluation. These two sources are compiled into the Super Aggregate Report, which is used to evaluate a statistically valid sample of waiver applicants and recipients. The sample evaluates level of care determinations and service planning, providing reportable data to use in Department discovery for specific waiver program trends.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's 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.
Department contract managers and program administrators remediate problems as they arise based on the severity of the problem or by nature of the compliance issues in addition to annual data collection and analysis.

The Department delegates responsibility to CMAs to perform waiver operative functions including case management, utilization review and prior authorization.

Issues or problems identified during annual program evaluations will be directed to the CMA administrator or director and reported in the individual agency's annual report of findings. In some cases, a plan of correction may be required. 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.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

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

◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

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

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

○ **Yes. The State requests that this waiver be considered for Independence Plus designation.**

◉ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

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

The child's parents and/or legal guardian who are interested in IHSS are required to completed Physician Statement and Authorized Representative forms. IHSS agencies who are willing and able to provide the support necessary for clients to participate must document this choice on the Physician's Statement. The child's parents and/or legal guardian works with the case manager who determines the level of care the child requires through the completion of a ULTC 100.2 and the development of the service plan. The case manager completes the PAR and then provides the child's parents and/or legal guardian with a list of certified IHSS agencies.

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

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

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. **Participant Direction Opportunities.** Specify the participant direction opportunities that are available in the waiver. *Select one*:

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

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

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

☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

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

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

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

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

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

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

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

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

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

☑ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

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

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

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

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

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

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

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

☐ **Governmental entities**

☐ **Private entities**

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

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

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

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

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

The Case Management Agency is responsible for providing information on the participant directed options IHSS to the child's parents and/or legal guardian during the initial assessment and service planning process and at the time of reassessment. The case manager will provide an informational packet including service description, eligibility criteria, and required paperwork to new and current child's parents and/or legal guardian.
A child's parent and/or legal guardian interested in participating in In Home Support Services(IHSS)are required to return the paperwork to the case management agency. The case manager will review the paper work for proper completion. The case manager will then provide to the child's parent and/or legal guardian a list of certified IHSS agencies from which to choose. The child's parent and/or legal guardian will submit his/her child's IHSS plan to the case manager for approval prior to beginning.

The child's parent and/or legal guardian interested in participating in IHSS must obtain a statement from his or her primary care physician indicating that the parent has sound judgment and the ability to direct the child's care or has an authorized representative who is able to direct the child's care on his or her behalf or the child has an IHSS agency that is able and willing to support the client as necessary to participate in IHSS.

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

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

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Case Management	☑
In Home Support Services	☑

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

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

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

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

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one)*.

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

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

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

Participation in IHSS is voluntary. A child's parents and/or legal guardian may choose to withdraw at anytime. If a child's parents and/or legal guardian choose to withdraw, he/she must contact the child's case manager who will assist the child's parents and/or legal guardians in transitioning to equivalent care in the community. A child's parents and/or legal guardian may choose to return to the child’s previous Medicaid funded attendant care program, as long as the child remains eligible for that program or a child's parents and/or legal guardians may choose to withdraw from IHSS.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

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

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	74	
Year 2	78	
Year 3	83	
Year 4	88	
Year 5	93	

Appendix E: Participant Direction of Services

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

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

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

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

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

The IHSS agency acts as the legal employer of participant-select attendants while delegating authority to the child's parents and/or legal guardian for referring, recruiting, discharging staff from providing services and scheduling of his or her attendants.

☐ **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:

- [x] **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.**
- [x] **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- [ ] **Determine staff wages and benefits subject to State limits**
- [x] **Schedule staff**
- [x] **Orient and instruct staff in duties**
- [x] **Supervise staff**
- [ ] **Evaluate staff performance**
- [x] **Verify time worked by staff and approve time sheets**
- [x] **Discharge staff (common law employer)**
- [ ] **Discharge staff from providing services (co-employer)**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

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

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

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

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

- [ ] **Reallocate funds among services included in the budget**
- [ ] **Determine the amount paid for services within the State's established limits**
- [ ] **Substitute service providers**
- [ ] **Schedule the provision of services**
- [ ] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [ ] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [ ] **Identify service providers and refer for provider enrollment**
- [ ] **Authorize payment for waiver goods and services**
- [ ] **Review and approve provider invoices for services rendered**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

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

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

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

The Case Management Agency notifies the child's parents and/or legal guardian when a denial of eligibility for the waiver occurs or services under the waiver are denied or reduced. Notice of client appeal rights is mailed using the Department approved Notice of Action form number 803 and/or prior authorization request (PAR) for services denial letter is generated by the Benefits Utilization System (BUS) and includes the appeal rights and instructions on how to file an appeal. The case management agency is required to provide information regarding the right to request a fair hearing to the child's parents and/or legal guardian or authorized representative when they apply for publicly funded programs as set forth in 10 C.C.R. 2505-10, Section 8.393.15 and 8.393.28 et seq.

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

Appeal rights are also included on the Long Term Care Plan Information form. The case manager reviews this form with the child's parent and/or legal guardian time of initial assessment and reassessment. A copy of this form is provided to the child's parent and/or legal guardian. During the annual on-site monitoring of the case management agencies by the Department monitors a random sample of client records will be reviewed. Included in the record review will be an examination of the Notice of Action form number 803 to ensure that each case management agency is using the approved form to convey information to the child's parents and/or legal guardian or authorized representative on fair hearing rights. Client appeal rights are maintained on a Notice of Action (803) form in the BUS. Case managers are instructed to send a Notice of Action whenever there is a change or reduction in services or when a client has been denied HCBS services due to functional or financial ineligibility.

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

Clients who are denied CHCBS services due to ineligibility are provided with appeal rights and referred to alternative community resources including: home health, and other state plan benefits, if applicable. The annual Administrative Review conducted by the Department requires case management agencies to report their methods for community referrals.

Every Medicaid action that is appealed with the OAC is reviewed by the Department. When the child's parents and/or legal guardian appeals a decision, the OAC notifies the Department of the appeal hearing and a case manager participates in the

hearing. Following the hearing, the administrative law judge issues an Initial Decision and sends it to the Office of Appeals (OA). The OA distributes the Initial Decision to all parties, including the Department, to review. All parties then have an opportunity to file exceptions to the administrative law judge's Initial Decision if they disagree with it. The OA is responsible for reviewing all of the documents presented at the hearing, as well as subsequent filings of exceptions to ensure that the Initial Decision complies with the Departments regulations. The OA then issues a Final Agency Decision, affirming, reversing, or remanding the administrative law judge's decision.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

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

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

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

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

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

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

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

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

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

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

If complaints are raised by the child's parents or legal guardian about the service planning process, case manager, or other CMA functions; case managers are required to document the complaint on the CMA complaint log and assist the client to resolve the complaint. This complaint log comes to the Department on a quarterly basis. The Department is then able to review the log and note trends to discern if a certain case manager or agency is receiving an increase in complaints.

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

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

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

The Department of Public Health and Environment, Health Facilities and Emergency Services Division (DPHE) maintain a Home Health Hotline. This hotline is set up for complaints about care providers, fraud, abuse, and misuse of personal property. DPHE evaluates the complaint and initiates an investigation. Most investigations will be initiated within three (3) days of DPHE receiving a complaint or for complaints considered to be a severe risk to the client's health and welfare an investigation is initiated within twenty four (24) hours after the complaint is received. Investigations may lead to targeted surveys or full surveys of the agency involved. Investigation surveys may result in deficient practice citations for agencies, which are reported to the Department and require that a plan of correction be submitted to DPHE within specified timelines. Immediate jeopardy situations require actions to correct the situation at the time of survey. A second critical incident line is maintained by DPHE for such issues as unexpected death or disability, abuse, neglect, and misuse of personal property for voluntary reporting by licensed agencies. 25-1-124 CRS, 2005 and 23-3-109 (1), (3),(7),(8) CRS, 2005. 42 CFR Chapter IV, Section 484.10(f).

The case management agency is responsible to inform the parents and/or legal guardian at the initial assessment and again at the CSR. In addition, case management agencies maintain a log system for complaints and grievances and either resolve the problem themselves or refer to the appropriate oversight agency.

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

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

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

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

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

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

Critical incidents are those incidents involving abuse, neglect, or exploitation, unexpected death or disability and, misuse of personal property. Critical incidents are required to be reported by all agencies, providers and contracted entities in the state, which include licensed home health care agencies, personal care agencies and homemaker agencies, and Case Management Agencies and Department staff. Oversight of portions of the State's critical incident reporting system is provided by the Department of Public Health and Environment (DPHE).

Critical incidents that involved alleged child abuse, neglect or exploitation are to be reported immediately(as soon as incident is reported or discovered)to the county department of human services, child protective unit in the county that the child resides and/or to the local law enforcement agency. Case managers are required to document any report made to a protective services unit in the Benefits Ulitization System (BUS)log notes with in 24 hours of the report and are required to provide and document follow up with in three days.

During annual on-site monitoring the Departments SEP reviewers examine log notes and complaint logs to ensure that issues discovered by the case manager are provided with follow up.Case managers report critical incidents to Department staff using the Critical Incident Reporting System (CIRS) accessible through the BUS. Additionally, case managers make phone calls to the children's protective services to report critical incidents.

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

The Department's interagency agreement with DPHE requires that the agency responds to and remediates quality of care complaints for services provided by Medicaid certified home health agencies.

The Department has developed an informational tool that is available to the child's parents and/or legal guardian at http://www.cdphe.state.co.us/hf/homecarecolorado.htm that will provide them with the results of the investigations. The Department provided all case management agencies with this informational tool. In addition, the Department will provide a link to the Departments website.

Case Managers Agencies are responsible for follow up with appropriate individuals and/or agencies in the event any issues or complaints have been presented by the client or others as set forth in 10 CCR 2505-10, Section 8.393.2. The child's parent and/or legal guardian are informed at time of initial assessment and reassessment to notify the case manager if there are changes in their care needs and/or problems with services.

The Department requires Case management agencies to send quarterly reports identifying referrals made to the Child Protective Services and complaints filed by the child's parent and/or legal guardian. These reports will identify the date and nature of the complaint received, action taken to resolve the issue or complaint, and nature of the resolution.

The Department reviews and tracks the on-going referrals and complaints to ensure that a resolution is reached and the client's health and safety has been maintained.

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.

A child's parents and/or legal guardian are informed of the case management agencies complaint policy and the availability of the Home Health Hotline, an 800 telephone number, by the case manager. Home health agencies are required to provide to the child's parents and/or legal guardian the Home Health Hotline number. Additionally, home health agencies are required to maintain an internal complaint log system under the Clients Rights condition of participation. The Department defines "Immediately", as an incident that has been discovered, reported or suspected and requires the case manager is to act on it right away.

The Colorado Department of Public Health and Environment (DPHE) reviews the complaint log during its annual surveys. Case management agencies are required to report to the county departments, Child Protective Services by phone as soon as a critical incident has been reported, suspected or discovered by the case manager.

The Department has developed an informational tool that is available to the child's parents and/or legal guardian at http://www.cdphe.state.co.us/hf/homecarecolorado.htm that provides them with the results of the investigations. The Department provided all case management agencies with this informational tool. In addition, the Department has a link to the tool.

Information regarding what qualifies as a critical events is included in the service plan and the child's parents and/or guardian will be required to sign the service plan. The case manager is required to inform the parent before they sign it, what is considered a critical event and how to report it. To ensure that this information has been given to the child's parents and/or guardian it is one of the questions on the yearly survey that is sent to the families.

The IHSS agency is responsible for providing the child's parents and/or legal guardian with information and referral services; independent living skills training; and individual and systems advocacy. This requirement includes informing the child's parents and/or legal guardian about the process for reporting abuse, neglect, and exploitation. A child's parents and/or legal guardian can notify the IHSS agency and/or the appropriate authority if the child has experienced abuse, neglect, or exploitation.

The Department has developed policies and procedures for the Critical Incident Reporting System. Similar resources are also available to clients and case managers about emergency backup and safety and prevention strategies. This information will include a list of client rights, how to file a complaint outside the case management agencies system, information describing the Critical Incident Reporting System, and time frames for starting the investigation, the completion of the investigation or informing the client/complainant of the results of the investigation. A child's parents and/or legal guardian will be encouraged to report critical incidents to their provider(s), case manager, Child Protective Services and/or any other client advocate. The information packet includes what types of incidents to report and to whom the incident should be reported.

Case managers must indicate 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 service plan and are provided a copy of the completed document. In 2011, a new service plan was created to ensure that the case manager discusses issues of abuse, neglect, and exploitation with the client. The Department uses its case management system, the Benefits Utilization System (BUS), 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 abuse, neglect, and exploitation.

Resource materials are available through the case manager and the Department's website. The information packet developed by the Department will be distributed by case managers to clients and/or client representatives at the initial and annual assessments. This information includes a list of client rights, how to file a complaint outside the CMA system, information describing the Critical Incident Reporting System, and time frames for starting the investigation, the completion of the investigation or informing the client/complainant of the results of the investigation.

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.

Oversight is provided by the Department of Health Care Policy and Financing (HCPF)and the Department of Public Health and Environment (DPHE). Critical incidents are those incidents involving abuse, neglect, or exploitation, unexpected death or disability and, misuse of personal property. Critical incidents are required to be reported by

licensed home health care agencies, personal care agencies, Case management agencies, and Department staff. The response to a critical incident is unique to the type of incident as well as whom the incident involved. However, the Department reviews all critical incidents. Below is a list of possible incidents, as well as who is responsible for follow up.
• Incidents involving surveyed providers(In Home Support Services)must be reported to the Department and DPHE and are responded to by DPHE
• Incidents involving non-surveyed providers (Case management agencies)must be reported to the Department and are responded to by the Department
• Incidents involving abuse, neglect, or exploitation shall be reported to the County Department of Social Services and are responded to by the county.
• All other incidents are responded to by the Department.

A Home Health Hotline is maintained by DPHE, Health Facilities and Emergency Services Division. This hotline is set up for complaints about quality of care, fraud, abuse, and misuse of personal property. DPHE evaluates the complaint and initiates an investigation. The investigation begins within twenty-four hours or up to three days depending upon the nature of the complaint and risk to the client's health and welfare. Investigation results of the critical incidents reported to DPHE are posted for public view on DPHE's web site at: http://www.cdphe.state.co.us/hf/homecarecolorado.htm

The reports provide the Department with information about the type of compliant or occurrence, the source of the complaint or occurrence, when the complaint or occurrence will be investigated, and the investigation findings. From these reports, Department staff can trend critical incidence or request to see a copy of individual complaint or occurrence reports from DPHE. DPHE will inform the department of their findings at the meeting conducted with DPHE monthly.

Parents and/or legal guardian who choose to participate in IHSS will receive training prior to their beginning the program about the management of critical incidents and events. The training will include information about recognizing and preventing potential abuse, exploitation, and, neglect. Parents and/or legal guardian of a child receiving IHSS will receive training about how to safely fire an attendant who they believe has subjected their child or them to abuse, neglect, and/or exploitation. Parents and/or legal guardian of a child receiving IHSS will also be encouraged to contact the proper authorities if they have been subjected to abuse, neglect, or exploitation by an attendant. Critical events and incidents that are reported to IHSS agencies follow the same procedures as all agencies surveyed or licensed by CDPHE.

Investigations may lead to targeted surveys or full surveys of the agency involved. Investigation surveys may result in deficient practice citations for agencies, which are reported to the Department. Deficiencies are categorized as isolated (1-49% of clients surveyed), patterned (50-99% of clients surveyed), widespread (100% of those surveyed) and/or immediate jeopardy/life threatening (100% of those surveyed). Depending upon the risk to the health and safety of clients, the deficiency will require at minimum that a plan of correction be submitted to CDPHE within specified timelines. If an agency has major deficiencies, the provider may lose their Medicaid certification.

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

CMAs must maintain a log system for complaints and grievances. Issues must be resolved internally or referred to the appropriate oversight agency as required by 25-1-124 and 23-3-109 (1), (3), (7), (8) CRS 2005, 200. 42 CFR Chapter IV, Section 484.10(f).

The Department does not currently have a formal process informing the complainant of the results of the investigation. However, the Department has recently initiated new process for the Departmental review of critical incidents and has improved the functionality of the Critical Incident Reporting System (CIRS) within the BUS.

The Department's CIRS administrator receives the final results of the investigation and a summary of the follow up conducted. The CIRS administrator reviews this information to ensure that the incident was adequately addressed and advises the case manager of any additional follow up required. The CIRS administrator will now require that the complaint is informed of the results of the investigation by a specified date when possible. The CIRS administrator tracks follow ups by due dates to ensure that they occur.

If the investigation involves the case manager or CMA, the CIRS administrator will convey the results of the

investigation to the Parents and/or legal guardian.

The information packet developed by the Department is provided to each client during his/her initial intake and annual Continued Stay Review (CSR). This information includes a list of client rights, how to file a complaint, information describing the Critical Incident Reporting System and time frames for starting the investigation, the completion of the investigation or informing the client/complainant of the results of the investigation. Clients will be encouraged to report critical incidents to their provider(s), case manager and/or any other client advocate. The information packet includes what types of incidents to report and to whom the incident should be reported.

State laws, regulations and policies referenced in the description are available through the operating or Medicaid office.

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.

The Department currently receives all Critical Incident occurrences for CHCBS participants, and monthly complaint reports from the Department of Public Health and Environment (DPHE) for licensed facilities and receives monthly complaint reports from DPHE for surveyed agencies (i.e. in home support services). The reports provide the Department with information about the type of compliant or occurrence, the source of the complaint or occurrence, when the complaint or occurrence will be investigated, and the investigation findings. From these reports, Department staff can trend critical incidences or request to see a copy of individual complaint or occurrence reports from DPHE.

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

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

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. **Use of Restraints.***(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

◉ **The State does not permit or prohibits the use of restraints**

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

The CHCBS waiver does not permit restraints or seclusion. If a Case Management Agency is made aware of it will be reported to the Department program administrator and to the Child's Protection Unit at the county department of Human Services.

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

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

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

Appendix G: Participant Safeguards

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

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

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

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

The CHCBS waiver does not permit restraints or seclusions. If a Case Management Agency is made aware of it will be reported to the Department program administrator and to the Child's Protection Unit at the county department of Human Services.

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

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

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

Appendix G: Participant Safeguards

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

c. **Use of Seclusion.***(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The State does not permit or prohibits the use of seclusion**

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

The CHCBS waiver does not permit restraints or seclusions. If a Case Management Agency is made aware of it will be reported to the Department program administrator and to the Child's Protection Unit at the county department of Human Services.

The use of seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-c -i and G-2-c-ii.

i. **Safeguards Concerning the Use of Seclusion.**Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. **Applicability.** Select one:

No. This Appendix is not applicable *(do not complete the remaining items)*

Yes. This Appendix applies *(complete the remaining items)*

b. **Medication Management and Follow-Up**

i. **Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Attendants that provide health maintenance activities through In Home Support Services (IHSS) may administer medications to the client. IHSS are excluded from portions of the nurse practice act, but attendants must be provided training and oversight by the parent, legal guardian or authorized representative.

When the child is initially and annually assessed for the waiver the case manager is required to review the child's medication regimen and enter the information into the Benefits Utilization System (BUS). In addition case managers are required to send the child's physician the Professional Medical Information Page (PMIP) annually. The physician is required to include information about the child's current medications on the PMIP.

When the case manager visits the child's parents and/or legal guardian in their home, they review and compare the medications listed on the PMIP with the medications the child has in the home. If a discrepancy is found, the case manger inquires further to identify any harmful practices.

Parents and/or legal guardian choosing IHSS for their child may choose to oversee their child's medication regimens or may choose to have an authorized representative oversee the regimen on their behalf. However, IHSS Agencies must either contract with or have on staff a Health Professional, who shall have monitoring responsibilities, defined as oversight of training of Attendants, verification of adequate skills and competence of Attendants to perform IHSS, and assessment of consumer safety. The Health Professional is responsible for counseling staff on difficult cases, and potentially dangerous situations. He/she must be available to consult with the client and/or the authorized representative or the attendant in the event a medical issue

arises, and shall investigate complaints and critical incidents.

DPHE monitors IHSS agencies according to the information provided in Appendix C of the waiver application to ensure IHSS agencies are complying with the above requirements.

ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

The Department requires that the attendant providing health maintenance through In Home Support Services (IHSS), have a licensed medical professional on staff to oversee the training requirements for attendants. The Department of Public Health and Environment (DPHE) surveys IHSS providers annually to ensure that medications are managed appropriately. If a harmful practice is, identified (DPHE) will cite the errors on the survey and require a plan of correction. If the IHSS agency continues to have medication errors DPHE can refer the compliance issues to the Department to revoke Medicaid certification.

If a case manger identifies a medication error during their monitoring of the client's medication regimen the case manager may report it as either a critical incident (if the error meets the level of a critical incident) or they may note the error and the follow up in their log notes. All critical incidents are reported to the Department and a sample of all log notes are reviewed by the Department annually. In addition, since the monitoring efforts vary depending upon the services the client is receiving the means by which the Department is informed of the findings also varies. Monitoring efforts of client medication regimens for clients receiving services from an IHSS agency or Home Health agency are reported to the Department by monthly and annual reports of DPHE survey findings.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. **Medication Administration by Waiver Providers**

i. **Provider Administration of Medications.***Select one:*

- ○ **Not applicable.***(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.***(complete the remaining items)*

ii. **State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Attendants that provide health maintenance activities through In Home Support Services (IHSS) may administer medications to the client. Attendants are excluded from portions of the nurse practice act, but must be provided training and oversight by the authorized representative.

iii. **Medication Error Reporting.***Select one of the following:*

- ◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
  Complete the following three items:

  (a) Specify State agency (or agencies) to which errors are reported:

  Medication errors are currently required to be reported to the Department of Public Health and Environment for clients receiving services from IHSS or Home Health agency are monitored by

DPHE. DPHE compiles the deficiencies and provides the Department with monthly and annual reports of DPHE survey findings.

If a harmful practice is identified (DPHE) will cite the errors on the survey and require a plan of correction and it is to be reported to the Department.

(b) Specify the types of medication errors that providers are required to *record:*

Incorrect doses and medication given client.
1. wrong time
2. wrong medication
3. wrong dose

(c) Specify the types of medication errors that providers must *report* to the State:

Incorrect doses and medication given client.
1. wrong time
2. wrong medication
3. wrong dose

Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.

Specify the types of medication errors that providers are required to record:

iv. **State Oversight Responsibility.**Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The Department requires that attendant providing health maintenance through IHSS, have a licensed medical professional on staff to oversee the training requirements for attendants. The Department of Public Health and Environment (DPHE) surveys IHSS providers annually to ensure that medications are managed appropriately. If a harmful practice is, identified (DPHE) will cite the errors on the survey and require a plan of correction. If the IHSS agency continues to have medication errors DPHE can refer the compliance issues to the Department to revoke Medicaid certification.

If a case manger identifies a medication error during their monitoring of the client's medication regimen the case manager may either report it as a critical incident (if the error meets the level of a critical incident) or they may note the error and the follow up in their log notes. All critical incidents are reported to the Department and a sample of all log notes are reviewed by the Department annually. In addition, since the monitoring efforts vary depending upon the services the client is receiving the means by which the Department is informed of the findings also varies. Monitoring efforts of client medication regimens for clients receiving services from an IHSS agency are reported to the Department by monthly and annual reports of DPHE survey findings.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's 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:
 # and % of waiver participants (and/or family or legal guardian) in a rep. sample who received information on how to report abuse, neglect, exploitation (A.N.E.) and other critical incidents. Numerator = # of waiver participants in the sample documented to have received information on how to report A.N.E. and other critical incidents Denominator = Total # of waiver participants in the sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Benefits Utilization System (BUS) 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% 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:
Number and percent of critical incidents including Abuse, Neglect, and Exploitation (A.N.E.) and unexplained death reviewed by the Department. Numerator = Number of A.N.E. and Death critical incidents reviewed by the Department. Denominator = Number of A.N.E. and Death Critical Incidents.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Benefits Utilization System (BUS) 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: Quarterly and ongoing	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

Performance Measure:
Number and percent of all critical incidents referred for investigation within the required timeframe. Numerator = Number of critical incidents referred for investigation within the required timeframe. Denominator = Number of critical incidents that required investigation.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Critical Incident Reports and Benefits Utilization System (BUS) 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**

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

Performance Measure:
Number and percent of abuse, neglect, or exploitation critical incidents that were reported by the Case Management Agency (CMA) within the required timeframe as specified in the approved waiver. Numerator = Number of abuse, neglect, or exploitation critical incidents reported by the CMA timely. Denominator = Total number of A.N.E. critical incidents

Data Source (Select one):
Other
If 'Other' is selected, specify:
Critical Incident Reports and Benefits Utilization System (BUS) 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:
Number and percent of annual reports provided to Case Management Agencies (CMAs) and providers on identified trends in critical incidents Numerator = Number of annual reports provided Denominator = 23 (total number of annual reports expected to be provided)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Critical Incident Reports and Benefits Utilization System (BUS) Data and/or CDPHE reports; Record Reviews

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

Performance Measure:
Number and percent of critical incidents involving restrictive interventions that followed the Department's policies and procedures Numerator = Number of critical incidents involing restrictive interventiosn that followed the Department's policies and procedures Denominator = Total number of critical incidents involving restrictive interventions

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

Critical Incident Reports and Benefits Utilization System (BUS) 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:

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

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.

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 uses information entered into the Critical Incident Reporting System (CIRS) by case managers as the primary method for discovery.

Annual review by the LTSS Division in collaboration with the quality improvement specialist is used to compare critical incident reporting trends with accuracy of documentation in case files reviewed.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's 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.
All information gathered in the CIRS is maintained in the client record and housed at the Department for review. In addition to annual data collection and analysis, Department contract managers and program administrators remediate problems as they arise based on the severity of the problem or by nature of the compliance issue. Issues or problems identified during annual program evaluations will be directed to the CMA administrator or director and reported in the individual agency's annual report of findings.

CMAs deficient in completing accurate and required critical incident reports will receive technical assistance and/or training by Department staff. CMAs will be required to provide training and education on the process for reporting abuse, neglect, or exploitation to any client whose record fails to document this requirement. In some cases, a plan of correction may be required.

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.

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**	☑ **Annually**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Specify:	
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: As needed by severity of incident or non-compliance.

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

- ◉ **No**
- ○ **Yes**
Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

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;

- 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 2)

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 Strategy encompasses all services provided under all waivers. The waiver specific requirements and assurances have been included in the appendices for each waiver.

Discovery and Remediation Information: The Department draws from multiple sources when determining the need for and methods to accomplish system design changes. Using data gathered from CDPHE and CIRS reports, annual programmatic and administrative evaluations, waiver participant survey data and stakeholder input, the Department's Long Term Services and Supports (LTSS) Division, in partnership with the Program and Performance Improvement section 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 Benefits Utilization System (BUS). Work groups form as necessary to discuss prioritization and selection of system design changes.

The Department uses standardized tools for critical incident reporting, service planning and Level Of Care assessments for its HCBS waiver populations. Through use of the BUS, data that are generated from assessments, service plans and critical incident reports and concomitant follow-up are electronically available to both CMAs and the Department, allowing for effective access and use for clinical and administrative functions as well as for system improvement activities. This standardization and electronic availability provide comparability across CMAs, waiver programs and allow for on-going analysis.

Trending: The Department will use waiver-specific performance measures to monitor program performance. There are no HCBS national performance measures to which the Department can compare results; therefore, the Department will use its performance results to establish baseline data and to trend and analyze over time. The Department's aggregation and analysis of data will be incorporated into annual reports which will provide information to identify aspects of the system which require action or attention.

The Department has consulted with the National Quality Enterprise (NQE) to develop sound statistical methodologies for review sampling. The goal is to review a statistically valid number of records from each waiver population so that, when aggregated, the number of reviews will also be statistically valid for the CMA reviews.

Prioritization: The Department relies on a variety of resources to prioritize changes in the BUS. In additional 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 Medicaid Management Information Systems (MMIS), the Department had 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.

Implementation: The Department continually works to enhance coordination with CDPHE. The Department will engage 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 will be reviewed and analyzed amongst program administrators and the HCBS quality oversight specialist. Results will also be shared with CMA representatives during quarterly CMA meetings. The Department will utilize these meetings to identify areas for opportunity and to implement additional improvement.

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.

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 based on baseline data once the baseline data has been collected.

Roles and Responsibilities: The LTSS Division and the Program and Performance Improvement section 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 recipients, advocates, CMAs, and other stakeholders.

Other state agencies, such as DHS, are responsible for developing and implementing a quality improvement program for its delegated waivers.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The LTSS Division HCBS quality oversight specialist 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 HOC members and 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 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).

The Department assures financial accountability for funds expended for home and community based services by maintaining documentation of the provider's eligibility to furnish specific waiver services which includes copies of the Medicaid Provider Agreement, copies of the Medicaid certification, verification of applicable State licenses, and any other documentation which demonstrates that the provider meets all standards established by the Department for the provision of services. Providers are required to maintain adequate time records to support claims for all services rendered. State regulations require a case record/medical record or file be developed and maintained for each client. Provider claims are submitted to the Medicaid Fiscal Agency for reimbursement. The Medicaid Management Information System (MMIS) is designed to meet federal certification requirements for claims processing.

Case Management Agencies establish parameters of audit trails relative to expenditure of funds specific to service costs and service units provided to clients. As stipulated in the Colorado State Plan, Title XIX of the Social Security Act (amended), State Regulations and contracts define and describe required financial records and their retention. Billing claims and payment warrant register records are maintained through the MMIS. Records are normally maintained by providers for a period of six years after the date of termination of contract. Records are maintained for an extended period beyond six years should it be deemed necessary to resolve any matter that might be pending. Records documenting the audit trail will be maintained by the Department and providers of waiver services for a minimum period of three years.

The Department has a Program Integrity (PI) Section that engages in post payment review of claims. The Department utilizes an Enterprise Surveillance Utilization Reporting System (ESURS) to create a peer group for each provider type and to identify all providers whose utilization is two standard deviations or more from the norm. Each month, these providers are referred to the Recovery Audit Contractor (RAC) or internal Program Integrity (PI) staff for a desk audit of provider records. The desk audits involve a review of prior authorized services, service plans, documentation created by the caregiver for each date of service billed, case management notes, supervisory visits, caregiver training, agency licensure and a review of complaint surveys. Documentation must substantiate claims for reimbursement and the number of units billed must match the time-in/time-out records for each visit. Generally, all desk audits start with an initial investigation of three years of claims data to ensure that services are documented prior to the submission of a claim and that those claims are equivalent to the services rendered. Should suspicious trends be identified, the audits may be expanded to include of up to six years of claims data and could result in referrals to law enforcement for further investigations. Any overpayments identified are recovered.

The PI Section initiates the suspension of Medicaid payments to any agency for which there is determined to be a credible allegation of fraud. Exceptions to the suspension of Medicaid payments may be granted for good cause as detailed in the Department's Standard Operating Procedures (SOP). Any indication of fraud is referred to the Medicaid Fraud Control Unit (MFCU). The MFCU has authority to hold individuals or entities accountable through criminal prosecution and/or civil litigation.

Additionally, a percentage of claims are chosen randomly through the MMIS and Explanation of Medicaid Benefits (EOMB) reports are sent to Medicaid clients on a monthly basis. Medicaid clients receiving EOMB reports are asked to confirm that the services were rendered by means of a response document enclosed. All returned EOMBs are forwarded to Program Integrity. Program Integrity reviews them and provides follow up when a discrepancy occurs between a provider claims and what the client reports. The Department may also send EOMB reports to an additional, targeted population when patterns of suspicious activity have been identified.

The Department's SOPs for case selection and recovery of overpayments are available on request.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. **Methods for Discovery: Financial Accountability**
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. *(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:
Number and percent of waiver claims paid according to the reimbursement methodology for the waiver. Numerator = Number of waiver claims in the sample paid according to the reimbursement methodology in the waiver. Denominator = Total number of paid waiver claims in the sample.

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

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

☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% 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:
Number and percent of clients in a representative sample whose units billed did not exceed procedure code limit. Numerator = Number of clients in a representative sample whose units billed did not exceed procedure code limit. Denominator = Total number of waiver clients in the sample with a PAR and billed claims for waiver services.

Data Source (Select one):
Other

If 'Other' is selected, specify:

MMIS Data and PAR 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% 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:

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

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:
Number and percent of waiver claims in a representative sample of participants paid at or below the rate as specified in the Provider Bulletin and Billing Manual Numerator = Number of waiver claims in the sample paid using the correct rate as specified in the Provider Bulletin and Billing Manual. Denominator = Total number of paid waiver claims in the sample.

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

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

	☐ **Continuously and 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:
Number and percent of waiver claims in a representative sample paid using the correct rate methodology as specified in the approved waiver application. Numerator = Number of waiver claims in the sample paid using the correct rate methodology as specified in the approved waiver application. Denominator = Total number of paid waiver claims in the sample.

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

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

		Confidence Interval = 95% 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:

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 CMA independent audit results and the post payment reviews administered by the Department's Program Integrity section are additional strategies employed by the Department to ensure the integrity of payments made for waiver services.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's 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.
LTSS 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 PI Section for investigation as detailed in Appendix I-1 of the application.

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: As needed based on severity of occurrence or compliance issue.

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

◉ **No**

○ **Yes**
Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. **Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The Children's Home and Community Based Service (CHCBS) waiver utilizes Fee-for-Service (FFS) rate methodologies. Each rate has a unit designation and reimbursement is equal to the rate multiplied by the number of units utilized. CHCBS FFS rate schedules are published through the Departments provider bulletin annually and posted to the Departments website.

The two Children's Home and Community Based Service (HCBS) waiver FFS rates were determined using a previous (historical) rate methodology for which documentation no longer exists. Once set, these rates were updated

annually to reflect legislative increases and decreases as approved by the Colorado Legislature and Governor. Although documentation is lacking, it is believed that the Department utilized data from the Bureau of Labor Statistics, similar services rates or rate methodologies, other information including Medicaid service rates in other states, and Medicare rates to set rates.

The CHCBS waiver has two rates set using the historic rate methodology, these services are listed below:
1. Case Management
2. In Home Support Services Health Maintenance

The Department hopes to transition all CHCBS FFS waiver rates listed above from the historic and undocumented rate methodology to the current rate methodology adopted in 2011. Beginning in 2011 the Department adopted a fee -for-service rate methodology that incorporates the following factors:

A. Indirect and Direct Care Requirements:
Salary expectations for direct and indirect care workers based on the Colorado mean wage for each position, direct and indirect care hours for each position, the full time equivalency required for the delivery of services to HCBS Medicaid clients, and necessary staffing ratios. Wages are determined by the Bureau of Labor Statistics and are updated by the Bureau every two years. Communication with stakeholders, providers, and clients aids in the determination of direct and indirect care hours required and the full time equivalent of each position. Finally, collaboration with policy staff ensures the salaried positions, wage, and hours required conform to the program or service design.

B. Facility Expense Expectations:
Incorporates the facility type through the use of existing facility type property records listing square footage and actual cost. Facility expenses also include estimated repair and maintenance costs, and utility expenses, and phone and internet expenses. Repair and maintenance price per square foot are determined by industry standards and vary for facilities that are leased and facilities that are owned. Utility pricing includes gas and electricity which are determined annually through the Public Utility Commission who provides summer and winter rates and therm conversions for appropriated pricing. Finally, internet and phone services are determined through the use of the Build Your Own Bundle tool available through the Comcast Business Class website.

C. Administrative Expense Expectations:
Identifies computer, software, office supply costs, and the total number of employees to determine administrative and operating costs per employee.

D. Capital Overhead Expense Expectations:
Identifies and incorporates additional capital expenses such as medical equipment, supplies, and IT equipment directly related to providing the service to Medicaid clients. Capital Overhead Expenses are rarely utilized for HCBS services, but may include items such as massage tables for massage therapy, or supplies for art and play therapy.

All Facility, Administrative, and Capital Overhead expenses are reduced to per employee cost and multiplied by the total FTE required to provide services per Medicaid client.

Following the development of the rate stakeholder feedback is solicited and appropriate and necessary changes may be made to the rate.

At this time no CHCBS waiver rates have utilized the new FFS rate methodology described above.

Rates for the CHCBS waiver are reviewed for appropriateness every five years with the waiver renewal.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

All billing claims flow directly from providers to the MMIS.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures*(select one)*:

- (●) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

All waiver services included in the child’s service plan are prior authorized by the case management agencies and forwarded to the fiscal agent for PAR data entry in the Medicaid Management Information System(MMIS). The MMIS system validates authorization for services when claims are filed. The first edit in the MMIS system when a claim is filed ensures that the waiver child is eligible for Medicaid.

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 into the MMIS system regularly to ensure updated verification of eligibility for dates of service claimed. The claim is a statement by the provider that the services were rendered. The audit process and post payment review processes review claims for accuracy. Case managers contact the child's parents and/or legal guardian monthly and the service providers monthly to ensure that services are being provided according to the service plan. Should a discrepancy between a providers claim and what the child's parents and/or legal guardian reports occur, or should the child's parents and/or legal guardian report that the provider is not providing services according to the service plan, the case manager reports the information to the Departments Program Integrity Section for investigation. If the providers child's records do not match the claims filed a payment recovery occurs.

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.**
- [x] **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- [ ] **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

  Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. **Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- ◉ **No. The State does not make supplemental or enhanced payments for waiver services.**
- ○ **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. **Payments to State or Local Government Providers.***Specify whether State or local government providers receive payment for the provision of waiver services.*

- ○ **No. State or local government providers do not receive payment for waiver services.**Do not complete Item I-3-e.
- ◉ **Yes. State or local government providers receive payment for waiver services.**Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

Select County Departments of Public Health provide In Home Health Services(IHSS)for waiver clients. The amount of the payment to public providers does not differ from the amount paid to private providers of the same service.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. **Amount of Payment to State or Local Government Providers.**

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

- (●) **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- (●) **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ( ) **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- (●) **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- ( ) **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- (●) **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- ( ) **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.*Select one:*

- (●) **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.**

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*:

- [x] **Appropriation of State Tax Revenues to the State Medicaid agency**
- [ ] **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I -2-c:

- [ ] **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. **Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

- (●) **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
- ( ) **Applicable**

Check each that applies:

- [ ] **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

- [ ] **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. **Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- (●) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**

Check each that applies:

- [ ] **Health care-related taxes or fees**
- [ ] **Provider-related donations**
- [ ] **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. **Services Furnished in Residential Settings.***Select one:*

- (●) **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- ( ) **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.**The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:
Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.*Select one:*

- (●) **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ( ) **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C -3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- (●) **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ( ) **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. **Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] **Nominal deductible**
- [ ] **Coinsurance**
- [ ] **Co-Payment**
- [ ] **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Hospital, Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	6046.97	31163.00	37209.97	177578.00	34841.00	212419.00	175209.03
2	9773.52	31478.00	41251.52	182106.00	35242.00	217348.00	176096.48
3	15850.10	31796.00	47646.10	186750.00	35647.00	222397.00	174750.90
4	24407.69	32117.00	56524.69	191512.00	36057.00	227569.00	171044.31
5	31886.12	32442.00	64328.12	196396.00	36472.00	232868.00	168539.88

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:	Level of Care:
		Hospital	Nursing Facility
Year 1	1522	731	791
Year 2	1522	731	791
Year 3	1522	731	791
Year 4	1522	731	791
Year 5	1522	731	791

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.

Total sum of waiver covered days divided by total point in time waiver recipients.

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 for these estimates is as follows:

For each individual service the Department estimated the number clients utilizing each service, the number of units per user, the average cost per unit and the total cost of the service. To estimate these factors 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 clients utiliziling each service, the number of units per user and the average cost per unit. These numbers were then multiplied together to calculate the total expenditure for each service and added to derive Factor D.

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 Children's Home and Community Based waiver clients, the Department analyzed historical D' values. D' has been steadily decreasing overtime, this is exected to continue. The Department chose the average growth FY 2008-09 to FY 2011-12.

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 nursing facility and hospital level of care costs, the Department examined utilization and average per user nursing facility and inpatient hospital costs. The Department trended expenditure per client using the average growth from FY 2009-10 to FY 2011-12.

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 nursing facility and inpatient hospital clients, the Department reviewed 5 years of historical data and chose 1.68% which was the average growth in per capita costs from FY 2008-09 to FY 2011-12.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services	
Case Management	
In Home Support Services	

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
Case Management Total:						**1100452.20**
Case Management	15 minutes	1220	107.00	8.43	**1100452.20**	
In Home Support Services Total:						**8103040.47**
Health Maintenance Activities.	15 minutes	189	6047.00	7.09	**8103040.47**	
				GRAND TOTAL:		**9203492.67**
				Total Estimated Unduplicated Participants:		**1522**
				Factor D (Divide total by number of participants):		**6046.97**
				Average Length of Stay on the Waiver:		324

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
Case Management Total:						**1138708.80**
Case Management	15 minutes	1226	108.00	8.60	**1138708.80**	
In Home Support Services Total:						**13736587.89**
Health Maintenance Activities.	15 minutes	277	6859.00	7.23	**13736587.89**	
				GRAND TOTAL:		**14875296.69**
				Total Estimated Unduplicated Participants:		**1522**
				Factor D (Divide total by number of participants):		**9773.52**
				Average Length of Stay on the Waiver:		324

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
Case Management Total:						**1160248.32**
Case Management	15 minutes	1232	109.00	8.64	**1160248.32**	
In Home Support Services Total:						**22963603.60**
Health Maintenance Activities.	15 minutes	406	7780.00	7.27	**22963603.60**	
				GRAND TOTAL:		**24123851.92**
				Total Estimated Unduplicated Participants:		**1522**
				Factor D (Divide total by number of participants):		**15850.10**
				Average Length of Stay on the Waiver:		324

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
Case Management Total:						**1176595.20**
Case Management	15 minutes	1238	110.00	8.64	**1176595.20**	
In Home Support Services Total:						**35971901.84**
Health Maintenance Activities.	15 minutes	596	8302.00	7.27	**35971901.84**	
				GRAND TOTAL:		**37148497.04**
				Total Estimated Unduplicated Participants:		**1522**
				Factor D (Divide total by number of participants):		**24407.69**
				Average Length of Stay on the Waiver:		324

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
Case Management Total:						**1193045.76**
Case Management	15 minutes	1244	111.00	8.64	**1193045.76**	
In Home Support Services Total:						**47337623.55**
Health Maintenance Activities.	15 minutes	735	8859.00	7.27	**47337623.55**	
				GRAND TOTAL:		**48530669.31**
				Total Estimated Unduplicated Participants:		**1522**
				Factor D (Divide total by number of participants):		**31886.12**
				Average Length of Stay on the Waiver:		324