

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 a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

All Quality 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. No other significant changes are being made to this renewal.

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):*

Colorado's Home and Community Based Services Waiver for children with Life Limiting Illness

C. Type of Request: renewal

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.0450

Draft ID: CO.014.02.00

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

Regular Waiver

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

07/01/15

1. Request Information (2 of 3)

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

Hospital

Select applicable level of care

Hospital as defined in 42 CFR §440.10

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

Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160

Nursing Facility

Select applicable level of care

Nursing Facility as defined in 42 CFR §§440.40 and 42 CFR §§440.155

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

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

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

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

1. Request Information (3 of 3)

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

Select one:

Not applicable

Applicable

Check the applicable authority or authorities:

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

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

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

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

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

§1915(b)(2) (central broker)

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

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

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

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

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

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

A program authorized under §1115 of the Act.

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

The purpose of this waiver is to keep children with Life -Limiting Illnesses out of the hospital and in the home as much as possible. This is a Palliative Care waiver that allows children to begin receiving services early in their diagnosis and allows the family to continue to pursue curative treatments while receiving palliative care. It removes the requirement of a physician certification that death is expected within nine months. If curative treatments are provided along with palliative care, there can be an effective continuum of care throughout the life of the child. This waiver serves children from birth through 18 years of age who are Medicaid eligible and diagnosed with a life-limiting illness.

Children receiving services through the waiver can receive in-home Respite Care consisting of personal care, nursing or home health aide depending upon the condition of the child; Expressive Therapies such as creative art, music or play therapy; Palliative/Supportive Care such as pain and symptom management and care coordination; Massage therapy; Therapeutic Grief Support and Bereavement Services. Case management is an administrative function. Additionally, clients will have access to all Medicaid State Plan benefit services including Hospice and Home Health.

The Department oversees the administration of the waiver. County Departments of Human Services determine financial eligibility. Case Management Agencies (CMA) assess the level of care and target population criteria. The nurse at the Hospice or Home Health agency will be assessing the child for the medical care that each child may require based on the physician orders and shall provide medical care coordination.

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

No

Yes

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

Geographic Limitation. A waiver of statewide requirements 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 statewide requirements 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:

- As specified in Appendix C, adequate standards for all types of providers that provide services under this waiver;
- 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:
For the original development of the waiver, a committee was formed consisting of physicians, nurses, hospice managers, hospital staff, and parents of children with life-limiting disorders, case managers and ethicists from across the state. Between June 2005 and September 2005, four meetings were held to develop the parameters of the waiver through participant input. Participants were briefed on Medicaid rules, enabling legislation, current limitations on services and the goal of the waiver as well as the role of CMS, the State, and the committee in the waiver process. Cost neutrality was discussed as well as what services could be included in the waiver. Parents shared thoughts regarding end of life care for their children.

In addition to the committee, other stakeholders were solicited for input such as Colorado Medical Society,

therapists who work with children, individuals on the national level who are experts in end of life issues, and other case managers who were experienced in caring for children with life-limiting illnesses.

For this renewal the Department held a large stakeholder meeting which consisted of nurses, hospice managers, case managers, parents of children with a life limiting illness, providers, and many client and parent advocates. The group went through the entirety of the current waiver and made suggestions for minor clarifying changes. In addition to this group the Department presented the information to the Children's Disability Advisory Committee on December 10, 2014 and requested feedback. Information was also provided via email to over 500 stakeholders and posted on the Department's website on January 30, 2015. The information posted on the Department website included a summary of the renewal as well as a copy of the full waiver.

The Department conducted a tribal consultation on January 29, 2015. The Department consulted with the Night Medical Advisory Committee (MCAC) in February 2015.

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:

Hammer

First Name:

Gretchen

Title:

Medicaid Director

Agency:

Colorado Department of Health Care Policy and Financing

Address:

1570 Grant Street

Address 2:

City:

Denver

State:

Colorado

Zip:

80203-1818

Phone:

(303) 866-3058

Ext:

TTY

Fax:

E-mail:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State:

Colorado

Zip:

Phone:

Ext:

TTY

Fax:

E-mail:

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are *readily* available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

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:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Colorado**

Zip:

Phone: Ext: TTY

Fax:

E-mail:

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 CLLI waiver participants live in their family home. This waiver does not have active participants residing in group homes or 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 CLLI waiver does not have any institutional like community settings and therefore does not need to implement any changes or transitions.

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

(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 has three types of contractual arrangements that govern how contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency.

The arrangements are described below:

The first is an Interagency Agreement between the Department and the Department of Public Health and Environment (DPHE). This agreement allows DPHE to survey and investigate complaints against the following HCBS providers: Personal Care, Palliative/Supportive care, Respite Care, Therapeutic Life Limiting Illness Support and Expressive Therapies. Once a provider has been surveyed by DPHE, they are referred to the

Department to obtain Medicaid Certification.

The second type of contract governs the relationship between the Department and the Case Management Agencies (CMA). The Department contracts annually with twenty-three Single Entry Point (SEP) agencies serving 25 districts throughout Colorado. The SEP agencies are made up of County Departments of Human and Social Services, County Departments of Public Health, County Area Agencies on Aging or County and District Nursing Services and three private, non-profit entities.

Single Entry Point (SEP) Case Management Agencies (CMAs) are contracted with the Department to provide case management services for clients participating in Home and Community-Based Services. These services include HCBS waiver operational and administrative services, intake screening, case management, functional and disability determination, services planning, referral care coordination, utilization review, the prior authorization of waiver services within limits, and service monitoring, reporting and follow-up. Only the three private, non-profit SEPs are selected through a competitive procurement process.

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

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

Appendix A: Waiver Administration and Operation

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

- Not applicable**
- Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

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

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

The Department contracts with 20 non-state public agencies to act as Case Management Agencies to perform Home and Community Based waiver operational and administrative services, case management, utilization review, and prior authorization of waiver services.

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

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

The Department contracts with 3 non-governmental non-state agencies to act as Case Management Agencies to perform Home and Community Based waiver operational and administrative services, case management, utilization review, and prior authorization of waiver services. These 3 Case Management Agencies are selected through a competitive bid process.

Appendix A: Waiver Administration and Operation

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

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 DPHE through monthly meetings and reports. Issues that arise which impact the agreement, problems discovered at specific agencies or widespread issues and solutions are discussed. In addition, the Department is provided with monthly and annual reports detailing the number of agencies that have been surveyed, the number of agencies that have deficiencies, the number of complaints received, complaints investigated, and complaints that have been substantiated. By gathering this information, the Department is able to develop strategies to resolve issues that have been identified. Further information about the relationship between DPHE and the Department is provided in Appendix G of the waiver application.

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

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 Case Management agency contract have been performed according to necessary waiver requirements. The BUS is an electronic record used by each Case Management Agency 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.

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 each individual Case Management Agency 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. The CMAs check the service plan and contact the agency involved with providing Children with Life Limiting Illness (CLLI) services to assure that the client is receiving one waiver service a month in order to continue on the CLLI Waiver.

Should the Monitors find that a Case Management Agency is not in compliance with policy or regulations; the agency is required to take corrective action. Technical assistance is provided to the Case Management agencies via several methods including phone, e-mail and in person. The Department conducts follow-up monitoring to assure corrective action implementation and ongoing compliance. If a compliance issue extends to multiple Case Management agencies, the Department provides clarification through Dear Administrator Letters (DAL), formal training, or both.

The Fiscal agent is under contract with the Department to manage the MMIS, process claims, assist providers in the provider enrollment/application process, PAR data entry, maintain the call center and respond to provider questions and complaints, and produce reports. When situations arise about claims and or billing issues, the fiscal agent contract manager is informed and assists in resolving the issues. The program administrator is the contact person for all the CLLI providers to assist with the problems of claims and or billing.

Xerox Contractor performance is assessed continually by a variety of means. The MMIS Fiscal Agent contract outlines operational and administrative functions to be performed by the Fiscal Agent. Weekly face-to-face status

meetings are held to review weekly statistics for operational issues such as access times and system up times, number of claims received and processed, etc. to ensure proper work flow. The agenda of the weekly status meetings include issues of current concern. Separate meetings are scheduled to address larger specific issues and are not part of the weekly status meeting. Communications directing action or requesting resolution of issues by the Fiscal Agent from Department staff are put in a formalized communication transmittal form which is reviewed for quality assurance and approved by a designee within the Department, sent via the MMIS Fiscal Agent's transmittal system to the Fiscal Agent, and then is worked on and followed through until it is mutually agreed between the Department and the Fiscal Agent that the item has been addressed and the transmittal can be closed. Another means of enforcing performance standards is through Service Level Agreements (SLAs) which are built into the contract and other contract language that specify requirements, performance and due dates.

The Data Analysis section has created a spreadsheet of the HCBS waivers services that is located on the shared drive in the Department. The spreadsheet reflects those services for the waivers that have been paid through ACS. This spreadsheet is updated quarterly based on claims submission to ACS for payment for each waiver. The information can be easily accessed by the program administrator for each waiver.

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	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Level of care evaluation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Prior authorization of waiver services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 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

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>

	<input checked="" type="checkbox"/> Other Specify: Monitoring schedule to be determined (TBD)	
--	--	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

Performance Measure:

and % of CMAs in a representative sample determined to have met all contractual obligations by desk reviews and/or on-site monitoring by the Department during the performance period, based on a 4 year cycle. Numerator = # of CMAs in a sample determined to have met all contractual obligations Denominator = # of CMAs expected to be 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 <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% with a +/- 5% margin of error
<input type="checkbox"/> Other	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified

Specify: <input type="text"/>		Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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):

Operating agency performance monitoring

If 'Other' is selected, specify:

using the 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	

		<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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 23 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 HCBS-CLLI 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 <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: In addition to annual review of CMAs, continuous reviews with the DPHE and ACS the department will gather data whenever there is an occurrence or issue that requires immediate 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
<input type="checkbox"/> Aged or Disabled, or Both - General					
	<input type="checkbox"/>	Aged			<input type="checkbox"/>
	<input type="checkbox"/>	Disabled (Physical)			
	<input type="checkbox"/>	Disabled (Other)			
<input checked="" type="checkbox"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input type="checkbox"/>	Brain Injury			<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>
	<input checked="" type="checkbox"/>	Medically Fragile	0	18	<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent			<input type="checkbox"/>
<input type="checkbox"/> Intellectual Disability or Developmental Disability, or Both					
	<input type="checkbox"/>	Autism			<input type="checkbox"/>
	<input type="checkbox"/>	Developmental Disability			<input type="checkbox"/>
	<input type="checkbox"/>	Intellectual Disability			<input type="checkbox"/>
<input type="checkbox"/> Mental Illness					
	<input type="checkbox"/>	Mental Illness			
	<input type="checkbox"/>	Serious Emotional Disturbance			

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

Medicaid eligible children, through the age of 18 who have been diagnosed with a life-limiting illness and who are at risk of hospitalization within one month but for the availability of the waiver services. A life-limiting illness means a medical condition that, in the opinion of the medical specialist involved, has a prognosis of death that is highly probable before the child reaches adulthood. Conditions that are incurable, irreversible, and that usually result in death are considered as one criterion for eligibility for this waiver. Children will be entered into the program based on their date of eligibility until program capacity has been reached.

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:

Upon becoming eligible for the waiver clients, parents, guardians or legal representatives are advised that Children with Life Limiting waiver services shall end upon the child reaching 19 years of age. A child who reaches the age of 19 and remains categorically eligible for Medicaid will be eligible for State Plan services, which include traditional hospice care. If the client is eligible for another HCBS waiver and space is available, the client will be enrolled in the waiver. The Case Management Agencies (CMA) case manager shall re-assess the client during his/her 18th year and notify the client and/or parents, guardians or legal representatives of other Medicaid benefits for which there is eligibility, the possibility of waiting lists for specific waivers, and how the client and family may be linked to the next service package when the client turns 19 years of age.

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Specify the percentage:

- Other**

Specify:

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

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

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

- The following dollar amount:**

Specify dollar amount:

The dollar amount (*select one*)

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

Specify the formula:

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

Specify percent:

- Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

- The participant is referred to another waiver that can accommodate the individual's needs.**
- Additional services in excess of the individual cost limit may be authorized.**

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

- Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

- a. Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due

to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	200
Year 2	222
Year 3	246
Year 4	272
Year 5	301

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	200
Year 2	200
Year 3	200
Year 4	200
Year 5	200

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:

A child age 0 to 18 who is Medicaid eligible, has been diagnosed with a life-limiting illness, and meets the hospital level of care. A life-limiting illness means a medical condition that, in the opinion of the medical specialist involved, has a prognosis of death that is highly probable before the child reaches adulthood. Conditions that are incurable, irreversible, and that usually result in death are considered as one criterion for eligibility for this waiver. Entrance into the waiver is based on date of eligibility until the waiver has reached capacity. Waiver services are prior authorized by the Case Management Agencies (CMA) case managers utilizing a cost containment calculation to ensure cost neutrality based on the average aggregate cost of institutionalization.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

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

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

2. Miller Trust State.

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

- No
- Yes

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

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

- Low income families with children as provided in §1931 of the Act

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

Select one:

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

Specify percentage:

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

Specify:

Children under the age of nineteen who meet the eligibility criteria pursuant to section 1902(a)(10)(A) of the federal Social Security Act.

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. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

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

- The following standard included under the State plan

Select one:

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

(select one):

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

Specify the percentage:

- A dollar amount which is less than 300%.

Specify dollar amount:

- A percentage of the Federal poverty level

Specify percentage:

- Other standard included under the State Plan

Specify:

- The following dollar amount

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

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

Specify:

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

- Other

Specify:

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

- Not Applicable (see instructions)**
- 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).

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 (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):

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

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

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

- Directly by the Medicaid agency**
 By the operating agency specified in Appendix A
 By an entity under contract with the Medicaid agency.

Specify the entity:

The Case Management Agencies have contracts with the state to perform case management services including Level of Care (LOC) evaluations and reevaluations.

- 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.

The nurse at the hospice agency shall also collaborate with the CMAs for the medical component of the services the client may require in order for the client to be safely cared for in the home.

- 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 state approved Universal Long Term Care (ULTC) instrument. The ULTC 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 nurse at the hospice agency shall also collaborate with the CMAs for the medical component of the services the client may require in order for the client to be safely cared for in the home.

- 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 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.

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. The reassessment process is the same as the initial assessment.

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

- Every three months
- Every six months
- Every twelve months
- Other schedule

Specify the other schedule:

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

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

Specify the qualifications:

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

Case Management Agencies (CMAs) are required to maintain a tracking system to assure that re-evaluations are completed on a timely basis. The Department monitors CMAs annually to ensure compliance through record reviews and reports electronically generated by the Benefits Utilization System (BUS). The BUS contains electronic client records and the timeframes for evaluation and re-evaluation. All CMAs 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 are required to keep documentation retrievable electronically by utilizing the Benefits Utilization System (BUS). The BUS database is housed at the Department and the documentation is accessible electronically to monitoring staff and program administrators.

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =

<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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.

Performance Measure:

Number and percent of waiver participants in a representative sample who received an annual redetermination of eligibility within 12 months of their last LOC evaluation
Numerator = Number of participants in the sample who received a redetermination within 12 months of their last LOC evaluation
Denominator = Number of participants in the sample who received a redetermination

Data Source (Select one):

Other

If 'Other' is selected, specify:

Benefits Utilization System Data

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = Confidence Interval = 95% with a +/- 5% margin of error
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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:

and % of new waiver participants assessed with the ULTC assessment tool prior to receiving waiver services. Numerator= # of new waiver participants receiving waiver services that were assessed with the ULTC assessment tool prior to receiving waiver services Denominator=Total # of new waiver participants receiving waiver services

Data Source (Select one):

Other

If 'Other' is selected, specify:

BUS Data/Super Aggregate Report/MMIS Claims data

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval =

		Confidence Interval = 95% with a +/- 5% margin of error
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

and % of waiver participants in a representative sample for whom a PMIP was completed and signed by a licensed medical professional according to Department regulation for initial determinations
Numerator = # of waiver 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):

Record reviews, on-site

If 'Other' is selected, specify:

BUS Data/Super Aggregate Report

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Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = Confidence Interval = 95% with a +/- 5% margin of error
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>

Performance Measure:

Number and percent of initial determinations in which the life limiting attestation was appropriately checked and signed by the physician. Numerator = Number of initial determinations with the life limiting attestation appropriately checked and signed by the physician Denominator = Total number of initial determinations

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

State review of form

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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 representative sample in which the ULTC assessment tool was applied appropriately for the initial assessment. Denominator = Total number of clients reviewed in sample

Data Source (Select one):

Other

If 'Other' is selected, specify:

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = Confidence Interval = 95% with a +/- 5% margin of error
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
		<input type="checkbox"/> Other

	<input type="checkbox"/> Continuously and Ongoing	Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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 23 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: Case Management Agencies (CMA)	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: as warranted by nature of discovery and/or severity of incidence

c. Timelines

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

- No**
- Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

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

The child's parents and/or legal guardian or representative are informed of any feasible alternatives under the waiver and given choice of either institutional or home and community based services during the initial assessment and care planning process, and at time of reassessment. Case managers identify the child's needs and supports through completion of a functional assessment using the state approved ULTC instrument and through the care planning process with the client and/or legal representative. Based on this assessment and discussion with the child's parents and/or legal guardian or representative, a long term service plan is developed. Case managers complete a long term care service plan information and summary form that is reviewed with the child's parents and/or legal guardian or legal representative and provides the child's parents and/or legal guardian or representative with a choice of providers.

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

Both written and electronically retrievable facsimiles of freedom of choice documentation are maintained in the Case Management Agency (CMA) and in the Benefit Utilization System (BUS) at the Department.

Appendix B: Participant Access and Eligibility

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

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

Case Management Agencies (CMA) employ several methods to assure meaningful access to waiver services by Limited English Proficiency persons. The CMAs 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 parent(s) 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	Respite Care		
Other Service	Bereavement Counseling		
Other Service	Expressive Therapy		
Other Service	Massage Therapy		
Other Service	Palliative/Supportive Care services		
Other Service	Therapeutic Life Limiting Illness Support: Individual Counseling, Family Counseling, Group Counseling		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Respite Care

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Respite Care means services provided to an eligible client who is unable to care for himself/herself on a short term basis because of the absence or need for relief of those persons normally providing care. Respite Care under this waiver is provided in a private residence of the client'/family's choice, whether that be the client's home or the home of the caregiver, and may be provided by different levels of providers depending upon the needs of the client. Respite care may be provided in the community.

Respite Care may be provided by a skilled or unskilled provider. A skilled respite provider would be either a licensed RN/LPN or CNA. Skilled respite is for clients with ongoing medical needs that can only be provided by an RN/LPN or CNA (i.e. suctioning).

Unskilled respite is for clients that will not have any medical needs that will need to be attended to (such as a G-tube feeding). This includes the possibility of the need for skilled/medical intervention.

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

Respite Care may be provided for up to a maximum of 30 days per year.

Respite Care services and State Plan nursing, home health aide, or private duty nursing services shall not be provided at the same time. Respite Care does not diminish services a client is entitled to under Early Periodic Screening, Diagnosis and Treatment however; it will not duplicate those services.

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency
Agency	Hospice
Agency	Personal Care Provider

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite Care

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License (specify):

Department of Public Health and Environment, Health Facilities and Emergency Section Division is currently licensing all home health providers in the state of Colorado Medicare/Medicaid Certified. Certified as a Medicaid provider of home health State Plan benefits. 10 C.C.R. 2505-10, Section 8.520.

Certificate (specify):

All Skilled home health agencies in Colorado must be certified by Medicare prior to be certified by the Department of Health Care Policy and Financing Medicare/Medicaid Certified. Certified as a Medicaid provider of home health State Plan benefits. 10 C.C.R. 2505-10, Section 8.520.

Other Standard (specify):

Home Health Agencies may provide skilled or unskilled respite. All skilled providers employed by a home health agency must have the appropriate license or certification as required by the Department of Regulatory Agencies. Skilled providers must be a licensed RN/LPN or CNA.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Home Health Agency Department of Public Health and Environment, Health Facilities and Emergency Services Division. According to survey cycle mandated by the Centers for Medicare and Medicaid Services.

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite Care

Provider Category:

Agency

Provider Type:

Hospice

Provider Qualifications

License *(specify):*

Hospice agency must be a licensed Medicare/Medicaid hospice provider in Colorado.

Certificate *(specify):*

Medicare/Medicaid Certified as a Medicaid provider of Hospice services. 10 C.C.R. 2505-10, Section 8.550.

Other Standard *(specify):*

Hospice Agencies may provide skilled or unskilled respite. All skilled providers employed by a hospice agency must have the appropriate license or certification as required by the Department of Regulatory Agencies. Skilled providers must be a licensed RN/LPN or CNA.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Department of Public Health and Environment, Health Facilities and Emergency Services Division. According to survey cycle, at least every 6-8 years for Hospice agencies.

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite Care

Provider Category:

Agency

Provider Type:

Personal Care Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Medicaid certified Personal care agency Certification as a Medicaid provider of Home and Community Based Services C.R.S; 10 C.C.R. 2505-10, Section 8.489.

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 every 9-15 months for the first three years of their Medicaid certification until eligibility for a Risk Based Survey can be established. Once a Risk Base is established providers survey schedules are modified to 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/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:

Bereavement Counseling

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Counseling provided to the participant and/or family members in order to guide and help them cope with the participant's illness and the related stress that accompanies the continuous, daily care required by a terminally ill child. Enabling the participant and family members to manage this stress improves the likelihood that the child with a life-threatening condition will continue to be cared for at home, thereby preventing premature and otherwise unnecessary institutionalization. Bereavement activities and opportunities for dialog offer the family a mechanism for expressing emotion and asking questions about death and grieving in a safe environment thereby potentially decreasing complications for the family after the child dies. Bereavement counseling is initiated and billed while the child is on the waiver but may continue after the death of the child for a period of up to one year.

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

Bereavement services are billable one time for a flat rate. The service may be billed once the family has shown interest in receiving the service and prior to the child's death. Providers are required to provide up to one year of bereavement counseling following the death of the waiver participant. A Master prepared Social Worker, Counselor, Licensed Psychologist or non-denominational Chaplain/Spiritual Care Counselor shall be the direct provider for this service and acuity level is determined by professional assessment of need.

When available and appropriate, State Plan services will be utilized prior to waiver services for the child or family.

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Therapist
Agency	Home Health Agency
Agency	Hospice

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Bereavement Counseling

Provider Category:

Individual

Provider Type:

Individual Therapist

Provider Qualifications

License (specify):

LCSW, LPC, LSW, LISW, Licensed Psychologist,
 Individual Licensed by State of Colorado and/or Licensed individual

Certificate (specify):

Non-denominational/Spiritual/Bereavement Counselor/Chaplain certified by appropriate associations.

Other Standard (specify):

Individual and Family Grief Loss or Bereavement counseling experience, pediatric/adolescent counseling experience of one year.

Verification of Provider Qualifications

Entity Responsible for Verification:

Colorado Department of Regulatory Agencies and Medicaid Fiscal Agent

Frequency of Verification:

Colorado Department of Regulatory Agencies and Medicaid Fiscal Agent

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Bereavement Counseling

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License (specify):

Department of Public Health and Environment, Health Facilities and Emergency Section Division is currently licensing all home health providers in the state of Colorado.

Certificate *(specify):*

All Skilled home health agencies in Colorado must be certified by Medicare prior to be certified by the Department of Health Care Policy and Financing

Medicare/Medicaid Certified. Certified as a Medicaid provider of home health State Plan benefits. 10 C.C.R. 2505-10, Section 8.520.

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:

Department of Public Health and Environment, Health Facilities and Emergency Services Division. According to survey cycle mandated by the Centers for Medicare and Medicaid Services (CMS).

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Bereavement Counseling

Provider Category:

Provider Type:

Hospice

Provider Qualifications

License *(specify):*

Hospice agency must be a licensed Medicare/Medicaid hospice provider in Colorado.

Certificate *(specify):*

Hospice agency must be a licensed Medicare/Medicaid hospice provider in Colorado.

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:

Department of Public Health and Environment, Health Facilities and Emergency Services Division. According to survey cycle, at least every 6-8 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

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:
Expressive Therapy

HCBS Taxonomy:

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

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

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

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

Service Definition (Scope):

Expressive Therapy means provision of creative art, music or play therapy which gives children the ability to creatively and kinesthetically express their medical situation. Expressive therapy functions as the interface between the mind and the body. These therapies are based on the theory that creative activity improves the capacity of the body to heal. Therapies may include book writing, painting, music therapy and scrapbook making. Use of these therapies can decrease a client’s feelings of isolation, improve communications skills, decrease emotional suffering due to health status, and develop coping skills. Expressive therapy is an activity which is not for recreation but related to the care and treatment of the patient’s disabling health problems.

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

Expressive Therapy is limited to 39 hours per year.

Service Delivery Method (check each that applies):

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency
Agency	Hospice Agency
Individual	Individual Therapist

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Expressive Therapy

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License (specify):

Department of Public Health and Environment, Health Facilities and Emergency Section Division is currently licensing all home health providers in the state of Colorado

Certificate (specify):

Medicare/Medicaid Certified. Certified as a Medicaid provider of home health State Plan benefits. 10 C.C.R. 2505-10, Section 8.520.

Other Standard (specify):

The individuals employed by the agency utilizing music therapy must hold a Bachelor's, Master's or Doctorate in Music Therapy and maintain certification from the Certification Board for Music Therapists. The individuals employed by the agency utilizing art or play therapy shall hold any of the following licenses: LCSW, LPC, LSW, LISW, Licensed Psychologist, Non-denominational/Spiritual/Bereavement Counselor. All individuals providing Expressive Therapy must have at least one year of experience in provision of art/play therapy or music therapy to pediatric/adolescent clients.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Department of Public Health and Environment, Health Facilities and Emergency Services Division. According to survey cycle mandated by the Centers for Medicare and Medicaid Services (CMS).

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Expressive Therapy

Provider Category:

Agency

Provider Type:

Hospice Agency

Provider Qualifications

License (specify):

Hospice agency must be a licensed Medicare/Medicaid hospice provider in Colorado.

Certificate (specify):

Medicare/Medicaid Certified as a Medicaid provider of Hospice services. 10 C.C.R. 2505-10, Section 8.550.

Other Standard (specify):

The individuals employed by the agency utilizing music therapy must hold a Bachelor's, Master's or Doctorate in Music Therapy and maintain certification from the Certification Board for Music Therapists. The individuals employed by the agency utilizing art or play therapy shall hold any of the following licenses: LCSW, LPC, LSW, LISW, Licensed Psychologist, Non-denominational/Spiritual/Bereavement Counselor. All individuals providing Expressive Therapy must have at least one year of experience in provision of art/play therapy or music therapy to pediatric/adolescent clients.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Department of Public Health and Environment, Health Facilities and Emergency Services Division.
According to survey cycle, at least every 6-8 years for hospice agencies.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Expressive Therapy

Provider Category:

Individual

Provider Type:

Individual Therapist

Provider Qualifications

License (specify):

Providers utilizing art or play therapy shall hold any of the following licenses: LCSW, LPC, LSW, LISW, Licensed Psychologist, Non-denominational/Spiritual/Bereavement Counselor Individual Licensed by State of Colorado and/or Licensed individual

Certificate (specify):

Providers utilizing music therapy must hold a Bachelor's, Master's or Doctorate in Music Therapy and maintain certification from the Certification Board for Music Therapists.

Other Standard (specify):

At least one year of experience in provision of art/play therapy or music therapy to pediatric/adolescent clients.

Verification of Provider Qualifications

Entity Responsible for Verification:

Colorado Department of Regulatory Agencies and Medicaid Fiscal Agent

Frequency of Verification:

Licensing intervals and Initial Medicaid provider application

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Massage Therapy

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Massage therapy shall only be used for the treatment of conditions or symptoms related to the client’s illness. This service is only available from a provider who is licensed, certified, registered and/or accredited by an appropriate national accreditation association in that profession and the intervention is related to an identified medical need. Massage therapy is the physical manipulation of muscles to ease muscle contractures, spasms, extension, muscle relaxation and muscle tension.

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

Limited to 24 hours a year.

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
Individual	Individual Therapist
Agency	Hospice

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Massage Therapy

Provider Category:

Provider Type:

Home Health

Provider Qualifications

License (specify):

Department of Public Health and Environment, Health Facilities and Emergency Section Division is currently licensing all home health providers in the state of Colorado.

Certificate (specify):

Medicare/Medicaid Certified. Certified as a Medicaid provider of home health State Plan benefits. 10 C.C.R. 2505-10, Section 8.520.

Other Standard (specify):

The individuals employed by the agency must be a massage therapist and meet all applicable state licensing or certification requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Department of Public Health and Environment, Health Facilities and Emergency Services Division. According to survey cycle mandated by the Centers for Medicare and Medicaid Services (CMS).

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Massage Therapy

Provider Category:

Individual

Provider Type:

Individual Therapist

Provider Qualifications

License (specify):

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

Certificate (specify):

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

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health Care Policy and Financing

Frequency of Verification:

Licensing intervals and Initial Medicaid provider application

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Massage Therapy

Provider Category:

Agency

Provider Type:

Hospice

Provider Qualifications

License (specify):

Hospice agency must be a licensed Medicare/Medicaid hospice provider in Colorado.

Certificate *(specify):*

Medicare/Medicaid Certified as a Medicaid provider of Hospice services. 10 C.C.R. 2505-10, Section 8.550.

Other Standard *(specify):*

The individuals employed by the agency must be a massage therapist and meet all applicable state licensing or certification requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Department of Public Health and Environment, Health Facilities and Emergency Services Division. According to survey cycle, at least every 6-8 years for Hospice agencies.

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:

Palliative/Supportive Care services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition *(Scope):*

Palliative care is specialized medical care for people with life limiting illnesses. This type of care focused on providing clients with relief from the symptoms, pain, and stress of serious illness, whatever the diagnosis. For

the purpose of this waiver Palliative Care includes care coordination and pain and symptom management. The services are provided by a Hospice or Home Care Agency who have received additional training in palliative care concepts such as adjustment to illness, advance care planning, symptom management, and grief/loss. Palliative/Supportive Care is care provided to manage, control, and alleviate symptoms such as pain, nausea, discomfort and anxiety related to the life-limiting diagnosis. Palliative/Supportive Care differs from State Plan Home Health benefit because the providers are required to have end of life care experience and/or training.

Care Coordination includes development and implementation of a care plan, home visits for regular monitoring of the health and safety of the client and central coordination of medical and psychological services. The Care Coordinator will organize the multifaceted array of services. This approach will enable the client to receive all medically necessary care in the community with the goal of avoiding institutionalization in an acute care hospital. Additionally, a key function of the Care Coordinator will be to support families with the majority of responsibility, otherwise placed on the parents, for condensing, organizing, and making accessible to providers, critical information that is related to care and necessary for effective medical management. The activities of the Care Coordinator will allow for a partnership between the care coordinator and the parents to better simplify and coordinate the system of care.

Administrative activities (specifically utilization management; i.e. review and authorization of service requests, level of care determinations, and waiver enrollment) are provided by the case manager at the CMA. These activities are not waiver services.

Pain and symptom management is defined as nursing care in the home by a registered nurse to manage the client’s symptoms and pain. Management includes regular, ongoing pain and symptom assessments to determine efficacy of the current regimen and available options for optimal relief of symptoms. Management also includes as needed visits to provide relief of suffering, during which, nurses assess the efficacy of current pain management and modify the regimen if needed to alleviate distressing symptoms and side effects using pharmacological, non-pharmacological and complementary/supportive therapies.

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

No limits on the number of services but documentation needs to cover the medical necessity of visits.

When a child is first diagnosed with the illness, the child and family might need a significant amount of Palliative/Supportive Care that may taper off during the treatment phase when the child has some improvement or remission of symptoms. As the child’s health deteriorates, supportive services may be required at an intensive level.

Palliative/Supportive Care and State Plan home health or hospice benefits may not be provided at the same time. State plan services should be exhausted prior to accessing Palliative/Supportive Care as via the waiver.

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency
Agency	Hospice agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Palliative/Supportive Care services

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License (specify):

Department of Public Health and Environment, Health Facilities and Emergency Section Division is currently licensing all home health providers in the state of Colorado

Certificate (specify):

All Skilled home health agencies in Colorado must be certified by Medicare prior to be certified by the Department of Health Care Policy and Financing Medicare/Medicaid Certified.Certified as a Medicaid provider of home health State Plan benefits. 10 C.C.R. 2505-10, Section 8.520.

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:

Home Health Agency Department of Public Health and Environment, Health Facilities and Emergency Services Division. According to survey cycle mandated by the Centers for Medicare and Medicaid Services.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Palliative/Supportive Care services

Provider Category:

Agency

Provider Type:

Hospice agency

Provider Qualifications

License (specify):

Hospice agency must be a licensed Medicare/Medicaid hospice provider in Colorado.

Certificate (specify):

Medicare/Medicaid Certified as a Medicaid provider of Hospice services. 10 C.C.R. 2505-10, Section 8.550.

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Environment, Health Facilities and Emergency Services Division.

Frequency of Verification:

Department of Public Health and Environment, Health Facilities and Emergency Services Division. According to survey cycle, at least every 6-8 years for Hospice agencies.

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:

Therapeutic Life Limiting Illness Support: Individual Counseling, Family Counseling, Group Counseling

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

Service Definition (Scope):

Therapeutic Life Limiting Illness Support is grief/loss or anticipatory grief counseling/support provided by a Licensed Clinical Social Worker (LCSW), Licensed Social Worker (LSW) Licensed Professional Counselor (LPC), Licensed Psychologist or non-denominational Chaplain/Spiritual Care counselor with experience working with clients with life-limiting illnesses and their families and according to hospice industry established practice guidelines. Support is intended to help the child and family in the disease process.

Therapeutic Life Limiting Illness Support has three components: Individual Counseling, Family Counseling, and Group Counseling.

Individual Counseling is provided to the client to decrease emotional suffering due to health status and develop coping skills. Enabling the participant to manage this stress improves the likelihood that the child with a life-threatening condition will continue to be cared for at home, thereby preventing premature and otherwise unnecessary institutionalization. Support will include but is not limited to attending physician visits, attending hospital discharge planning meetings, connecting the family with community resources such as funding or transportation, etc.

Family Counseling is provided to the family/caregiver to alleviate the feelings of devastation and loss related to a diagnosis and prognosis for limited lifespan, surrounding the failing health status of the client, and impending

death of a child. Support is provided to the family members in order to guide and help them cope with the client’s illness and the related stress that accompanies the continuous, daily care required by a terminally ill child. Enabling the family members to manage this stress improves the likelihood that the child with a life-threatening condition will continue to be cared for at home, thereby preventing premature and otherwise unnecessary institutionalization. Support will include but is not limited to attending physician visits, attending hospital discharge planning meetings, connecting the family with community resources such as funding or transportation, etc.

Group Counseling may be provided to multiple clients on the waiver at the same time to decrease emotional suffering due to health status and develop coping skills.

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

Therapeutic Life Limiting Illness Support is limited to 98 hours every 365 days based on the date the client entered the program. Therapeutic Life Limiting Illness Support will be provided according to the assessment of the client in the continuum of care after a diagnosis of a life-limiting illness or condition. When a child is first diagnosed with the illness, the child and family might need a significant amount of anticipatory grief/loss counseling that may taper off during the treatment phase when the child has some improvement or remission of symptoms. As the child’s health deteriorates, supportive services may be required at an intensive level.

When available and appropriate, State Plan services will be utilized prior to waiver services for the child or family.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Therapist
Agency	Hospice agency
Agency	Home Health agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Therapeutic Life Limiting Illness Support: Individual Counseling, Family Counseling, Group Counseling

Provider Category:

Individual

Provider Type:

Individual Therapist

Provider Qualifications

License (*specify*):

LCSW, LPC, LSW, LISW, Licensed Psychologist,
 Individual Licensed by State of Colorado and/or Licensed individual

Certificate (*specify*):

Non-denominational/Spiritual/Bereavement Counselor/Chaplain certified by appropriate associations.

Other Standard (*specify*):

Individual and Family Grief Loss or Bereavement counseling experience, pediatric/adolescent counseling experience of one year.

Verification of Provider Qualifications

Entity Responsible for Verification:

LCSW, LPC, LSW, LISW, Licensed Psychologist
 Colorado Department of Regulatory Agencies and Medicaid Fiscal Agent

Frequency of Verification:

LCSW, LPC, LSW, LISW, Licensed Psychologist
 Colorado Department of Regulatory Agencies and Medicaid Fiscal Agent

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Therapeutic Life Limiting Illness Support: Individual Counseling, Family Counseling, Group Counseling

Provider Category:

Agency

Provider Type:

Hospice agency

Provider Qualifications

License (specify):

Hospice agency must be a licensed Medicare/Medicaid hospice provider in Colorado.

Services must be provided by licensed, certified, and/or registered individuals operating within the applicable scope of practice.

Certificate (specify):

Medicare/Medicaid Certified as a Medicaid provider of Hospice services. 10 C.C.R. 2505-10, Section 8.550.

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:

Department of Public Health and Environment, Health Facilities and Emergency Services Division.
 According to survey cycle, at least every 6-8 years.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Therapeutic Life Limiting Illness Support: Individual Counseling, Family Counseling, Group Counseling

Provider Category:

Agency

Provider Type:

Home Health agency

Provider Qualifications

License (specify):

Department of Public Health and Environment, Health Facilities and Emergency Section Division is currently licensing all home health providers in the state of Colorado.

Services must be provided by licensed, certified, and/or registered individuals operating within the applicable scope of practice.

Certificate (*specify*):

All Skilled home health agencies in Colorado must be certified by Medicare prior to be certified by the Department of Health Care Policy and Financing Medicare/Medicaid Certified. Certified as a Medicaid provider of home health State Plan benefits. 10 C.C.R. 2505-10, Section 8.520.

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:

Department of Public Health and Environment, Health Facilities and Emergency Services Division.
According to survey cycle mandated by the Centers for Medicare and Medicaid Services (CMS).

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:

Case Management Agencies (CMA) provide case management services throughout the state. The State assures that this waiver will be compliant with all applicable regulations related to case management as determined by CMS. Any amendments required to achieve such compliance will be submitted to CMS at least 90 days in advance of that date.

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):

It is policy for participants in Certified Nurses Aide state approved educational programs to have Colorado Bureau of Investigation (CBI) background investigations when they are admitted to the program. Health care agencies and other independent training sites in Colorado that provide these educational programs require applicants for Certified Nurses Aide to comply. Compliance with the requirement for a state background check is monitored by the Department of Regulatory Agencies for Certification of Nurses Aides. CBI background checks register arrests for crimes relevant to vulnerable populations such as child abuse, domestic violence, assault and battery and violent crime felony arrests. Prosecution may be checked through the criminal justice system.

Hospice agencies usually complete background checks on nurses, therapists and counselors when they hire these professionals though there is no state regulation requirement.

Home Health Agencies as of July 1,2009 are now licensed by the Colorado DPHE and are required to perform background checks on all employees are indicated in 6 CCR 1011-1 Section 6.3

Background checks are required to be completed on Owners and Administrators of Nursing Facilities (NF) as well as on any NF staff or volunteers who have personal contact with the residents of the facility. It is the responsibility of an NF to ascertain whether prospective staff or volunteers have been convicted of a felony or misdemeanor that could pose a risk to the health, safety and welfare of the residents, when making employment decisions.

NFs are licensed by the Department of Public Health and Environment (DPHE) as such; they are surveyed on a 9 to 15 month cycle. During this survey DPHE reviews employment records of the facility's staff to ensure NF are completing required criminal background checks. If DPHE discovers the facility is not completing the required checks they will record it as a deficiency and require the facility to correct the problem according to process described in Appendix G.

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 State makes payment to legally responsible individuals for furnishing personal care or similar services. The personal care or similar services for which such payment may be made to legally responsible individuals; the legally responsible individuals who may furnish such services, State policies that specify the extraordinary circumstances when such payments may be authorized, and the controls that are employed to ensure that payments are made only for services rendered:

Payment to relatives/legal guardians may be made for personal care under the Respite Service. Relatives shall be defined as all persons related to the client by virtue of Blood, Marriage, Adoption or common law. Payments to relatives /legal guardians are only for extraordinary care that is beyond that which would ordinarily be provided to a child of the same age and development stage.

The services for the Respite Care is made under the Home Health agency or Personal care provider agency that employs the relatives/legal guardians as Certified nurse's aide after meeting all the requirements to be hired as a caregiver through the agency.

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.*

- 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.

Payment is not made directly to relatives /guardians for Respite Services. Relatives/legal guardians providing Respite shall be employees of a Certified Medicaid Agency and can be qualified to provide the service. Services provided by relatives/legal guardians for Respite are only for extraordinary care that is beyond that which

would ordinarily be provided to a child of the same age and developmental stage. The CMA case manager assessment utilizing the ULTC100.2 tool and the Service plan determine that the care is extraordinary. All Respite services are prior authorized by the CMA Case manager. Respite care is limited to 30 days per year. The Department monitors this benefit through the CMA case management annual review, by MMIS claims adjudication and post payment review of records, and agency surveys to ensure that controls are in place and 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:

Under the Department's rules, any provider can apply to enroll. Applications for each provider type are available on-line or by calling the fiscal agent. Providers who apply to become certified Home and Community Based Services providers for Personal Care and Respite Services will be surveyed by the Department of Public Health and Environment, Health Facilities and Emergency Services Division (DPHE) to ensure compliance with all applicable rules.

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:

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):

Reports to State Medicaid Agency on delegated

If 'Other' is selected, specify:

MMIS Data/CDPHE Reports

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>

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):

Reports to State Medicaid Agency on delegated

If 'Other' is selected, specify:

MMIS

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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-certified waiver providers that meet the initial waiver provider qualifications
Denominator = Total number of newly enrolled non-licensed/non-certified waiver providers

Data Source (Select one):

Other

If 'Other' is selected, specify:

MMIS Data

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample

		Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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-certified waiver providers that continually meet waiver provider qualifications
 Denominator = Total number of enrolled non-licensed/non-certified waiver providers

Data Source (Select one):

Other

If 'Other' is selected, specify:

MMIS Data

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Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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 <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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 <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. Timelines

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

- No**
- Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

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

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

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

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

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

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

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

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

Massage Therapy: Massage therapy shall only be used for the treatment of conditions or symptoms related to the client's illness. This service is only available from a provider who is licensed, certified, registered and/or accredited by an appropriate national accreditation association in that profession and the intervention is related to an identified medical need. Massage therapy is the physical manipulation of muscles to ease muscle contractures, spasms, extension, muscle relaxation and muscle tension. This service is provided in the home and community, which retains a client's right to choice

and allows the individual to remain independent. Accordingly, all sections of 42 CFR 441.301(c)(4)(i-vi) are met.

Bereavement Counseling: Counseling provided to the participant and/or family members in order to guide and help them cope with the participant's illness and the related stress that accompanies the continuous, daily care required by a terminally ill child. Enabling the participant and family members to manage this stress improves the likelihood that the child with a life-threatening condition will continue to be cared for at home, thereby preventing premature and otherwise unnecessary institutionalization. Bereavement activities and opportunities for dialog offer the family a mechanism for expressing emotion and asking questions about death and grieving in a safe environment thereby potentially decreasing complications for the family after the child dies. Bereavement counseling is initiated and billed while the child is on the waiver but may continue after the death of the child for a period of up to one year. This service is provided in the home and/or community, which retains a client's right to choice and allows the individual to remain independent. Accordingly, all sections of 42 CFR 441.301(c)(4)(i-vi) are met.

Expressive Therapy: Expressive Therapy is the provision of creative art, music or play therapy which gives children the ability to creatively and kinesthetically express their medical situation. Expressive therapy functions as the interface between the mind and the body. These therapies are based on the theory that creative activity improves the capacity of the body to heal. Therapies may include book writing, painting, music therapy and scrapbook making. Use of these therapies can decrease a client's feelings of isolation, improve communications skills, decrease emotional suffering due to health status, and develop coping skills. Expressive therapy is an activity which is not for recreation but related to the care and treatment of the patient's disabling health problems. This service is provided in the home and community, and ultimately allows the individual to remain independent and engaged in their community. This service and setting allow for the client to be fully integrated and chosen by the client while protecting their right to privacy and optimizing both independence and choice. Accordingly, all sections of 42 CFR 441.301(c)(4)(i-vi) are met.

Palliative/Supportive Care Services: Palliative care is specialized medical care for people with life limiting illnesses. This type of care focused on providing clients with relief from the symptoms, pain, and stress of serious illness, whatever the diagnosis. For the purpose of this waiver Palliative Care includes care coordination and pain and symptom management. The services are provided by a Hospice or Home Care Agency who have received additional training in palliative care concepts such as adjustment to illness, advance care planning, symptom management, and grief/loss. Palliative/Supportive Care is care provided to manage, control, and alleviate symptoms such as pain, nausea, discomfort and anxiety related to the life-limiting diagnosis. Palliative/Supportive Care differs from State Plan Home Health benefit because the providers are required to have end of life care experience and/or training. Care Coordination includes development and implementation of a care plan, home visits for regular monitoring of the health and safety of the client and central coordination of medical and psychological services. The Care Coordinator will organize the multifaceted array of services. This approach will enable the client to receive all medically necessary care in the community with the goal of avoiding institutionalization in an acute care hospital. Additionally, a key function of the Care Coordinator will be to assume the majority of responsibility, otherwise placed on the parents, for condensing, organizing, and making accessible to providers, critical information that is related to care and necessary for effective medical management. The activities of the Care Coordinator will allow for a seamless system of care. Administrative activities (specifically utilization management; i.e. review and authorization of service requests, level of care determinations, and waiver enrollment) are provided by the case manager at the CMA. These activities are not waiver services.

Pain and symptom management is defined as nursing care in the home by a registered nurse to manage the client's symptoms and pain. Management includes regular, ongoing pain and symptom assessments to determine efficacy of the current regimen and available options for optimal relief of symptoms. Management also includes as needed visits to provide relief of suffering, during which, nurses assess the efficacy of current pain management and modify the regimen if needed to alleviate distressing symptoms and side effects using pharmacological, non-pharmacological and complementary/supportive therapies.

This service is provided in the home and community, which retains a client's right to choice and allows the individual to remain independent. Accordingly, all sections of 42 CFR 441.301(c)(4)(i-vi) are met.

Therapeutic Life Limiting Illness Support: Individual Counseling, Family Counseling, Group Counseling: Therapeutic Life Limiting Illness Support provides Individual Counseling, Family Counseling, Group Counseling Therapeutic Life Limiting Illness Support is grief/loss or anticipatory grief counseling/support provided by a Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor (LPC), Licensed Psychologist or non-denominational Chaplain/Spiritual Care counselor with experience working with clients with life-limiting illnesses and their families and according to hospice industry established practice guidelines. Support is intended to help the child and family in the disease process. Therapeutic Life Limiting Illness Support has three components: Individual Counseling, Family Counseling, and Group Counseling. Individual Counseling is provided to the client to decrease emotional suffering due to health status and develop coping

skills. Enabling the participant to manage this stress improves the likelihood that the child with a life-threatening condition will continue to be cared for at home, thereby preventing premature and otherwise unnecessary institutionalization. Support will include but is not limited to attending physician visits, attending hospital discharge planning meetings, connecting the family with community resources such as funding or transportation, etc.

Family Counseling is provided to the family/caregiver to alleviate the feelings of devastation and loss related to a diagnosis and prognosis for limited lifespan, surrounding the failing health status of the client, and impending death of a child. Support is provided to the family members in order to guide and help them cope with the client's illness and the related stress that accompanies the continuous, daily care required by a terminally ill child. Enabling the family members to manage this stress improves the likelihood that the child with a life-threatening condition will continue to be cared for at home, thereby preventing premature and otherwise unnecessary institutionalization. Support will include but is not limited to attending physician visits, attending hospital discharge planning meetings, connecting the family with community resources such as funding or transportation, etc.

Group Counseling may be provided to multiple clients on the waiver at the same time to decrease emotional suffering due to health status and develop coping skills.

This service is provided in the home and/or community, which retains a client's right to choice and allows the individual to remain independent. Accordingly, all sections of 42 CFR 441.301(c)(4)(i-vi) are met.

Respite: Respite Care means services provided to an eligible client who is unable to care for himself/herself on a short term basis because of the absence or need for relief of those persons normally providing care. Respite Care under this waiver is preferentially provided in the client's residence and may be provided by different levels of providers depending upon the needs of the client. Respite Care may be provided by a skilled or unskilled provider. A skilled respite provider would be either a licensed RN/LPN or CNA. Skilled respite is for clients with ongoing medical needs that can only be provided by an RN/LPN or CNA (i.e. suctioning). Unskilled respite is for clients that will not have any medical needs that will need to be attended to (such as a G-tube feeding). This includes the possibility of the need for skilled/medical intervention. This service is provided in the home and ultimately allows the individual to remain independent and engaged in their community. This service and setting allow for the client to be fully integrated and chosen by the client while protecting their right to privacy and optimizing both independence and choice. Accordingly, all sections of 42 CFR 441.301(c)(4)(i-vi) are met.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Service Care Plan developed collaboratively between Case Management Agency and Hospice Nurse Care Manager with input from Physician

- 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:

Case managers working for the CMA shall have a degree of Bachelor of Arts or Bachelor of Science in the Human Services field. The majority of case managers have a Bachelor of Sociology or Psychology. Some case managers are Master of Social Work. Case managers will receive specialized training for the waiver target population as described at Appendix B-6-c: Qualifications of Individual Performing Initial Evaluation.

- 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 care planning process.

The nurse of the Hospice agency shall collaborate with the CMA case managers for the medical component in the planning of the services for the care of the client that may be required in order for care to be safely delivered in the home.

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 convenient for all participants. In addition, the client 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):

Case management functions include the responsibility to document, monitor, and oversee the implementation of the service plan [10 C.C.R. 2505-10, Section 8.390]. The case manager meets face-to-face with the child, the client's parents and/or legal guardian to complete a comprehensive assessment of the client's needs in the client's residence.

When scheduling to meet with the client and /or client's parents and/or legal guardian the case manager makes reasonable attempts to schedule the meeting at a time convenient for the client, the client's parents and/or legal guardian to complete a comprehensive assessment of the client's needs. The client'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 client's parents and/or legal guardian provide the case manager with information about the client's medical status, needs, preferences, and goals. In addition, the case manager obtains diagnostic and health status information from the client's medical provider, and collateral information from agencies providing services to the client and determines the client's functional capacity using the Uniform Long Term Care (ULTC) assessment tool. The case manager works with the client's parents and/or legal guardian to identify risk factors and addresses risk factors with appropriate parties.

Once the service plan is developed, options for services and providers are explained to the client and /or client's parent and/or guardian by the case manager. The client'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 client and /or client'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 client and /or client's parent and/or guardian has been informed of the choice of providers and documents that the client and /or client's parents and/or legal guardian has chosen to have services provided in the community or in a hospital. The service plan is completed within 15 working days of the client being determined eligible for CLLI services. The client and /or client's parents and/or legal guardian sign the service plan. CLLI services begin when all criteria is met which includes program and financial.

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

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

Upon Department approval, the annual assessment and/or development of the service plan may be completed by the case manager at an alternate location or via the telephone. Such approval may be granted for situations in which there is a documented safety risk to the case manager or client (e.g. natural disaster, pandemic, etc.)

State laws, regulations, and policies that affect the service plan development process are available through the Medicaid agency

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 care planning process during a face-to-face interview in the client's home and are documented on the care plan form. This population is particularly at risk for anticipatory grief, isolation from peers, depression and parental distress and/or burnout related to the life-limiting diagnosis and physical condition of the client. Clients are eligible for the waiver due to their risk of institutionalization. The waiver service package will help to mitigate crises in these risk areas by making Respite, Counseling, Palliative/Supportive Care, and Expressive Therapy services available. Individual/Caregiver Counseling would help to mitigate the risk of isolation and encourage open dialog between clients and the family caregivers for the purpose of expressing and overcoming feelings of grief and distress. Expressive Therapy allows the client to express feelings through art, music, and play safely and effectively. Respite services would mitigate parental distress and burnout by providing caregivers with a period of relaxation free from care giving duties. Palliative/Supportive Care provides comfort and palliation of distressing symptoms including anxiety related to the life-limiting diagnosis. Case managers evaluate the risk level of the clients and the family or caregiver with whom they reside at the initial assessment interview, quarterly and annually. Referrals to appropriate agencies such as Child Protection Services are made immediately when the client is at risk for physical abuse, mental abuse, neglect or exploitation. An emergency back-up plan is developed with the client and family/caregiver with physician input at the time of the initial assessment in the event that scheduled services are unable to be provided or caregivers are unable to provide the necessary care due to unforeseen circumstances, absence or injury.

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 client and /or 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 list of PHW providers is limited to ten

(10) Hospice providers and five (5) home health agency providers that is able to bill specifically for PHW services at this time.

The Department is making efforts to increase participation of providers in the PHW. The case managers do have the current list and when a provider is added, the department does inform the case manager of the new provider via email to all CMAs.

If the client and/or child's parents and / or legal guardian have freedom of choice for those providers that are participating in the PHW. The case manager can contact other PHW providers and with the consent of the client and /or child's parents and /or legal guardians can request the new PHW to conduct an assessment for PHW services. If the new provider is agreeable to the client and /or child's parents and /or legal guardian the case manager can approve a new PAR for the continuation of care for the child.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The case management agencies (CMAS) are required to prepare service plans according to their contract with the Department and CMS waiver requirements. The Department monitors each CMA annually for compliance. A representative 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 shall 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 review,

service plans and prior authorizations are compared with the documented level of care for appropriateness and adequacy. Targeted review of service plan documentation and authorization review is part of the overall administrative and programmatic evaluation by the Department.
Please see the Global QIS for additional information about the Departments timelines for implementing additional procedures.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Specify the other schedule:

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

- Medicaid agency
- Operating agency
- Case manager
- Other

Specify:

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.

Department Responsibilities

The Department oversees the function of the Case Management Agencies. The Department is implementing a monitoring strategy for Case Management Agencies who administer the Pediatric Hospice Waiver. The monitoring strategy combines a programmatic review in addition to an administrative review. The evaluation includes a representative sample of the service plan development, authorization and service utilization compared to the client's documented ULTC-100.2 assessment. The monitors review the service plan on the BUS and will review the actual record at the case management agency to ensure that all requirements for the service plan has been met and that the parents have been informed that they have the right to choose the provider, the case management agency, the waiver as well as a choice to in the home care or institutionalization. The department reviews the Critical Incident Reports (CIRS) and the BUS notes to identify any health and welfare issues pertaining to the clients on the waiver.

Service plans and tools used by each agency are reviewed by the monitors for appropriateness and adequacy to ensure they meet the needs of waiver clients. The service plans should include coordination of waiver and non-waivered services, assignment of responsibilities, and process for updating the plan as needed. The monitors review

the service plan to assure that individuals health and welfare needs are assessed and that each service plan contains at a minimum the medical and other non waived services provided to the client, the frequency of services, the provider types, and other non medical services. Case managers are required to review back up plans with client and /or parents and/or legal guardians should an emergency arise or a scheduled service provider not show for the scheduled visit.

In 2007, the Department implemented a new service plan, which includes a section for health services and other non-waiver services. At the same time, the Department added “acute care benefits” and a “Behavioral Health Organizations” break out sessions to the annual case managers training conference to ensure case managers have a greater understanding of the additional health services available to long-term care clients.

The QIS currently being addressed in PHW is to improve functionality of BUS to be able to collect monitoring data and run reports. Expected Completion Date is slated for 09/01/2010. Information will be collected in Excel 1st year with BUS changes to occur in year 2.

The Department will take steps to improve access to information using the Departments web site to assist the client and/or family members to make informed decisions about waiver services, informal supports, as well as State Plan benefits.

Case Manager Responsibility

The case manager is required to meet face to face with the family and the child, in the client’s home, at the time of the initial assessment and then again at the CSR assessment. Case managers are responsible for service plan development, implementation and monitoring. Parents and/or legal guardian are required to contact the case managers when significant changes occur in the child’s physical or mental condition, in which case a new assessment and service plan will be completed.

Each case management agency is obligated to provide clients with a free choice of qualified providers and to ensure clients continue to exercise the choice the Department has added a signature section to the service plan that indicates whether they have been offered choice of providers.

The client and/or 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 client and /or 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 client and/or 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 client and /or child’s parents and/or legal guardian. Case managers document the issue and the follow- up in the BUS.

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.

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:

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 whose SPs address health and safety risks through a contingency plan Denominator = Total number of waiver participants in the sample

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Program Review Tool

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	

		<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% with a +/- 5% margin of error
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of waiver participants in a representative sample whose SPs 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):

Record reviews, on-site

If 'Other' is selected, specify:

Program Review Tool

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% with a +/- 5% margin of error
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>

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 waiver 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

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Program Review Tool

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% with a +/- 5% margin of error
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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.

Performance Measure:

Number and percent of waiver participants in a representative sample whose SPs were developed according to the Department’s SP policies and procedures

Numerator = Number of waiver participants in the sample whose SPs

demonstrate that the Department’s policies and procedures were followed

Denominator = Total number of waiver participants in the sample

Data Source (Select one):

Other

If 'Other' is selected, specify:

Benefits Utilization System Data

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	

		<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% with a +/- 5% margin of error
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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 with a prior Service Plan that was updated within 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 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% with a +/- 5% margin of error
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input type="checkbox"/>	<input type="checkbox"/>

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% with a +/- 5% margin of error
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:

	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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 sample 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 Claims Data and Benefits Utilization System Data

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% with a +/- 5% margin of error
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):

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:

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 provider and contact information. Numerator = # of waiver participants in the sample whose Service Plans indicate a fact sheet was provided Denominator = Total number of waiver participants in the sample

Data Source (Select one):

Other

If 'Other' is selected, specify:

Benefits Utilization System Data

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

	<input type="checkbox"/> Continuously and Ongoing	Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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 whose SPs document these choices Denominator = Total number of waiver participants in the sample

Data Source (Select one):

Other

If 'Other' is selected, specify:

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample

		Confidence Interval = 95% with a +/- 5% margin of error
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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 23 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. Timelines

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

- No**
- Yes**

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

Appendix E: Participant Direction of Services

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

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

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

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

- Yes. The State requests that this waiver be considered for Independence Plus designation.
- No. Independence Plus designation is not requested.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

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

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

The CMA case manager notifies clients or their legal representative in writing when a denial of eligibility for the waiver occurs or services under the waiver are denied or reduced. Written notice of client appeal rights is included in the notice of adverse action and mailed using a Department approved form and/or a prior authorization request for services denial letter is generated by the fiscal agent that includes the appeal rights and instructions on how to file an appeal. The CMA is required to provide information to the client and/or parents, guardians or legal representative who applies for or receives publicly funded benefits regarding the right to request a fair hearing as set forth in 10 CCR 2505-10, Sections 8.393.15 and 8.393.28 et seq. See also recipient appeals rule, 10 C.C.R. 2505-10, Section 8.057.

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 applicant and/or client defining the proposed action and information on appeal rights. The process and procedures for requesting a fair hearing with the State Office of Administrative Courts are listed on the reverse side of the notice. The notice includes language that instructs the client that they may receive assistance with the appeal process from any person of their choice, the Office of Administrative Courts, or the local Legal Aide Office. CMA case managers are also required to assist applicants and/or clients in developing a written request for an appeal if the client requests that they do so and the client is unable to complete one on their own. Appeal rights are also included on the Long Term Care Plan Information form.

Notification-Participants are notified of adverse action through issuance of a written form entitled the Long Term Care Waiver Program Notice of Action (LTC 803 Form). The LTC 803 form informs the participant that waiver services will not be discontinued during the appeal process if the participant files an appeal on or prior to the effective date of the action. The CMAs is required to generate the LTC 803 Form utilizing the Benefits Utilization System (BUS) and mail it to the participant at least ten days before the date of the intended action. Participants are also provided a copy of the brochure A Guide to Getting a Fair Medicaid Hearing at the time notification is provided. HCPF rules and regulations regarding notification are located at 10 CCR 2505-10 8.057.2.

The case manager reviews this form with the client and/or authorized representative at the time of initial assessment and reassessment. The client and/or child's parents and /or legal guardians signs this form and a copy is provided to the client and/or parents, guardians or legal representative.

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/suspension or termination or denial of provider choice in services or when a client has been denied PHW services due to functional ineligibility. This documentation is maintained at the CMAs.

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

Clients who have not received PHW services and are denied 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. The Department is analyzing this information and developing a best practice model to be used for case manager training purposes.

Every Medicaid action that is appealed with the Office of Administrative Courts (OAC) is reviewed by the Department. When a client 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 is in compliance with the Department's 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:

Colorado Department of Public Health and Environment, Health Facilities and Emergency Services Division and the CMAs (case management agencies).

- 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).

A Home Health Hotline is maintained by the Colorado Department of Public Health and Environment, Health Facilities and Emergency Services Division (CDPHE). This hotline is set up for complaints about care provided, fraud, abuse and misuse of personal property. CDPHE evaluates the complaint and initiates an investigation.

Depending upon the nature of the complaint and the risk to the client's health and welfare, the investigation is started within twenty-four hours to up to three days. Investigations may lead to targeted surveys or full surveys at the agency involved. Investigation surveys may result in deficient practice citations for agencies which are reported to the Department and require that a plan of correction be submitted to CDPHE within specified timelines. Immediate jeopardy situations require actions to correct the situation at the time of survey. In addition, CMAs maintain a log system for complaints and grievances and either resolve the problem themselves or refer to the appropriate oversight agency. 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.

The information on the nature of the complaints is forwarded to the Department in reports that are reviewed and analyzed in order to discover trends, plan training, or initiate changes in the regulations to address situations that might lead to a complaint.

25-1-124 C.R.S., (2005) and 25-3-109 C.R.S., Subparts (1), (3), (7), and (8), (2005).
42 C.F.R. Chapter IV, Section 484.10(f)

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

The client/child's parents and or legal guardian is informed that the filing of a grievance is not a prerequisite or substitute for a fair hearing and this is to be done by the case manager.

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 licensed healthcare agencies, case management agencies (CMA), and Department staff. Oversight is provided by the Department, Department of Public Health and Environment (DPHE), or the Department of Human Services (DHS).

Critical incidents that involved alleged child abuse, neglect or exploitation, unexpected death or disability and, misuse of personal property 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 as required in 10 CCR 2505-10, Section 8.393.2. Case managers are required to document any report made to a protective services unit in the Benefits Utilization System (BUS) log notes within 24 hours of the report and are required to provide and document follow up within three days. During annual on-site monitoring the Department's CMA reviewers examine log notes and complaint logs to ensure that issues discovered by the case manager are provided with follow up. Case management agencies are required to report to the county departments as soon as incident is reported or discovered. 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 Child's Protection Program.

The Department has developed an informational tool that is available to the child's parents and/or legal guardian at <http://www.cdphs.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 Department's website.

Case Management Agencies (CMAs) 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 will require CMAs 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 by the case manager. The Department has developed Policies and Procedures for the Critical Incident Reporting System. Resources are also available to clients and case managers about emergency backup and safety and prevention strategies.

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.

Information regarding what qualifies as a critical event 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. 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.

The Department has developed educational materials available to clients and case managers about Emergency Backup and Safety and Prevention Strategies. 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.

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.

- 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.

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 and homemaker agencies, Case management agencies, and Department staff. Oversight is provided by the Department, the Department of Public Health and Environment (DPHE), or the Department of Human Services (DHS). 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 (i.e. respite providers and home health providers) 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 Complaint system is maintained by DPHE, Health Facilities and Emergency Services Division HFEMS. This system is accessible through internet, email, phone, or facsimile for all complaints.

DPHE investigates complaints for all health provider entities regulated by the HFEMS and fall under the Public Health Survey jurisdiction; complaints include quality of care, patient/resident rights, building and equipment safety. Complaints are reviewed and prioritized based on actual or potential patient/resident harm. Compliant investigations are conducted either on-site or off-site depending on the nature of the complaint and typically include interviews with staff and/or patients/residents and a review of medical records/patient chart.

In addition to complaint investigations, all healthcare entities licensed or surveyed by Public Health jurisdiction are required to self-report incidents and occurrences to DPHE: HFEMS Division within 24 hours OR one(1) business day. Reportable occurrences include unexplained death, brain injury, life threatening complications or errors from transfusion or anesthesia, severe burns, missing persons, physical/sexual abuse, neglect, misappropriation or property, diverted drugs, and malfunction or misuse of equipment. DPHE survey jurisdiction will review and evaluate all reported occurrences and cite deficiencies where it finds violation to health facility or licensing regulation. Occurrence data is made available to the public on the DPHE website at <http://www.colorado.gov/cs/Satellite/CDPHE-HF/CBON/1251624626798>.

The Department maintains an Interagency Agreement with the Department of Public Health and Environment: Division of Health Facilities and Emergency Services for the management of health facility licensure; survey and certification. DPHE provides the department with monthly reports of information about the type of complaints or occurrence reported, nature of complaints or occurrences, investigation details and their outcome. These reports include 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 and complaints. Once a complaint has been made or occurrences reported, Investigations may lead to targeted surveys or full surveys of the agency involved. Where deficiencies are cited, agencies must submit and execute an approved plan of correction to DPHE in order to maintain licensure.

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 CWA participants, and receives monthly complaint reports from DPHE for surveyed agencies. The reports provide the Department with information about the type of complaint or occurrence, the source of the complaint or occurrence, when the complaint or occurrence 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.

In an effort to better monitor case management agencies compliance with this requirement the Waiver Administrator has conducted a parent/legal guardian survey that is administered to the child's parents and or legal guardian annually. The surveys are distributed to every CLLI child's parents and or legal guardian. The surveys identify client satisfaction with waiver services, case management services, Medicaid and other medical services, etc. Future surveys will also inquire whether or not the child's parents and or legal guardian were provided choices, including but not limited to: a choice in waiver services, LTC service delivery (HCBS Waiver or institution), qualified providers, participation in service planning, etc. The child's parents and or legal guardian will also be asked whether or not 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 the case management agency and improvements will be implemented.

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:

Department of Public Health and Environment surveys for use of restraints in home health agencies and hospice agencies.

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:

Department of Public Health and Environment surveys for use of restraints in home health agencies and hospice agencies.

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:

Department of Public Health and Environment surveys for unauthorized use of seclusion in home health agencies and hospice agencies.

- 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.

- 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.

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

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).

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:

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

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

- 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.

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 instances of 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 participants (and/or family or guardian) in a representative sample who received information/education on how to report abuse, neglect, exploitation A.N.E. & other critical incidents. Numerator = # of participants in the sample documented to have received information/education on how to report A.N.E. & other critical incidents Denominator = Total # of waiver participants in the sample

Data Source (Select one):

Other

If 'Other' is selected, specify:

Benefits Utilization System Data

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

<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% with a +/- 5% margin of error
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:
Number and percent of critical incidents including Abuse, Neglect and Exploitation (ANE) and unexplained death reviewed by the Department.

Numerator = Number of ANE and Death critical incidents reviewed by the Department
Denominator = Number of ANE and Death critical incidents

Data Source (Select one):

Other

If 'Other' is selected, specify:

BUS Data

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% with a +/- 5% margin of error
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="text"/>	
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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):

Critical events and incident reports

If 'Other' is selected, specify:

And BUS Data

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified

		Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of abuse, neglect, or exploitation critical incidents that were reported by the Case Management Agency (CMA) within 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):

Critical events and incident reports

If 'Other' is selected, specify:

And 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review

<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>

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 involving restrictive interventions that followed the Department’s policies and procedures
Denominator = Total number of critical incidents involving restrictive interventions

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

And BUS Data

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:

	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: as needed by severity of incidence 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.

The Department operates other HCBS waivers listed below. This Quality Strategy encompasses all services provided under these waivers. The waiver specific requirements and assurances have been included in the appendices for each waiver.

Waiver Name – Waiver Control Number
Brain Injury – 0288.R03.00
Children’s Extensive Support – 4180.R03.01
Children’s Home and Community Based Services –4157.R04.00
Children’s Habilitation Residential Program - *0305.R03.00
Children with Autism – 0434.R01.01
Community Mental Health Supports- 0268.R04.01
Developmentally Disabled - 0007.R0.01
Elderly, Blind and Disabled – 0006.R06.01
Supported Living Services - 0293.R03.01
Spinal Cord Injury – 0961.R00.00

*This waiver program is operated by DHS, Division of Child Welfare.

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 addition to using information from annual reviews, analysis of performance measure data, and feedback from case managers, the Department factors in appropriation of funds, legislation and federal mandates.

For changes to the 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 <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Quality Improvement Committee	<input checked="" type="checkbox"/> Annually
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Other Specify: <input type="text"/>

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 cost containment of waiver services is based upon the estimated annual average per capita Medicaid cost for hospital level of care that would be incurred for clients served in the Children with Life Limiting Illness (CLLI) waiver, were the waiver not granted.

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 time records adequate to support claims for all services rendered. Rules 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. Formal contracts with CMA (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 of Health Care Policy and Financing (HCPF) has a Program Integrity Section that engages in post payment review of claims by monitoring the MMIS reports requested for specific provider types on a periodic basis. Program Integrity staff perform case reviews to ensure that services for which claims have been filed are documented prior to a claim being generated. Services are determined to be equivalent to what has been claimed and paid or recoveries are requested and processed. Program Integrity selects cases for review based on a priority and/or periodic basis. HCPF's Policies and Procedures for Case Selection and Recovery of Overpayment for Disallowed Medicaid Services are available on request.

Information about payment rates are communicated using provider bulletins. The provider bulletin is available to the public on the Department's website. In addition, all HCBS services are approved using a PAR which includes a column indicating "cost per unit". The case manager is required to provide all waiver clients with a copy of the approved PAR if requested.

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 in 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 Claims Data

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% with a +/- 5% margin of error
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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 claims 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% with a +/- 5% margin of error
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
		<input type="checkbox"/> Other

	<input type="checkbox"/> Continuously and Ongoing	Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% with a +/- 5% margin of error
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>

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 <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95% with a +/- 5% margin of error
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: <input type="text"/>

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	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 Department’s methodology for calculating home and community based services (HCBS) rates identifies all factors necessary to provide services and the accessibility of the service through research, facility site visits and feedback from stakeholders. The expected price of factors identified as necessary to provide the service to Medicaid clients are determined and calculated. The factors considered in the determination of fee-for-service waiver rates for art and play therapy, music therapy, massage therapy, care coordination, pain and symptom management, unskilled in-home respite care, CNA in-home respite care, skilled in-home respite care, and therapeutic grief counseling are as follows:

A. Indirect and Direct Care Requirements:

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

C. Administrative Expense Expectations:

Identifies computer, software, office supply costs, and the total number of employees to determine administrative and operating costs per employee of providing services.

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.

The Department uses information gathered from research, facility site visits, and stakeholder feedback to establish the unit value (such as the length of time being paid for) and the price. Once the rate has been determined, comparisons of other state Medicaid rates and private pay rates for similar or identical services are analyzed to ensure the appropriateness of the determined rate. Once a rate is implemented, the Department may apply rate increases or decreases when funds are approved or reduced through the appropriations process. The following services received a 2% rate increase for FY2014-15 following appropriation of across the board rate increases by the legislature: art and play therapy, music therapy, and massage therapy.

Bereavement counseling is a bundled payment and does not differ by the number of counseling sessions received. The bundle assumes 15 sessions per family and utilizes the therapeutic grief counseling rate. Reconciliation to ensure number of sessions received per family equates to 15 sessions does not occur. The following services received a targeted rate increase for FY2014-15 following appropriation of funds by the legislature: Care Coordination, Pain and Symptom Management, Bereavement Counseling, Therapeutic Grief Counseling, Unskilled In-Home Respite and Skilled In-Home Respite. As these services received targeted rate increases, these services did not receive the 2% across the board rate increase.

- 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:

Fee for service billing claims flow directly from providers to the Medicaid Management Information System which is administered by the Department's Fiscal agent Affiliated Computer Services (ACS).

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 that are included in a waiver client's service plan are prior authorized by Case Management agency case managers and forwarded to the fiscal agent for 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 client is eligible for Medicaid. The Colorado Benefits Management System electronic files are downloaded to 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 provided. The audit process and post payment review processes review claims for accuracy. Case managers contact waiver clients quarterly and the service providers regularly to ensure that services are being provided according to the care plan. Should a discrepancy between what a provider claims and what the client reports occur, or should the client report that the provider is not providing services according to the care plan, the case manager reports the information to the Department's Program Integrity Unit for investigation. The Program Integrity Unit notifies the program administrator for the waiver about the investigation under way and reports the results. If the provider's patient care records do not match the claims filed a payment recovery is initiated. Additionally, a percentage of claims are chosen randomly through the MMIS and explanation of benefits reports are generated to Medicaid clients routinely throughout the year. Medicaid clients receiving these are asked to confirm that the services were provided by means of a response document included.

- e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

- a. **Method of payments -- MMIS** (*select one*):

- Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.
- The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.
- The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

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

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

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

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

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

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

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

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

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

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

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

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

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

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

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

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

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

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

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

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

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

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

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

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

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

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

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

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:*

- 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

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	5753.68	53618.83	59372.51	272966.60	61016.78	333983.38	274610.87
2	5934.29	54744.82	60679.11	287433.83	64812.02	352245.85	291566.74
3	6140.00	55894.46	62034.46	302667.82	68843.33	371511.15	309476.69
4	6396.51	57068.25	63464.76	318709.21	73125.39	391834.60	328369.84
5	6661.51	58266.68	64928.19	335600.80	77673.79	413274.59	348346.40

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		Hospital	
Year 1	200		200
Year 2	222		222
Year 3	246		246
Year 4	272		272
Year 5	301		301

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

- b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The Department estimated the average length of stay (ALOS) on the waiver by reviewing historic data pulled from the Medicaid Management Information System (MMIS). The Department chose to trend ALOS on half of the growth in ALOS from FY 2010-11 to FY 2012-13. This is a conservative approach to predicting ALOS as the Children with Life Limiting Illnesses (CLLI) Waiver ALOS varies quite a bit year-to-year.

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 utilizing 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. For services that are new to the waiver, the Department chose similar percent of total utilization and utilization patterns to that of the same services on pediatric hospice waivers in North Dakota and California.

- 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 the CLLI Waiver, the used historic Factor D' data. The Department chose the average growth in cost per utilizer from FY 2011-12 to FY 2012-13, 2.10%. The Department believes this to be the most appropriate trend given current utilization patterns of state plan services for the disabled to 59 (AND/AB) eligibility type.

This waiver may serve dual clients. The costs used for estimating and for 372 reporting are actual costs incurred. If a client is receiving coverage for Medicare part D then those prescription drug costs are not included.

- 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 hospital costs, the Department examined utilization and average per user hospital costs. The Department trended expenditure using the average growth in hospital per capita cost from FY 2010-11 to FY 2012-13, 5.30%. The Department believes this methodology to be most consistent across various reports.

- 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 hospital level of care clients, the Department reviewed CLLI historical Factor G' data and chose 6.22% which is the average growth in Factor G' from FY 2010-11 to FY 2012-13. The Department believes this trend to be most appropriate to forecast G' as it mirrors total growth in acute care costs for the selected population.

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	
Respite Care	
Bereavement Counseling	
Expressive Therapy	
Massage Therapy	
Palliative/Supportive Care services	
Therapeutic Life Limiting Illness Support: Individual Counseling, Family Counseling, Group Counseling	

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
Respite Care Total:						202008.48
Respite Care Skilled RN/LPN up to 4 Hour Visit	15 minutes	7	178.00	15.31	19076.26	
Respite Care Unskilled per Day	Day	18	4.00	75.68	5448.96	
Respite Care Unskilled up to 4 Hour Visit	15 minutes	6	509.00	5.37	16399.98	
Respite Care Skilled CNA per Day	Day	42	14.00	125.10	73558.80	
GRAND TOTAL:						1150735.77
Total Estimated Unduplicated Participants:						200
Factor D (Divide total by number of participants):						5753.68
Average Length of Stay on the Waiver:						204

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Care Skilled CNA up to 4 Hour Visit	15 minutes	8	178.00	5.37	7646.88	
Respite Care Skilled RN/LPN per Day	Day	29	10.00	275.44	79877.60	
Bereavement Counseling Total:						9999.00
Bereavement Counseling	Lump Sum	9	1.00	1111.00	9999.00	
Expressive Therapy Total:						51513.00
Music Therapy Individual	15 minutes	48	30.00	15.80	22752.00	
Art and Play Therapy Group	15 minutes	5	18.00	8.84	795.60	
Art and Play Therapy Individual	15 minutes	48	36.00	15.80	27302.40	
Music Therapy Group	15 minutes	5	15.00	8.84	663.00	
Massage Therapy Total:						21103.11
Massage Therapy	15 minutes	19	63.00	17.63	21103.11	
Palliative/Supportive Care services Total:						684356.04
Pain and Symptom Management	Hour	70	18.00	96.63	121753.80	
Care Coordination	15 minutes	146	192.00	20.07	562602.24	
Therapeutic Life Limiting Illness Support: Individual Counseling, Family Counseling, Group Counseling Total:						181756.14
Individual Therapeutic End of Life Support per 15 minute Visit	15 minutes	53	51.00	24.53	66304.59	
Family Therapeutic End of Life Support per 15 minute Visit	15 minutes	117	40.00	24.53	114800.40	
Group Therapeutic End of Life Support per 15 minute Visit	15 minutes	5	9.00	14.47	651.15	
GRAND TOTAL:					1150735.77	
Total Estimated Unduplicated Participants:					200	
Factor D (Divide total by number of participants):					5753.68	
Average Length of Stay on the Waiver:						204

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
Respite Care Total:						234036.44
Respite Care Skilled RN/LPN up to 4 Hour Visit	15 minutes	32	192.00	15.31	94064.64	
Respite Care Unskilled per Day	Day	20	6.00	75.68	9081.60	
Respite Care Unskilled up to 4 Hour Visit	15 minutes	6	530.00	5.37	17076.60	
Respite Care Skilled CNA per Day	Day	46	14.00	125.10	80564.40	
Respite Care Skilled CNA up to 4 Hour Visit	15 minutes	9	178.00	7.00	11214.00	
Respite Care Skilled RN/LPN per Day	Day	8	10.00	275.44	22035.20	
Bereavement Counseling Total:						9999.00
Bereavement Counseling	Lump Sum	9	1.00	1111.00	9999.00	
Expressive Therapy Total:						57018.72
Music Therapy Individual	15 minutes	53	30.00	15.80	25122.00	
Art and Play Therapy Group	15 minutes	6	18.00	8.84	954.72	
Art and Play Therapy Individual	15 minutes	53	36.00	15.80	30146.40	
Music Therapy Group	15 minutes	6	15.00	8.84	795.60	
Massage Therapy Total:						23324.49
Massage Therapy	15 minutes	21	63.00	17.63	23324.49	
Palliative/Supportive Care services Total:						765626.97
Pain and Symptom Management	Hour	77	19.00	96.63	141369.69	
Care Coordination	15 minutes	162	192.00	20.07	624257.28	
Therapeutic Life Limiting Illness Support: Individual Counseling, Family Counseling, Group Counseling Total:						227406.47
GRAND TOTAL:						1317412.09
Total Estimated Unduplicated Participants:						222
Factor D (Divide total by number of participants):						5934.29
Average Length of Stay on the Waiver:						208

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Individual Therapeutic End of Life Support per 15 minute Visit	15 minutes	58	63.00	24.53	89632.62	
Family Therapeutic End of Life Support per 15 minute Visit	15 minutes	130	43.00	24.53	137122.70	
Group Therapeutic End of Life Support per 15 minute Visit	15 minutes	5	9.00	14.47	651.15	
GRAND TOTAL:					1317412.09	
Total Estimated Unduplicated Participants:					222	
Factor D (Divide total by number of participants):					5934.29	
Average Length of Stay on the Waiver:						208

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
Respite Care Total:						259531.29
Respite Care Skilled RN/LPN up to 4 Hour Visit	15 minutes	9	207.00	15.31	28522.53	
Respite Care Unskilled per Day	Day	22	8.00	75.68	13319.68	
Respite Care Unskilled up to 4 Hour Visit	15 minutes	7	552.00	5.37	20749.68	
Respite Care Skilled CNA per Day	Day	51	14.00	125.10	89321.40	
Respite Care Skilled CNA up to 4 Hour Visit	15 minutes	9	178.00	7.00	11214.00	
Respite Care Skilled RN/LPN per Day	Day	35	10.00	275.44	96404.00	
Bereavement Counseling Total:						11110.00
Bereavement Counseling	Lump Sum	10	1.00	1111.00	11110.00	
Expressive Therapy Total:						63275.52
Music Therapy Individual	15 minutes	59	30.00	15.80	27966.00	
GRAND TOTAL:					1510453.00	
Total Estimated Unduplicated Participants:					246	
Factor D (Divide total by number of participants):					6140.00	
Average Length of Stay on the Waiver:						212

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Art and Play Therapy Group	15 minutes	6	18.00	8.84	954.72	
Art and Play Therapy Individual	15 minutes	59	36.00	15.80	33559.20	
Music Therapy Group	15 minutes	6	15.00	8.84	795.60	
Massage Therapy Total:						25545.87
Massage Therapy	15 minutes	23	63.00	17.63	25545.87	
Palliative/Supportive Care services Total:						859822.80
Pain and Symptom Management	Hour	86	20.00	96.63	166203.60	
Care Coordination	15 minutes	180	192.00	20.07	693619.20	
Therapeutic Life Limiting Illness Support: Individual Counseling, Family Counseling, Group Counseling Total:						291167.52
Individual Therapeutic End of Life Support per 15 minute Visit	15 minutes	65	78.00	24.53	124367.10	
Family Therapeutic End of Life Support per 15 minute Visit	15 minutes	144	47.00	24.53	166019.04	
Group Therapeutic End of Life Support per 15 minute Visit	15 minutes	6	9.00	14.47	781.38	
GRAND TOTAL:					1510453.00	
Total Estimated Unduplicated Participants:					246	
Factor D (Divide total by number of participants):					6140.00	
Average Length of Stay on the Waiver:						212

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
Respite Care Total:						298687.32
GRAND TOTAL:					1739849.79	
Total Estimated Unduplicated Participants:					272	
Factor D (Divide total by number of participants):					6396.51	
Average Length of Stay on the Waiver:						217

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Care Skilled RN/LPN up to 4 Hour Visit	15 minutes	10	224.00	15.31	34294.40	
Respite Care Unskilled per Day	Day	24	11.00	75.68	19979.52	
Respite Care Unskilled up to 4 Hour Visit	15 minutes	8	575.00	5.37	24702.00	
Respite Care Skilled CNA per Day	Day	57	14.00	125.10	99829.80	
Respite Care Skilled CNA up to 4 Hour Visit	15 minutes	10	178.00	7.00	12460.00	
Respite Care Skilled RN/LPN per Day	Day	39	10.00	275.44	107421.60	
Bereavement Counseling Total:						13332.00
Bereavement Counseling	Lump Sum	12	1.00	1111.00	13332.00	
Expressive Therapy Total:						69824.04
Music Therapy Individual	15 minutes	65	30.00	15.80	30810.00	
Art and Play Therapy Group	15 minutes	7	18.00	8.84	1113.84	
Art and Play Therapy Individual	15 minutes	65	36.00	15.80	36972.00	
Music Therapy Group	15 minutes	7	15.00	8.84	928.20	
Massage Therapy Total:						27767.25
Massage Therapy	15 minutes	25	63.00	17.63	27767.25	
Palliative/Supportive Care services Total:						959611.41
Pain and Symptom Management	Hour	95	21.00	96.63	192776.85	
Care Coordination	15 minutes	199	192.00	20.07	766834.56	
Therapeutic Life Limiting Illness Support: Individual Counseling, Family Counseling, Group Counseling Total:						370627.77
Individual Therapeutic End of Life Support per 15 minute Visit	15 minutes	72	96.00	24.53	169551.36	
Family Therapeutic End of Life Support per 15 minute Visit	15 minutes	160	51.00	24.53	200164.80	
	15 minutes				911.61	
GRAND TOTAL:					1739849.79	
Total Estimated Unduplicated Participants:					272	
Factor D (Divide total by number of participants):					6396.51	
Average Length of Stay on the Waiver:					217	

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Group Therapeutic End of Life Support per 15 minute Visit		7	9.00	14.47		
GRAND TOTAL:						1739849.79
Total Estimated Unduplicated Participants:						272
Factor D (Divide total by number of participants):						6396.51
Average Length of Stay on the Waiver:						217

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
Respite Care Total:						340868.06
Respite Care Skilled RN/LPN up to 4 Hour Visit	15 minutes	11	242.00	15.31	40755.22	
Respite Care Unskilled per Day	Day	27	15.00	75.68	30650.40	
Respite Care Unskilled up to 4 Hour Visit	15 minutes	8	599.00	5.37	25733.04	
Respite Care Skilled CNA per Day	Day	63	14.00	125.10	110338.20	
Respite Care Skilled CNA up to 4 Hour Visit	15 minutes	12	178.00	7.00	14952.00	
Respite Care Skilled RN/LPN per Day	Day	43	10.00	275.44	118439.20	
Bereavement Counseling Total:						14443.00
Bereavement Counseling	Lump Sum	13	1.00	1111.00	14443.00	
Expressive Therapy Total:						77415.36
Music Therapy Individual	15 minutes	72	30.00	15.80	34128.00	
Art and Play Therapy Group	15 minutes	8	18.00	8.84	1272.96	
Art and Play Therapy Individual	15 minutes	72	36.00	15.80	40953.60	
GRAND TOTAL:						2005115.53
Total Estimated Unduplicated Participants:						301
Factor D (Divide total by number of participants):						6661.51
Average Length of Stay on the Waiver:						222

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Music Therapy Group	15 minutes	8	15.00	8.84	1060.80	
Massage Therapy Total:						31099.32
Massage Therapy	15 minutes	28	63.00	17.63	31099.32	
Palliative/Supportive Care services Total:						1070972.10
Pain and Symptom Management	Hour	105	22.00	96.63	223215.30	
Care Coordination	15 minutes	220	192.00	20.07	847756.80	
Therapeutic Life Limiting Illness Support: Individual Counseling, Family Counseling, Group Counseling Total:						470317.69
Individual Therapeutic End of Life Support per 15 minute Visit	15 minutes	79	119.00	24.53	230606.53	
Family Therapeutic End of Life Support per 15 minute Visit	15 minutes	177	55.00	24.53	238799.55	
Group Therapeutic End of Life Support per 15 minute Visit	15 minutes	7	9.00	14.47	911.61	
GRAND TOTAL:					2005115.53	
Total Estimated Unduplicated Participants:					301	
Factor D (Divide total by number of participants):					6661.51	
Average Length of Stay on the Waiver:						222