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:
There are no changes to services in this renewal application for the Home and Community Based Services (HCBS)-Developmental Disabilities (DD) Waiver. Language changes have been made to reflect the move of the Division for Developmental Disabilities (DDD) out of the Colorado Department for Human Services (CDHS) to the Department of Health Care and Policy Financing (HCPF) and the change of name for the DDD to the Division for Intellectual and Developmental Disabilities (DIDD). Additionally, minor changes to the language through out this renewal application were made to correct spelling, punctuation, grammatical, and syntax errors. Rule reference numbers were updated where applicable.

The sections on Quality Improvement Strategy and Performance Measures have been revised to reflect changes to Waiver Assurances required by the Centers for Medicaid and Medicare (CMS).

In Appendix B 3a the unduplicated number of participants is significantly higher than the counts in the Waiver Year 5 of the previous waiver. The State received an increase in appropriations which enable the State to serve more people in the HCBS -DD waiver.

In Appendix C, Section C-1 Summary of Services, Supported Employment Provider Specifications the requirement for an approved Supported Employment training course was removed.

The Colorado General Assembly approved a 2.5% rate increase effective July 2014, this rate increase is reflected in the calculations in Appendix J.

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*):
Developmental Disabilities (HCBS-DD)

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.0007
Waiver Number:CO.0007.R07.00
Draft ID: CO.11.07.00

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

Regular Waiver

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

07/01/14

Approved Effective Date: 07/01/14

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**
If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

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

☐ **Nursing Facility**

Select applicable level of care

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

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

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

1. Request Information (3 of 3)

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

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

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

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

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

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

- ☐ **§1915(b)(1) (mandated enrollment to managed care)**
- ☐ **§1915(b)(2) (central broker)**
- ☐ **§1915(b)(3) (employ cost savings to furnish additional services)**
- ☐ **§1915(b)(4) (selective contracting/limit number of providers)**

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

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

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

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

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

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
The purpose of the HCBS-DD waiver is to provide services and/or supports to individuals with intellectual and developmental disabilities who are in need of services and supports 24 hours a day that will allow them to live safely and particpate in the community.

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

·Residential habilitation
·Supported employment
·Prevocational Services
·Day habilitation (facility based and non-facility based)
·Transportation services to and from day program
·Specialized medical equipment and supplies
·Behavioral services
·Dental services
·Vision services.

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

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

The Department contracts with non-state entities called Community Centered Boards (CCBs) who provide a statewide

network of case management agencies for individuals enrolled in the HCBS-DD waiver. Case Managers assist the participant in identifying, through a participant-centered service planning process, those services and supports needed to maintain them in their communities.

3. Components of the Waiver Request

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

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

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

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

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

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

- ○ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ◉ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

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

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

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

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

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

4. Waiver(s) Requested

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

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

- ○ **Not Applicable**
- ◉ **No**
- ○ **Yes**

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

- ◉ **No**
- ○ **Yes**

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

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

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

5. Assurances

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

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

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

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

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

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

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

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

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

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

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

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

I. **Public Input.** Describe how the State secures public input into the development of the waiver:
2014 Waiver renewal:

The Department of Health Care Policy and Financing (The Department) notified in writing the Tribal Governments on 10/31/13 that maintain a primary office and/or majority population in the State. These Tribal Governments include the Ute Mountain Ute Tribe and the Southern Ute Tribe. Evidence of each notice is available through the Department.

The Department consulted with the Medical Advisory Community on August 28, 2013.

Public comment: The public was able to submit input by email, phone, letter, and fax. The comment period was open from January 15, 2014 through February 14, 2014.

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:

Thompson

First Name:

Lori

Title: Assistant Director for Program Services

Agency: Division for Intellectual and Developmental Disabilities

Address: 1570 Grant Street

Address 2:

City: Denver

State: **Colorado**

Zip: 80203

Phone: (303) 866-5142 **Ext:** ☐ **TTY**

Fax: (303) 866-2573

E-mail: lori.thompson@state.co.us

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Colorado**

Zip:

Phone: **Ext:** ☐ **TTY**

Fax:

E-mail:

8. Authorizing Signature

This document, together with 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: Lori Thompson

State Medicaid Director or Designee

Submission Date: Jul 7, 2014

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

Last Name: Brennan

First Name: Suzanne

Title: Medicaid Director

Agency: Department of Health Care Policy and Financing

Address: 1570 Grant

Address 2:

City: Denver

State: **Colorado**

Zip: 80203

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

Fax: (303) 866-2573

E-mail:
suzanne.brennan@state.co.us

Attachments

Attachment #1: Transition Plan

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.

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:

   (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.
The Office of Community Living, The Division for Intellectual and Developmental Disabilities
(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:
   (a) The Division for Intellectual and Developmental Disabilities (DIDD) is responsible for the design, implementation, and administration of all activities associated with this waiver.

   (b) The Department maintains regulations, organizational charts, and individual position descriptions and performance plans that describe the roles and responsibilities related to this waiver program. The waiver application also serves as the authoritative document used to designate the persons and positions responsible for the ensuring waiver requirements are met.

   (c) The designated State Medicaid Director and his/her designee are ultimately responsible for the administration of this waiver and must approve all waiver amendment, renewal, or new waiver applications prior to their submission and implementation.

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

Appendix A: Waiver Administration and Operation

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

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

The Department of Health Care Policy and Financing (the Department) maintains an Interagency Agreement with the Colorado Department of Public Health and Environment (CDPHE) to perform quality assurance and quality improvement activities. This agreement allows CDPHE to survey and investigate complaints against Residential, Day Habilitation, Prevocational, Supported Employment, and Non-Medical Transportation HCBS providers.

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:

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

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

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

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.**Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
The Department of Health Care Policy and Financing is responsible for assessing the performance of the Community Centered Boards (CCB)in conducting waiver operational and administrative functions.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
The Department of Health Care Policy and Financing (The Department) provides on-going oversight of the Interagency Agreement with the Colorado Department of Public Health and Environment (CDPHE) through monthly meetings and reports. Issues that impact the agreement, problems discovered at specific agencies or widespread issues and solutions are discussed. In addition, the Department is provided with monthly and annual reports detailing the number of agencies that have been surveyed, the number of agencies that have deficiencies, the number of complaints received, complaints investigated, and complaints that have been substantiated. The Interagency Agreement between the Department and CDPHE requires that all complaints be investigated and reported to the Department. By gathering this information the Department is able to develop strategies to resolve issues that have been identified. Further information about the relationship between CDPHE and the Department is provided in Appendix G of the waiver application.

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

The administrative evaluation is used to monitor compliance with agency operations and functions as outlined in waiver and department contract requirements. The Department reviews documents used by the CCBs during the administrative evaluation. These documents include: job descriptions (to assure appropriateness of qualifications), release of information forms, prior authorization forms, complaint logs and procedures, service provider choice forms, tracking worksheets and/or databases, agency case review tool, professional medical information (to assure licensed medical professional completion, and all other pertinent client signature pages including intake forms and service plan agreements. The administrative review also evaluates agency specific resource development plans, community advisory activity, and provider or other community service coordination. Should the monitors find that a CCB is not in compliance with policy or regulations the agency is required to take corrective action. Technical assistance is provided to CCBs in person or via phone and e-mail. The Department conducts follow-up monitoring to assure corrective action implementation and ongoing compliance. If a compliance issue extends to multiple CCBs, the Department provides clarification through Dear Administrator Letters (DALs), formal training, or both.

The programmatic evaluation consists of a desk audit using a standardized tool in conjunction with the Benefits Utilization System (BUS) to audit client files and assure that all components of the CCB contract have been performed according to necessary waiver requirements. The BUS is an electronic record used by each CCB to maintain waiver participant specific data. Data includes: participant referrals, screening, Level of Care (LOC) assessments, individualized service plans, case notes, reassessment documentation, and all other case management activities. Additionally, the BUS is used to track and evaluate timelines for assessments, reassessments, and notice of action requirements to assure that processes are completed according to Department prescribed schedules. The Department reviews a sample of participant files to measure 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 Department oversees the fiscal agent operating the Medicaid Management Information System (MMIS). The fiscal agent is required to submit weekly reports to the Department on meeting performance standards as established in the contract. The reports include summary data on timely and accurate coding, claims submission, and claims reimbursement, time frames for completion of data entry, processing of claims and Prior Authorizations. The Department monitors the fiscal agent's compliance with Service Level Agreements through reports submitted by the fiscal agent on customer service activities included provider enrollment, provider publication, and provider training. The Department is able to request ad hoc reports as needed to monitor any additional issues or concerns.

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

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.**In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function.All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the 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 Case Management Agencies (CMAs) that performed delegated functions as identified in the Administrative Tool. Numerator: Number of CMAs that performed delegated functions as identified in the Administrative Tool. Denominator: Total number of CMAs serving waiver participants.

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of data reports as specified in the Interagency AGreement (IA) with the Colorado Department of Public Health and Environment (CDPHE). 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):
Other
If 'Other' is selected, specify:
Reports to the Department

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of CMAs determined to have met all contractural obligations by on-site monitoring visits by the Department during the perfromance period, based on a four year cycle. Numerator: Number of CMAs determined to have met all contractual obligations. Denominator: Number of CMAs expected to be reviewed during the performance period.

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

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

Data Aggregation and Analysis:

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

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 CMA evaluations as a primary method of discovery and reports from the Colorado Department of Public Health & Environment. The Administrative Tool used to evaluate CMA operations provides for reportable data to be used in the Department. The Department also monitors the report generated by its fiscal agent in order to track and trend claims.

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.
In accordance with the State Operations Manual, the Department maintains an interagency agreement with the Department of Public Health and Environment (CDPHE) to manage aspects of provider qualifications, surveys and complaints/critical incidents; and contracts with the CMAs to perfrom operations, case management, utilization review and prior authorization. Delegated responsibilities of these entities are monitored, corrected and remediated by the Department.

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

If issues or problems are identified during the course of a CMA audit, Department contract managers will communicate findings directly with the CMA administrator, as well as document findings within the agency's annual report of audit findings and where needed, require a plan of correction.

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, CMA administrator) to ensure appropriate remediate has occurred.

The Department maintains administrative authority over this waiver in its contracts and provider agreements

with CMAs and waiver service providers. The Department has the access and authority to review any required documentation.

ii. **Remediation Data Aggregation**

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

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

c. **Timelines**

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☑ Intellectual Disability or Developmental Disability, or Both					
	☐	Autism			☐
	☑	Developmental Disability	18		☑
	☐	Intellectual Disability			☐
☐ Mental Illness					
	☐	Mental Illness			
	☐	Serious Emotional Disturbance			

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

"Developmental disability" means a disability that is manifested before the person reaches twenty-two years of age, that constitutes a substantial disability to the affected individual, and that is attributable to mental retardation or related conditions which include cerebral palsy, epilepsy, autism, or other neurological conditions when those conditions result in impairment of general intellectual functioning or adaptive behavior similar to that of a person with mental retardation. Unless otherwise specifically stated, the federal definition of "developmental disability" found in 42 U.S.C. sec. 15001 et seq. shall not apply. (C.R.S. 27-10.5-102 11 (a), as amended).

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

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Specify the percentage:

Other

Specify:

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

Cost Limit Lower Than Institutional Costs. The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

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

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

The following dollar amount:

Specify dollar amount:

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	4818
Year 2	4843
Year 3	4868
Year 4	4893
Year 5	4918

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	4695
Year 2	4695
Year 3	4695
Year 4	4695
Year 5	4695

Appendix B: Participant Access and Eligibility

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

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

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

Purpose(s) the State reserves capacity for:

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

Appendix B: Participant Access and Eligibility

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

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

18-21 Transition

Purpose *(describe):*

Positions are made available for children who age out of foster care or the HCBS-Children's Extensive Supports Waiver in order to continue access to services without interruption that will allow them to continue living safely in the community.

Describe how the amount of reserved capacity was determined:

The number of positions reserved is based on the average number actual transitions over the last three waiver years.

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

Waiver Year	Capacity Reserved
Year 1	55
Year 2	55
Year 3	

Waiver Year	Capacity Reserved
	55
Year 4 (renewal only)	55
Year 5 (renewal only)	55

Appendix B: Participant Access and Eligibility

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

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

Emergency

Purpose *(describe):*

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

Describe how the amount of reserved capacity was determined:

The amount of reserve capacity was determined by taking an average of the annual emergency enrollments authorized during the last five fiscal years.

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

Waiver Year	Capacity Reserved
Year 1	40
Year 2	40
Year 3	40
Year 4 (renewal only)	40
Year 5 (renewal only)	40

Appendix B: Participant Access and Eligibility

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

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

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

Purpose *(describe):*

Positions are made available for individuals transitioning from an institutional setting to community services through the Money Follows the Person Grant referred to as Colorado Choice Transitions (CCT) and other deinstitutionalization requests. Institutions include skilled nursing facilities, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IDD) and Mental Health Institutes.

Describe how the amount of reserved capacity was determined:

The amount of reserve capacity for deinstitutionalization is determined by the number of individuals identified as requesting community placement.

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

Waiver Year	Capacity Reserved
Year 1	30
Year 2	30
Year 3	30
Year 4 (renewal only)	30
Year 5 (renewal only)	30

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

- (●) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

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

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

The Division for Intellectual and Developmental Disabilities (DIDD), acting as the Operating Agency for the HCBS-DD waiver, oversees the statewide allocation and management of waiver capacity for the HCBS-DD waiver. Waiting lists are administered in accordance with Health Care and Policy Financing (HCPF) rules set forth at 10 CCR 2505-10 8.500.7 and Department of Human Services (DHS)/DIDD Management of Waitlist guidelines. The guidelines apply to all persons, children and adults, who would receive services through the Community Centered Board (CCB).

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

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

Reserve Capacity:

1.Individuals transitioning from foster care placement.

2.Deinstitutionalization
3.Individuals who meet the high risk criteria or have emergency needs

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

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - (●) **§1634 State**
   - ( ) **SSI Criteria State**
   - ( ) **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - ( ) **No**
   - (●) **Yes**

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

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

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

  Select one:

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

  Specify percentage:

- [ ] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- [ ] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- [ ] **Medically needy in 209(b) States (42 CFR §435.330)**

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

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

Specify:

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

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

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

Select one and complete Appendix B-5.

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

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

Check each that applies:

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

Select one:

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

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

Specify percentage:

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

Specify dollar amount:

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

☐ **Medically needy without 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 4)

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 State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

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 *(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 4)

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

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

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

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

  Select one:

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

    (*select one*):

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

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

Specify dollar amount:

A percentage of the Federal poverty level

Specify percentage:

Other standard included under the State Plan

Specify:

The following dollar amount

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

The following formula is used to determine the needs allowance:

Specify:

Other

Specify:

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

Not Applicable

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

Specify:

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

SSI standard

Optional State supplement standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

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

Not Applicable (see instructions)

AFDC need standard

- **Medically needy income standard**
- **The following dollar amount:**

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

  Specify:
- **Other**

  Specify:

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

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

Select one:

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

  Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 4)

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 4)

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

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly

income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):

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

  Specify percentage:

- ○ **The following dollar amount:**

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

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

  Specify formula:

- ○ **Other**

  Specify:

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

Select one:

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

  Explanation of difference:

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

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

Select one:

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

Appendix B: Participant Access and Eligibility

B-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:

Community Centered Boards (CCB)

- ○ **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:

CCBs employ staff to conduct the level of care evaluations. Staff is required to have:

A Bachelor's level degree of education, or five (5) years of experience in the field of developmental disabilities, or some combination of education and experience appropriate to the requirements of the position.

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 CCB case manager uses the Uniform Long-Term Care functional needs assessment form, also known as the ULTC-100.2, to determine an individual's institutional level of care need, along with the Professional Medical Information Page (PMIP.) Regulations for the use of the ULTC 100.2 and PMIP, are set forth at 2505-10 CCR, §8.401. To qualify for services, an individual must demonstrate deficits in 2 of 6 Activities of Daily Living (ADL) or require at least moderate assistance in Behaviors or Memory/Cognition under Supervision. The ADLs include bathing, dressing, toileting, mobility, transferring, and eating. An individual is also required to be determined in need of long term care by a medical professional that will attest to the fact that without long term care services, the individual would need care in an institution. Copies of the ULTC 100.2 form and the laws, regulations, policies concerning the level of care criteria are available to the Centers for Medicare and Medicaid Services (CMS) upon request.

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

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

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

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

The case manager performs a face to face assessment of the participant's abilities to perform activities of daily living and need for supervision due to behavioral, memory or cognitive issues. Case managers are required to complete a participant assessment within twelve months of the previous assessment. A re-assessment may be completed sooner if the participant's condition changes, if required by program criteria, or if requested by the participant or the participant's guardian. The assessment is conducted at the individual's place of residence through observation, participant and collateral interviews (e.g. family, legal guardian and natural supports). The participant's primary care provider and medical professionals may also provide information.

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

- ( ) **Every three months**
- ( ) **Every six months**
- (●) **Every twelve months**
- ( ) **Other schedule**

Specify the other schedule:

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

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

Specify the qualifications:

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

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

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

CCBs maintain the evaluation/re-evaluation records in the BUS. The Department electronically accesses the documentation through the BUS for the purpose of monitoring.

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 a 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)

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
This sub-assurance has been removed from HCBS waiver requirements by the Centers for Medicare and Medicaid Services (CMS). The state continues to conduct annual level of care re-evaluations as part of its Quality Improvement Strategy.

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of new waiver participants assessed with the ULTC assessment tool prior to receiving waiver services. Numerator: Number of new waiver participants receiving waiver services that were assessed with the ULTC assessment tool. Denominator: Total number of new waiver participants receiving waiver services.

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of cases in a representative sample in which the ULTC 100.2 Tool was applied appropriately. Numerator: Number of cases in a representative sample in which the ULTC 100.2 Tool was applied appropriately Denominator: Total number of clients reviewed in 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):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = + or - 5%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The Department uses data from the Benefits Utilization System (BUS) as its primary method for discovery.

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 responsiblity to 20 Case Management Agencies (CMAs) to perform waiver functions including case management, utilization review and prior authorization.

If complaints are raised by the waiver participant 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 participant to resolve the complaint. This complaint log comes to the Department on a quarterly basis. The department is then able to review the log and note trends to discern if further remediation by the Department is necessary.

In addition to being available to the participant as needed, case managers are required to contact participants quarterly and inquire about the quality of services participants 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 participant may also contact the case manager's supervisor or the Department if they do not feel comfortble contacting the case manager directly. The contact information for the case manager's supervisor, the CMA administrator, and the Department are included on the copy of the service plan that is provided to the participant. The participant also has the option of lodging an anonymous complaint to the case manger, CMA, or the Department.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

   The Community Centered Board (CCB) case manager informs the individual, the family, the guardian and/or authorized representative, of the feasible alternatives available under the waiver and provides the choice of institutional or community based services. Information is provided during the initial assessment, the Service Plan development process and during the annual re-evaluation on alternatives for service delivery, including choice of types of services available through the waiver and among qualified providers. The case manager documents that the choice was offered in the Service Plan on the Business Utilization System (BUS).

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

   A hard copy of the current Choice Form is maintained in the master record of each individual at the case management agency's office. Freedom of Choice is documented in the Benefits Utilization System (BUS).

Appendix B: Participant Access and Eligibility

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

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
The Community Centered Board (CCB) agencies employ several methods to assure meaningful access to waiver services by Limited English Proficiency persons. The CCB agencies either employ or have access to Spanish and other language speaking persons to provide translation to participants. Documents include a written statement in Spanish instructing participants how to obtain assistance with translation. For languages where there are no staff who can translate on site, translation occurs by first attempting to have a family member translate, or aligning with specific language or ethnic centers such as the Asian/Pacific Center, or by using the Language Line available through the American Telephone & Telegram.

Appendix C: Participant Services

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

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

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

Service Type	Service		
Statutory Service	Supported Employment		
Extended State Plan Service	Dental Services		
Extended State Plan Service	Vision Services		
Other Service	Behavioral Services		
Other Service	Non Medical Transportation		
Other Service	Specialized Medical Equipment and Supplies		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04020 day habilitation
Category 2:	**Sub-Category 2:**
04 Day Services	04070 community integration
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 **:**

- (selected) **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)*:

Day Habilitation includes assistance with acquisition, retention or improvement in self-help, socialization and adaptive skills that takes place in a non-residential setting, separate from the participant's private residence or other residential living arrangement, except for the occasion of extreme medical and/or safety needs. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. These services are individually coordinated through the participant's Service Plan. Day

Habilitation Services and Supports encompass two types of habilitative environments: Specialized Habilitation (SH) and Supported Community Connections (SCC). Day Habilitation Sevices does not include sheltered workshops.

Specialized Habilitation (SH) services focus on enabling the participant to attain his or her maximum functional level or to be supported in such a manner to allow the person to gain an increased level of self-sufficiency. These services are generally provided in non-integrated settings where a majority of the persons have a disability, such as program sites. Such services include assistance with self-feeding, toileting, self-care, sensory stimulation and integration, self-sufficiency, maintenance skills, and supervision. Specialized habilitation services may serve to reinforce skills or lessons taught in school, therapy or other settings and, where appropriate, are coordinated with any physical, occupational, or speech therapies listed in the Service Plan. Day habilitation does not include sheltered workshop activities.

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

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

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

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

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Centered Board (CCB)/ Organized Health Care Delivery System (OHCDS)
Agency	Program Approved Service Agency (approved by the Department of Health Care Policy and Financing): Supported Community Connections
Agency	Program Approved Service Agency (approved by the Department of Health Care Policy and Financing): Specialized Habilitation

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:
Agency
Provider Type:
Community Centered Board (CCB)/ Organized Health Care Delivery System (OHCDS)
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
The Department of Health Care Policy and Financing Program Approval
Other Standard *(specify):*
DHS/DDD Rules: 2-CCR-503-1 § 16.221 B; CDHCPF Rules: 10CCR 2505-10 § 8.500.5

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

an Associates Degree from an Accredited college and two years of successful experience in human services;

or four years successful experience in human services.

Direct Care Staff: Be at least 18 years of age, have the ability to communicate effectively, be able to complete required forms and reports, and be able to follow verbal and written instructions. Have the ability to provide services in accordance with an Individual Services and Support Plan (ISSP). Have completed minimum training based on State training guidelines. Have necessary ability to perform the required job tasks and have the interpersonal skills needed to effectively interact with persons with developmental disabilities.
Verification of Provider Qualifications
Entity Responsible for Verification:
The Department of Health Care Policy Financing
Frequency of Verification:
Initially and every three years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:
Agency
Provider Type:
Program Approved Service Agency (approved by the Department of Health Care Policy and Financing): Supported Community Connections
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
The Department of Health Care Policy and Financing Program Approval
Other Standard *(specify):*
DDD Rules: 2-CCR-503-1 16.221 B; CDHCPF Rules: 10CCR 2505-10 § 8.500.5
Program Management: Baccalaureate or higher degree from an accredited college or university in the area of Education, Social Work, Psychology, or related field, and one year of successful experience in human services; or an Associates degree from an accredited college and two years of

successful experience in human services; or four years successful experience in human services.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy and Financing

Frequency of Verification:

Initially and every three years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:

Agency

Provider Type:

Program Approved Service Agency (approved by the Department of Health Care Policy and Financing): Specialized Habilitation

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

The Department of Health Care Policy and Financing Program Approval

Other Standard *(specify):*

DDD Rules: 2-CCR-503-1 16.221 B; CDHCPF Rules: 10CCR 2505-10 § 8.500.5

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy and Financing

Frequency of Verification:

Initially and every 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Prevocational Services

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

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

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

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

- (selected) **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):*

Prevocational Services prepare a participant for paid community employment. Services include teaching such concepts as following directions, attendance, task completion, problem solving, and safety that are associated with performing compensated work. Services are identified in the participant's Service Plan and are directed to habilitative rather than explicit employment objectives. Services are provided in a variety of locations separate from the participant's private residence or other residential living arrangement. Participants are compensated in accordance with applicable federal laws and regulations. Prevocational services can be differentiated from Supported Employment services by using the following criteria:

1) Compensation is paid at less than 50 percent of the minimum wage (agencies that pay less than minimum wage shall ensure compliance with department of labor regulations); and

2) Goals for prevocational services are general in nature and are not primarily directed at teaching job specific skills.

The intended outcome of prevocational services is to obtain paid or unpaid community employment within five years. Prevocational services may continue longer than five years when documenatation in the annual service plan demonstrates this need and the need is based on an annual assessment. A comprehensive assessment and review for each person enrolled in prevocational services shall occur at least once every five years. The purpose of this assessment and review is to determine whether or not the person has developed the skills necessary for paid or unpaid community employment.

Participants who receive prevocational services may also receive Supported Employment and/or Day Habilitation Services. A participant's Service Plan may include two or more types of day services (i.e. Day

Habilitation Services and Supports, Supported Employment or Prevocational Services), however different types of day services may not be billed during the same period of the day.
Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C 1401 et seq.).
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The number of units available for Day Habilitation Services in combination with Prevocational Services is 4800 units. When used in combination with Supported Employment Services, the total number of units available for Day Habilitation Services in combination with Prevocational Services will remain at 4800 units and the cumulative total, including Supported Employment Services, may not exceed 7112.

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

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Program Approved Service Agency (approved by the Department of Health Care Policy and Financing)
Agency	Community Centered Board (CCB)/Organized Health Care Deliver System (OHCDS)

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:
Agency
Provider Type:
Program Approved Service Agency (approved by the Department of Health Care Policy and Financing)
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
The Department of Health Care Policy and Financing Program Approval
Department of Labor Certificate
Other Standard *(specify):*
DDD Rules: 2-CCR-503-1 16.221 B; CDHCPF Rules: 10CCR 2505-10 § 8.500.5

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy and Financing

Frequency of Verification:

Initially and every 3 years.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:

Agency

Provider Type:

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

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

The Department of Health Care Policy and Financing Program Approval
Department of Labor Certificate

Other Standard *(specify):*

DHS/DDD Rules: 2-CCR-503-1 § 16.221 B; CDHCPF Rules: 10CCR 2505-10 § 8.500.5

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

an Associates Degree from an accredited college and two years of successful experience in human services; or four years successful experience in human services.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy and Financing

Frequency of Verification:

Initially and every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

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

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

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):*

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

Individual Residential Services and Supports (IRSS) in which three (3) or fewer participants receiving services may live in a single residential setting or in a host home setting. The living environment does not require state licensure. However, the Department of Health Care Policy and Financing (the Department) must approve the service agencies to provide such services. Monitoring of IRSS services to participants is the responsibility of the Community Centered Board (CCB) case managers and the monitoring of IRSS provider agencies is the responsibility of the Department. Specific requirements for case management monitoring of all providers is located at 2 CCR 503-1 16.460. The Department monitors IRSS providers on an ongoing basis and for the

purpose of provider certification, as described in Appendix H of the application.

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

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

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

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

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

The CCB is expected to review the list of qualified provider service agencies in its designated service area to verify that each agency has maintained a current program approval certification issued by the Department, and a current license from the CDPHE if licensed as a community group home for the developmental disabled. The Department and CCBs provide ongoing monitoring of all residential habilitation providers and the Department, through interagency agreement with CDPHE, is responsible for monitoring all individual and group residential service providers for certification purposes every three years. The Colorado CDPHE is responsible to monitor

each individually licensed group home every three years. There are no differences with these processes if the provider or group home is operated by the CCB or by some other agency.

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

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Program Approved Service Agencies (approved by the Department of Health Care Policy and Financing): Individual Residential Services and Supports
Agency	Program Approved Service Agencies (approved by the Department of Health Care Policy and Financing): Group Residential Services and Supports

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:
Agency

Provider Type:
Program Approved Service Agencies (approved by the Department of Health Care Policy and Financing): Individual Residential Services and Supports

Provider Qualifications

License *(specify)*:
None

Certificate *(specify)*:
The Department of Health Care Policy and Financing Program Approval

Other Standard *(specify)*:
DDD Rules: 2-CCR-503-1 16.221 B; CDHCPF Rules: 10CCR 2505-10 § 8.500.5

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy and Financing
Frequency of Verification:
Initially and every three years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:
Agency
Provider Type:
Program Approved Service Agencies (approved by the Department of Health Care Policy and Financing): Group Residential Services and Supports
Provider Qualifications
License *(specify):*
Colorado Department of Public Health and Environment (CDPHE)
Certificate *(specify):*
The Department of Health Care Policy and Financing Program Approval
Other Standard *(specify):*
DDD Rules: 2-CCR-503-1 16.221 B; CDHCPF Rules: 10CCR 2505-10 § 8.500.5

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

Direct Care Staff: Be at least 18 years of age, have the ability to communicate effectively, be able to complete required forms and reports, and be able to follow verbal and written instructions. Have the ability to provide services in accordance with an Individual Services and Support Plan (ISSP). Have completed minimum training based on State training guidelines. Have necessary ability to perform the required job tasks and have the interpersonal skills needed to effectively interact with persons with developmental disabilities.
Verification of Provider Qualifications
Entity Responsible for Verification:
Community Centered Board as the Organized Health Care Delivery System (OHCDS)
The Department of Health Care Policy and Financing (HCPF)
Colorado Department of Public Health and Environment (CDPHE)
Frequency of Verification:
Initially and every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

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

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

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

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

employment programs; or payments for training that are not directly related to an individual's supported employment program.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The number of units available for Supported Employment is 7,112 units. The limits for combined Day Habilitation Services and Supports and Prevocational Services is 4800 and when these services are used in combination with Supported Employment, the cumulative total cannot exceed 7,112 units. This number of units is the equivalent of 1,778 hours of service per year or on average 7 hours a day for 254 service days.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:
Agency
Provider Type:
Program Approved Service Agency: Supported Employment
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
The Department of Health Care Policy and Financing Program Approval
Other Standard *(specify):*
DDD Rules: 2-CCR-503-1 16.246; CDHCPF Rules: 10CCR 2505-10 § 8.500.5

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

Employment Consultant/Job Coach: Same requirements listed under Residential and Day Program Direct Care.

Verification of Provider Qualifications
Entity Responsible for Verification:
The Department of Health Care Policy and Financing
Frequency of Verification:
Initially and every three years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:
Agency
Provider Type:
Community Centered Board (CCB)/ Organized Health Care Delivery System (OHCDS)
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
The Department of Health Care Policy and Financing (the Department) Program Approval
Other Standard *(specify):*
DDD Rules: 2-CCR-503-1 16.246; CDHCPF Rules: 10CCR 2505-10 § 8.500.5

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

Employment Consultant/Job Coach: Same requirements listed under Residential and Day Program Direct Care.
Verification of Provider Qualifications
Entity Responsible for Verification:
The Department
Frequency of Verification:
Initially and every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Extended State Plan Service
Service Title:
Dental 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):*
Dental services through the waiver are available to participants age 21 and over. Covered Dental Services are for diagnostic and preventative care to abate tooth decay, restore dental health, and are medically appropriate. Services include preventative, basic, and major services. These dental services require prior authorization at the local Community Centered Board (CCB) level pursuant to the Prior Authorization Request (PAR) Process.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Dental services under the waiver are provided only when the services are not available through the Medicaid State Plan due or through a third party. Dental Services under the waiver are not available to a client eligible for Earily and Periodic Screening Diagnositic and Treatment (EPSDT) services. General limitations to dental services (i.e. frequency) will follow the Department Guidelines using industry standards and are limited to the most cost effective and efficient means to alleviate or rectify the dental issues associated with the individual. Implants are not a covered service for participants who smoke daily due to substantiated increased rate of implant failures for chronic smokers. Subsequent implants are not a covered service when prior implants fail. Full mouth implants and/or full mouth crowns are not covered. Services not covered under the waiver Dental Services include, but are not limited to: cosmetic dentistry, orthodontia, emergency extractions, intraveneous sedation, general anesthesia and hospital fees. Cosmetic dentistry is defined as aesthetic treatments designed to improve the appearance of the teeth and/or smile (e.g. whitening, contouring, veneers).

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

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

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

Provider Category:
Individual
Provider Type:
Dental Hygienist/ Assistant
Provider Qualifications
License *(specify)*:
Per State Board of Dental Examiners
Certificate *(specify)*:

Other Standard *(specify)*:
C.R.S. 12-35-101 et. esq.3 CCR 709.1: Colorado Board of Dental Examiners, Rules and Regulations
Verification of Provider Qualifications
Entity Responsible for Verification:
The Department of Health Care Policy and Financing(the Department),Community Centered Boards (CCB) as the Organized Health Care Delivery System (OHCDS)
Frequency of Verification:
Initially and as determined by the the Quality Improvement Strategy (QIS) Qualified Provider Work group

Appendix C: Participant Services

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

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

Provider Category:
Individual
Provider Type:
Dentist
Provider Qualifications
License *(specify)*:
Per State Board of Dental Examiners
Certificate *(specify)*:

Other Standard *(specify)*:
C.R.S. 12-35-101 et. seq.3 CCR 709.1: Colorado Board of Dental Examiners, Rules and Regulations
Verification of Provider Qualifications
Entity Responsible for Verification:
The Department of Health Care Policy and Financing (the Department), Community Centered Boards (CCB) as the Organized Health Care Delivery System (OHCDS)
Frequency of Verification:
Initial and as determined by the the Quality Improvement Strategy (QIS) Qualified Provider Work group

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Vision Services

HCBS Taxonomy:

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

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

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

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

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):*

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

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

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Optometrist
Individual	Opthalmologist

Appendix C: Participant Services

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

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

Provider Category:
Individual
Provider Type:
Optometrist
Provider Qualifications
License *(specify):*
C.R.S. 12-40-101 et. Seq.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
The Department of Health Care Policy and Financing (the Department), Community Centered Board (CCB) as the Organized Health Care Delivery System (OHCDS)
Frequency of Verification:
Initial and as determined by the the Quality Improvement Strategy (QIS) Qualified Provider Work group

Appendix C: Participant Services

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

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

Provider Category:
Individual
Provider Type:
Opthalmologist
Provider Qualifications
License *(specify):*
C.R.S. 12-40-101 et. Seq.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
The Department of Health Care Policy and Financing (the Department),Community Centered Board (CCB) as the Orgainzed Health Care Delivery System (OHCDS)

Frequency of Verification:
Initially and as determined by the the Quality Improvement Strategy (QIS) Qualified Provider Work group

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Behavioral Services

HCBS Taxonomy:

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

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

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

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):*
1) Behavioral Consultation Services include consultations and recommendations for behavioral interventions and development of behavioral support plans that are related to the participants's developmental disability and are necessary for the participant to acquire or maintain appropriate adaptive behaviors, interactions with others and behavioral self management. Intervention modalities shall relate to an identified challenging behavioral

need of the participant. Specific goals and procedures for the Behavioral Services must be established. Participants with co-occurring diagnoses of developmental disabilities and Medicaid covered mental health conditions shall have identified needs met by each of the appropriate systems without duplication but with coordination by the Behavioral Services professional to obtain the best outcome for the participant.

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

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

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

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

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

Exclusions:

Services covered under Medicaid Early and Periodic Screening, Diagnositic, and Treatment (EPSDT), for a covered mental health diagnosis in the Medicaid State Plan, covered by a third party source or available from a natural support shall not be reimbursed.

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

Limits:

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

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

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

4) Behavioral Line Services are limited to 960 units per Service Plan year. One unit is equal to 15 minutes of service. Requests for Behavioral Line Services units must be prior authorized by the Department of Health Care Policy and Financing (the Department) in accordance with Prior Authorization Request (PAR) procedures that include specific approval criteria.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title

Provider Category	Provider Type Title
Individual	Behavioral Consultant
Individual	Behavioral Line Staff
Individual	Counselor
Individual	Behavioral Plan Assessor
Agency	Program Approved Service Agency (approved by the Department of Health Care Policy and Financing)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Services

Provider Category:
Individual
Provider Type:
Behavioral Consultant
Provider Qualifications
License *(specify):*
This provider may be qualified in several ways as described in "Other Standard" below. One option is to be licensed in field of practice as described in #1 below.
Certificate *(specify):*
This provider may be qualified in several ways as described in "Other Standard" below. One option is to be nationally certified as a Board Certified Behavior Analyst or certified by a similar nationally recognized organization with established standards of practice, as described in #2 below.
Other Standard *(specify):*
2-CCR-503-1 16.220-DD, 10 CCR 2505-10,8.500.5
Behavioral Consultants shall meet one of the following minimum requirements:
1. Shall have a Master's degree or higher in behavioral, social or health sciences or education and be nationally certified as a "Board Certified Behavior Analyst" (BCBA), or certified by a similar nationally recognized organization. Shall have at least 2 years of directly supervised experience developing and implementing behavioral support plans utilizing established approaches including Behavioral Analysis or Positive Behavioral Supports that are consistent with best practice and research on effectiveness for people with developmental disabilities; or

2. Shall have a Baccalaureate degree or higher in behavioral, social or health sciences or education and be 1) certified as a "Board Certified Associate Behavior Analyst" (BCABA) or 2) be enrolled in a BCABA or BCBA certification program or completed a Positive Behavior Supports training program and 3) working under the supervision of a certified or licensed Behavioral Services Provider.
Verification of Provider Qualifications
Entity Responsible for Verification:
Qualified Provider, Qualified Provider Agency, Program Approved Service Agency (PASA) approved by the Department of Health Care Policy Financing (the Department) , the Community Centered Board (CCB)as the Organized Health Care Delivery System (OHCDS)
Frequency of Verification:
Initially and as determined by the the Quality Improvement Strategy (QIS) Qualified Provider Work group

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Behavioral Services

Provider Category:
Individual
Provider Type:
Behavioral Line Staff
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
N/A
Other Standard *(specify):*
Behavioral Line Staff shall meet the following minimum requirements:
Must be at least 18 years of age, graduated from high school or earned a high school equivalency degree and have a minimum of 24 hours training, inclusive of practical experience in the implementation of positive behavioral supports and/or applied behavioral analysis and that is consistent with best practice and research on effectiveness for people with developmental disabilities. Works under the direction of a Behavioral Consultant.
Verification of Provider Qualifications
Entity Responsible for Verification:
Qualified Provider, Qualified Provider Agency, Program Approved Service Agency (PASA) approved by the Department of Health Care Policy Financing (the Department), the Community Centered Board CCB)as the Organized Health Care Delivery System (OHCDS).
Frequency of Verification:
Initially and on-going by the Behavioral Consultant under whom the Behavioral Line Staff works.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Services

Provider Category:
Individual
Provider Type:
Counselor
Provider Qualifications
License *(specify):*
This provider may be qualified in several ways as described in "Other Standard" below. One option is to be licensed in field of practice as described below.
Certificate *(specify):*
This provider may be qualified in several ways as described in "Other Standard" below. One option is to be nationally certified as a "Board Certified Behavioral Analyst" (BCBA) or certified by a similar nationally recognized organization as described below.
Other Standard *(specify):*
Counselors shall meet one of the following minimum requirements:
1. Shall hold the appropriate license or certification for the provider's discipline according to state law or federal regulations and represent one of the following professional categories: Licensed Clinical Social Worker, Certified Rehabilitation Counselor, Licensed Professional Counselor, Licensed Clinical Psychologist, or BCBA and must demonstrate or document a minimum of two years experience in providing counseling to individuals with developmental disabilities; or

2. Have a Baccalaureate degree or higher in behavioral, social or health science or education and work under the supervison of a licensed or certified professional as set forth above in Individual/Group Counseler Provider Qualifications.
Verification of Provider Qualifications
Entity Responsible for Verification:

Qualified Provider, Qualified Provider Agency, Program Approved Service Agency (PASA) approved by the Department of Health Care Policy and Financing (the Department), the Community Centered Board (CCB) as the Organized Health Care Delivery System (OHCDS)
Frequency of Verification:
Initially and as determined by the Quality Improvement Strategy(QIS) Qualified Provider Work Group

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Services

Provider Category:
Individual
Provider Type:
Behavioral Plan Assessor
Provider Qualifications
License *(specify):*
This provider may be qualified in several ways as described in "Other Standard" below. One option is to be licensed in field of practice as described below.
Certificate *(specify):*
This provider may be qualified in several ways as described in "Other Standard" below. One option is to be nationally certified as a "Board Certified Behavior Analyst" (BCBA) or certified by a similar nationally recognized organization as described below.
Other Standard *(specify):*
Behavioral Plan Assessor shall meet one of the following minimum qualifications:
1. Shall have a Master's degree or higher in behavioral, social or health science or education and be nationally certified as a BCBA or certified by a similar nationally recognized organization. Shall have at least 2 years of directly supervised experience developing and implementing behavioral support plans utilizing established approaches including Behavioral Analysis or Positive Behavioral Supports that are consistent with best practice and research on effectiveness for people with developmental disabilities; or

2. Shall have a Baccalaureate degree or higher in behavioral, social or health science or education and be 1)certified as a "Board Certified Associate Behavior Analyst" (BCABA) or 2)be enrolled in a BCABA or BCBA certification program or completed a Positive Behavior Supports training program and working under the supervision of a certified or licensed Behavioral Services provider.
Verification of Provider Qualifications
Entity Responsible for Verification:
Qualified Provider, Qualified Provider Agency, Program Approved Service Agency (PASA) approved by the Department of Health Care Policy and Financing (the Department), the Community Centered Board (CCB) as the Organized Health Care Delivery System (OHCDS)
Frequency of Verification:
Initially and as determined by the Quality Improvement Strategy (QIS) Qualified Provider Work Group

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Services

Provider Category:
Agency

Provider Type:
Program Approved Service Agency (approved by the Department of Health Care Policy and Financing)
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
Program approved by the Department of Health Care Policy and Financing (the Department)
Other Standard *(specify):*
When the provider is a Program Approved Service Agency then the qualifying staff member must meet the qualifications of the Behavioral Consultant in order to bill for Behavioral Services.
Verification of Provider Qualifications
Entity Responsible for Verification:
The Department of Health Care Policy and Financing (the Department) or the Community Centered Board (CCB) as the Organized Health Care Delivery System (OHCDS)
Frequency of Verification:
Initially and as determined by the the Quality Improvement Strategy (QIS) Qualified Provider Work group

Appendix C: Participant Services

C-1/C-3: Service Specification

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

HCBS Taxonomy:

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

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

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

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

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

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

Service is not included in the approved waiver.

Service Definition *(Scope)*:
Service offered in order to enable waiver participants to gain access to Day Habilitation and Supported Employment services as specified by the Service Plan that are not related to medical interventions as covered in the State Plan. Transportation to and from work is a benefit in conjunction with Supported Employment service except when the Supported Employment service occurs at a frequency less than the number of days worked. In that case, transportation to and from the place of employment is a benefit when the participant does not have resources available, including personal funds, natural supports, and/or third party resources. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State plan, defined at 42 CFR §440.170(a) (if applicable), and does not replace them. Transportation services under the waiver are offered in accordance with the participant's Service Plan. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge are utilized.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Transportation to and from day program shall be reimbursed based on the applicable transportation band. The number of units available for Transportation Services is 508 units per Service Plan year or approximately 42 trips per month. A unit is a per-trip charge for to and from Day Habilitation and Supported Employment programs.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Centered Board (CCB)/ Organized Health Care Delivery System (OHCDS)
Individual	Program Approved Service Agency (approved by the Department of Health Care Policy and Financing): GRSS/IRSS/SH/SCC/SE
Agency	Public Transportation Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Non Medical Transportation

Provider Category:
Agency
Provider Type:
Community Centered Board (CCB)/ Organized Health Care Delivery System (OHCDS)
Provider Qualifications
License *(specify)*:
Colorado Drivers License or Commercial Drivers License, or C.R.S. 40-10-101 et.seq.
Certificate *(specify)*:

Other Standard *(specify)*:
DHS Rules:2-CCR-503-116.640-16.644 Appropriate amount of liability coverage.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy and Financing (the Department)

Frequency of Verification:

Intially and every 3 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Non Medical Transportation

Provider Category:

Individual

Provider Type:

Program Approved Service Agency (approved by the Department of Health Care Policy and Financing): GRSS/IRSS/SH/SCC/SE

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

None

Other Standard *(specify):*

DHS Rules:2-CCR-503-116.640-16.644 Required liability coverage.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Community Centered Board (CCB) as the Organized Health Care Delivery System (OHCDS)
The Department of Health Care Policy and Financing (the Department)

Frequency of Verification:

Initially and on-going by the CCB
Every three years by the Department

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Non Medical Transportation

Provider Category:

Agency

Provider Type:

Public Transportation Agency

Provider Qualifications

License *(specify):*

Public Utilities Commission (PUC) Division

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Program Approved Service Agency (PASA) approved by the Department of Health Care Policy and Financing (the Department)
Frequency of Verification:
On-going, Program Approved Service Agency uses only PUC licensed public transportation

Appendix C: Participant Services

C-1/C-3: Service Specification

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

HCBS Taxonomy:

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

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

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

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

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

- (selected) **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):*
Specialized Medical Equipment and supplies include:

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

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

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

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

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

Specialized Medical Equipment and Supplies are in addition to any medical equipment and supplies furnished under the State plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design, and installation.

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

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Vendor
Agency	Pharmacy
Agency	Medical Supply Company

Appendix C: Participant Services

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

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

Provider Category:
Agency

Provider Type:
Vendor

Provider Qualifications

License *(specify)*:
The product or service to be delivered must meet all applicable state licensing requirements

Certificate *(specify)*:

Other Standard *(specify)*:
The product or service to be delivered must meet all applicable manufacturer specifications, state and local building codes, and Uniform Federal Accessibility Standards.

Verification of Provider Qualifications

Entity Responsible for Verification:
Program Approved Service Agency (PASA)approved by the Department of Health Care Policy and Financing (the Department)
The Community Centered Board (CCB) as the Organized Health Care Delivery System (OHCDS)

Frequency of Verification:

Initially and on-going according to the nature of the realtionship. Qualifications of all vendors will be verified intially. Qualifications for providers with whom on-going purchases are made will be verified as determined by the the Quality Improvemetn Strategy (QIS) Qualified Provider Work group.

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Pharmacy
Provider Qualifications
License *(specify):*
Pharmacy License
Certificate *(specify):*
The Department of Health Care Policy and Financing (the Department): Medicaid Provider
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
The Department of Health Care Policy and Financing (the Department)
Frequency of Verification:
Initially and as determined by the the Quality Improvement Strategy (QIS) Qualified Provider Work group

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Medical Supply Company
Provider Qualifications
License *(specify):*
Business License
Certificate *(specify):*
The Department of Health Care Policy and Financing (the Department): Medicaid Provider
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
The Department of Health Care Policy and Financing (the Department)
The Community Centered Board (CCB) as the Organized Health Care Delivery System (OHCDS)
Frequency of Verification:

Initially and as determined by the the Quality Improvement Strategy (QIS) Qualified Provider Work group

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:

Community Centered Boards provide Targeted Case Management services.

Appendix C: Participant Services

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

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

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

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

Administration and compliance with this requirement is reviewed at the time of survey of on-site surveys of Program Approved Service Agencies (PASA) and Case Management Agencies (CMA).

All PASAs and Community Centered Boards (CCBs) are required to complete employment reference checks prior to hire. Pre-employment criminal history and background investigations are required for all applicants for positions in which the staff person or contractor can expected to be alone with the participant or is expected to provide direct waiver services, which includes all direct care staff (e.g., residential care staff, day program staff, transportation staff, etc.), host home providers, case managers, nurses, program supervisors, managers and directors. The scope of the criminal investigations includes statewide and federal databases. Review of compliance with requirements for such criminal history and background investigations occurs at the time of on-site program quality surveys of all PASAs and CCBs. Requirements for such investigations are included in Standards for Program Administration.

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).**

i. Types of Facilities Subject to §1616(e). Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Community Residential Homes for Persons With Developmental Disabilities	

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

All community residences for persons with developmental disabilities (i.e. community group homes) are licensed by the Colorado Department of Public Health and Environment (CDPHE) and must meet the rules located at 6 CCR 1011-1, Standards for Hospitals and Health Facilities Chapter 8, Facilities for Persons with Developmental Disabilities. These rules require community group homes comply with local building codes, maintain a home like environment and to be located no closer than 750 ft. between homes. Pursuant to state statute 27-10.5-109.5 C.R.S. all group homes must also comply with local zoning requirements. This requirement is to align with The Colorado Department of Public Health and Environment (CDPHE) regulation that Community Residential Homes be no closer than 750 feet and is not a zoning law. Living environments utilized shall be selected in accordance with Department guidelines implementing section 1616(e) of the Social Security Act (42 U.S.C. section 1382e (e)(1)) and addressing building capacity, including the maximum number of persons receiving services and the number of units which may be utilized under a single roof or in a single setting. The selection of a living environment shall include consideration of the following:
a. Opportunities for community inclusion for persons receiving services;
b. Individual choice, including preference to be close to family; and,
c. Distance from other homes (e.g., apartments, houses) of persons receiving services so that persons with developmental disabilities are not grouped in a conspicuous manner.

Homes of persons receiving services and supports shall, at minimum, meet HUD Section 8 Housing Quality Standards. The home (exterior and interior) and grounds shall be maintained in good repair to protect the health, comfort and safety of the participants and be free of offensive odors, accumulation of dirt, rubbish and dust. Additionally, homes must meet the following standards:

a. Bedrooms shall meet minimum space requirements (single 80 square feet, double 120 square feet). (Not applicable for studio apartments.)
b. Adequate and comfortable furnishings and adequate supplies shall be provided and maintained in good condition.
c. All areas of a home needing to be accessed by persons receiving services who use a wheelchair or other assistive technology devices shall be accessible.
d. The primary entry to the home of a person receiving services who utilizes a wheelchair or other assistive technology devices shall be accessible.
e. Main areas of the home shall be fully accessible at all times (kitchen, dining room, general living areas)

Participants shall live safely in environments common to other citizens with reasonable supports provided to protect their health and safety while simultaneously promoting community inclusion.

Providers shall actively work to make available to each person the patterns and conditions of everyday life, which are consistent with those of persons without disabilities, including jobs and homes to the maximum extent possible. All services and supports offered will be appropriate to the chronological age of the person and shall take individual preferences into consideration.

The Department of Health Care Policy and Financing (the Department) staff or a designee is also required to visit and review the proposed new group home site prior to initial program approval by the Department. The requirements in this section are applied prior to licensure of new group homes and at the time of license renewal per 6 CCR 1011-1 8 and 10 CCR and 10 CCR 2505-10 8.6.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Community Residential Homes for Persons With Developmental Disabilities

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Supported Employment	☐
Specialized Medical Equipment and Supplies	☐
Behavioral Services	☐
Dental Services	☐
Non Medical Transportation	☐
Vision Services	☐
Residential Habilitation	☑
Day Habilitation	☐
Prevocational Services	☐

Facility Capacity Limit:

4 to 8 Beds

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

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

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

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

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

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

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

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

Payment may be made to family members who meet provider qualifications for the following services in the HCBS-DD waiver: Residential Habiliation Services and Supports, Day Habilitation Services and Supports, Supported Employment, Prevocational Services, and Non-Medical Transportation. For the purpose of this section family shall be defined as all persons related to the participant by virtue of blood, marriage, adoption, or common law, and legal guardians as court appointed.

The family member providing services shall meet requirements set forth by the qualified program approved service agency (PASA) through which the family member provides services. The family member must be at least 18 years of age, trained to perform appropriate tasks to meet the participant's needs, and demonstrate the ability to provide support to the participant as defined in the participant's Service Plan and Hiring Agreement.

Participants and/or legal guardians, who choose to hire a family member must document their choice on the Service Plan. The Service Plan is developed under the coordination and direction of the community centered board Interdisciplinary Team (IDT) who provide oversight regarding the appropriateness of the family member providing services. The Service Plan identifies the needs of the person and reflects discussion on how to best meet those needs. The waiver services identified in the Service Plan are submitted for approval using a Prior Authorization Request (PAR.) When the PAR is approved those services are uploaded into the Medicaid Management Information System (MMIS). Only those approved services may be reimbursed. Family members other than spouses may be employed to provide services except a family member who is an individual's authorized representative may not be reimbursed for the provision of services.

- **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

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

- **Other policy.**

Specify:

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

All parties interested in becoming Home and Community Based Services (HCBS)-Developmental Disabilities (DD) providers have access to required forms and instructions for completing the forms on the Department of Health Care Policy and Financing (the Department) website. Applications to become a DD provider are submitted to the Department, Division of Intellectual and Developmental Disabilities.

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:
The # and % of providers surveyed (initial or renewal licensure/certification) during the performance period, by type, that met qualifications for waiver services rendered. Numerator: # of providers surveyed that met qualifications prior to furnishing waiver services or that made any required corrections within prescribed timelines. Denominator: Total # of providers surveyed.

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

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

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

Performance Measure:
The # and % of non-licensed/non-certified providers surveyed (initial or periodic) during the performance period, by type, that met qualifications for waiver services rendered. Numberator: # of providers surveyed that met qualitifcations prior to furnishing waiver services or that made any required corrections within prescribed timelines. Denominator: Total # of providers surveyed.

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

Responsible Party for data		**Sampling Approach** *(check each that applies):*

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

Data Aggregation and Analysis:

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

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

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

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

Performance Measure:
Number and percent of providers surveyed in the performance period, by type, trained in accordance with Department regulations. Numerator: Number of surveyed providers trained in accordance with Department regulations. Denominator: Total number of surveyed providers that required training.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of providers surveyed during the performance period that met requirements for use of physical or mechanical restraints. Numerator: Number of surveyed providers that met requirements for use of physical or mechanical restraints. Denominator: Total number of surveyed providers.

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of providers surveyed in the performance period that met due process requirements for implementing a suspension of rights. Numerator: Number of surveyed providers that met due process requirements for implementing a suspension of rights. Denominator: Total number of surveyed providers.

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

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

☑ **Other** Specify: Colorado Department of Public Health and Environment	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of providers surveyed that met the requirements for the use of training and support plans with restrictive procedures. Numerator: Number of waiver surveyed providers that met the requirements for use of training and support plans with restrictive procedures. Denominator: Total number of surveyed providers.

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

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

collection/generation *(check each that applies):*		
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Colorado Department of Public Health and Environment	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The Department maintains an interagency agreement with the Colorado Department of Public Health and Environment (CDPHE) to verify provider qualifications, conduct surveys, and investigate complaints/critical incidents. Providers that have obtained a satisfactory survey are referred to the Department for certification as a Medicaid Provider. Each certified provider is re-sureveyed accouding to the CDPHE 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.
Deficient practice citations from the Colorado Deaprtment of Public Health and Environment (CDPHE) are issued to providers that are surveyed and found to not be in compliance with the established standards. Citations require, at minimum, a plan of corrections. Providers that are unable to correct deficient practices within prescribed timelines are recommended for termination by CDPHE and are terminated by the Department.

In addition to CDPHE surveys, individual problems are discovered and addressed through service coordination and monitoring. Case Managers inquire about the quality of service sruing the required quarterly contact. If an issue is reported, the case manager assists the participant in its resolution. This may include changing providers or assisting the participant in resolving the issue with the provider.

Participants, family meembers, and/or advocates who have concerns or complaints about providers my also contact the participant's case manager and/or the Department. Participants are provided with this information during the initial and annual service planning process using the "Client Roles and Responsiblities" and the case managers "Roles and Responsiblities" form. If on-going system-wide issues are identified, the Department is notified for remediation.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

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

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

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

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

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

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:
Service Plan

a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- [ ] **Registered nurse, licensed to practice in the State**
- [ ] **Licensed practical or vocational nurse, acting within the scope of practice under State law**
- [ ] **Licensed physician (M.D. or D.O)**
- [ ] **Case Manager** (qualifications specified in Appendix C-1/C-3)
- [x] **Case Manager** (qualifications not specified in Appendix C-1/C-3).

  Specify qualifications:

  Must meet the Medicaid State Plan requirements for Targeted Case Management

  A Bachelor's degree from an accredited college or university; or,

  A two year degree plus two years of experience in the field of developmental disabilities; or

  Five years experience in the field of developmental disabilities
- [ ] **Social Worker**

  Specify qualifications:
- [ ] **Other**

  Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

The following safeguards to potential conflicts of interest in Service Plan development arising from Community Centered Boards (CCBs) dual roles as case management and provider agencies are as follows:

Separation of Case Management from Service Provision: rule 2-CCR 503-1 § 16.410 requires case management to be the responsibility of the executive level of the Community Centered Board and to be separately administered from the delivery of services. This rule also requires each CCB to adopt policies and procedures that create safeguards necessary to avoid conflicts of interest between case management and service provision.

Standardized Assessment of Participant Needs - CCBs are required to complete the Support Intensity Scale (SIS) assessment for each participant. The assessment ensures that the case manager has standard information on the service and support needs of each participant prior to Service Plan development. Additionally, instructions for case managers on Service Plan development include specific reference to assessment items in the SIS.

Standardized Service Plan Documents- CCBs are required to complete each participant's Service Plan on the Benefits Utilization System (BUS). The Service Plan includes a mandatory data field to include documentation that the participant has been informed of potential conflicts of interest, the option to choose another provider or whether the participant needs/requests information on a potential new service provider.

Global Quality Improvement Strategy (QIS)- Implementation of the Global QIS will include desk reviews by the Department of Health Care Policy and Financing (The Department) staff of a representative sample of participants' level of care assessments and Service Plans. The programmatic tool used in the assessment as well as the participants selected in the sample will be specified by the Department. Aggregated data from the desk reviews will be reviewed and analyzed by the Department Oversight Committee to evaluate performance and identify the need for quality improvement projects.

Standardized Process for Provider Selection- All CCBs and case managers have received specific instructions from the Department regarding processes to be implemented to assist participants with selecting a service provider. This process requires completion of the Service Provider Selection form at the time of initial enrollment in the waiver or, when a change in provider is requested, when the participant or guardian expresses dissatisfaction with the participant's current provider or when a provider terminates services. All participants are provided with a copy of a document entitled "Selecting a Service Agency: A Guide to Provider Selection" at the time of initial enrollment and when participants and guardians request information on qualified providers. Lastly, all case managers are required to monitor participants' satisfaction with choices in service providers at the time of Service Plan development and within six months of Service Plan implementation. Such monitoring must be documented in the Service Plan and in case manager contact notes maintained on the BUS.

Client Satisfaction Survey- Per 2 CCR 503-116.622 all agencies are required to conduct an evaluation of participant satisfaction no less than once every three years. This is monitored during on site program quality surveys.

The Department's On-site Program Quality Surveys- Every three years, the Department staff complete surveys of CCBs and review, specifically, separation of case management from service delivery, the Service Plan development process, provider selection processes and monitoring of participant satisfaction with services and provider choice. The on-site survey process also includes interviews with participants and guardians regarding Service Plan development and choice from among qualified providers. More information on this process is included Appendix H.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Each Community Centered Board (CCB) is contractually obligated to provide information to participants about the potential services, supports and resources that are available. To assist participants in the Service Plan process, there is a resource document entitled "Start Here: A Resource Guide", which is broadly distributed in the developmental disabilities service system and available on the Department of Health Care Policy and Financing website. The brochure provides information and suggestions to assist participants and other parties on how to be actively involved in their service planning. The authority of a participant to determine who is included in the process is identified in DHS/DDD rule 2 CCR 503-1 16.430.

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):

Service planning includes development of the Service Plan on the Benefits Utilization System (BUS). Service Plan development is completed annually following the ULTC 100.2 assessment and at the time of enrollment in waiver services. The Service Plan is also reviewed every six months or when the needs or circumstances of the participant indicate that a review is needed. The Colorado Code of Regulations (10 CCR 2505-10 8.607.4 B.) specifies that: Every effort shall be made to convene the meeting at a time and place convenient to the person receiving services, their legal guardian, authorized representative and parent(s) of a minor.

(a) Participation and Timing- Service Plan development is the responsibility of the participant's targeted case manager. Participation in the process includes the case manager, the participant, guardian, and the authorized representative if one has been appointed, representatives of the service provider agencies and other persons that the participant and/or his/her guardian may wish to include. Service Plans are developed on an annual basis and coincide with the span date of the participant's level of care assessment.

(b) Assessments and Needs/Preferences- All participants have a Supports Intensity Scale (SIS) assessment completed prior to Service Plan development. The SIS does not have to be renewed annually but must be updated whenever the participant's needs change significantly. Additionally, the case manager is responsible for collecting all current assessments for the participant, specifically, all current medical exams/assessments (e.g., physical, dental, psychiatric, vision, etc.), professional evaluations (e.g., physical therapy, occupational therapy, behavioral, nursing, nutrition, etc.), and other needed evaluations (e.g., behavioral functional analysis, safety, day habilitation, residential skills, risk assessment, etc.). The BUS includes a specific section on medical information that includes information on medical care providers, diagnoses, medications, allergies, limitations or restrictions, prosthetics/adaptive equipment, participant's medical support needs (e.g., needs assistance with medications, needs health support due to age, etc.) high-risk concerns (e.g., aspiration, diabetes, bowel obstruction, etc.), advanced directives and a section to list any other health concerns including provisions for risk management plan information to be completed by the case manager to direct services to address each participant's health, medical and psychiatric/behavioral needs. When the case manager, participant and other stakeholders determine a risk management plan is needed, information regarding responsibility for developing and monitoring the plan is included in the data fields for that service plan.

(c) Informing Participants on Service and Provider Availability- At the time of Service Plan development each participant is asked about the types of services he or she needs. The Service Plan document lists each long-term care

service available in the waiver. Additionally, the brochure entitled "Developmental Disabilities General Comparison Guide" includes a listing of services available under the waiver. At the time of plan development, the case manager also reviews the preferences and needs for change with the participant and the case manager documents the participant's preferences and needs for change in BUS. Needs for change includes specific areas of participant need (e.g., needs a job, etc.) and includes a data field stating "Wants a new provider". The participant or his/her guardian are offered free choice from among qualified providers at the time of initial Service Plan development. When a participant or his/her guardian state that they want a new service or provider it is documented in this section of the BUS and the participant's right to have free choice from among qualified providers is discussed. The case manager will then make available a listing of qualified providers available in the participant's geographic area and assist the participant as needed or requested. When the participant has not already selected a new provider, or if he/she requests, the case manager arranges for a request for proposal (RFP) to provide services to the participant to be developed and released to either specific qualified providers selected by the participant or to all available qualified providers in the person's geographic area. If there is no available provider meeting the participant's requirements and the participant requests additional assistance, the case manager will also send the RFP qualified providers in other geographic areas of the state. When proposals for services are received in response to the RFP, the case manager reviews the proposals with the participant and supports the participant in selecting from those proposals.

(d) Ensuring Service Plans Address Participant Goals, Needs and Preferences- The Service Plan document includes data fields to be completed by the case manager that documents service goals and individual participant goals for the Service Plan year. All case managers are trained on the use of the Service Plan document. Additionally, The Department of Health Care Policy Financing (the Department) reviews the CCB's performance in service planning on-site at least every three years and through desk reviews on an ongoing basis. Please see Appendix H for additional information.

(e) Coordination of Waiver and Other Services- Coordination of all services is the responsibility of the case manager. The Service Plan provides a listing of all state plan benefits, waiver services and non-waiver services (e.g., subsidized housing, rehabilitation services, etc.), including the provider of each service, the frequency and, where applicable, the number of units and unit cost of services. Case managers are required to document coordination activities in contact notes maintained on the BUS. Coordination of services and supports by the case manager is specifically required by DHS/DDD rule set forth at 2 CCR 503-1 16.430.

(f) Responsibilities to Implement and Monitor the Plan- Case managers are required to monitor implementation of the Service Plan, that services are having their intended effect, that services continue to be appropriate, that health and safety needs are addressed, the participant's rights are respected, and the participant satisfaction with services and supports pursuant to DHS/DDD rule set forth at 2 CCR 503-1 16.460. The Service Plan lists the responsible provider for each waiver service and specifies the frequency and number of units of service to be provided. The Service Plan also lists the responsibilities of the participant and case manager in implementing the Service Plan. The new Service Plan form developed in the BUS includes specific documentation that the participant has been provided the opportunity to choose from among qualified providers. Additionally, the Department conducts interviews with participants at the time of on-site program quality surveys of CCB administration and case management to ensure participants are provided choice from among qualified providers. The Department also monitors complaint information from participants, family members/guardians, authorized representatives, and advocates to ensure any complaint regarding choice from among all qualified providers is addressed.

(g) Service Plan Updates- Case managers are responsible for reviewing the Service Plan at least every six months. They are required to update or revise the Service Plan at least annually,as the needs or circumstances of the participant change or upon the participant's request. Updating or revising the Service Plan usually includes convening a meeting with the participant, guardian, authorized representative and other parties involved in developing the original Service Plan. This meeting is convened when adding new services, terminating unneeded services, changing the frequency and/or number of units of services, and changing the service provider listed in the Service Plan. Such changes are documented in the Service Plan as a revision, includes the reason for the revision and the date of the revision. A face to face meeting is conducted during the Service Plan update conducted during the annual continued stay review. 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 the case manager or client (e.g. natural disaster, pandemic, etc.).

The Service Plan also includes specific information on the participant's appeal rights and when services are reduced, denied or terminated, the participant is provided with a Notice of Adverse Action, which also includes information

on the participant's right to a Medicaid fair hearing. Information on the state dispute process, including a termination of services from a provider agency, is included in the information provided to the participant at the time of service plan development and at any time a provider agency notifies the participant that it intends to terminate services.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Risk Assessment and Mitigation- The initial step of risk assessment includes completion of the Supports Intensity Scale (SIS), completion of other required assessments/exams by service providers (e.g., physical exam, psychiatric assessments, behavioral assessments, etc.) to identify conditions or circumstances that present a risk of adverse outcome for the participant. Concerns identified by the case manager in completing the level of care assessment (e.g., abuse, neglect, exploitation, mistreatment, behavior supports, eating, medical supports, etc.) are identified in the Service Plan. All case managers are with provided with training and written instructions on completing the Service Plan.

Back-up Plans- The Service Plan document includes a specific section entitled "Contingency Plan". The plan identifies the provision of necessary care for medical purposes, which may include backup residential services, in the event that the participant's family, caregiver or provider is unavailable due to an emergency or unseen circumstances. All case managers have received training and written instruction on completing this section of the Service Plan.

The Department of Health Care Policy and Financing (the Department) staff monitor Case Management Agency (CMA) performance in completing the risk assessment and risk planning activities/documentation. This monitoring occurs at the time of On-site Program Quality Surveys of Community Centered Board (CCB) Administration and Case Management and as part of the Global Quality Improvement Strategy (QIS) when completing desk reviews of Service Plans maintained on the BUS. For more information on these processes please see Appendix H.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

At the time of enrollment, all participants, guardians, and authorized representatives are provided with a document entitled "Selecting a Service Agency: A Guide to Provider Selection". When a participant is selecting a service provider, he/she is provided with a statewide list of qualified providers available to provide waiver services. If the participant has pre-selected a provider, the case manager will refer him/her directly to that provider and, if the provider agrees to serve the participant, the placement is completed. If the participant has not pre-selected a provider, the case manager and the participant will develop and issue a Request for Proposals for the participant to solicit interest from among qualified providers. The participant can then select a provider from the responding qualified providers and if the provider agrees to serve the participant, the placement is completed. If the participant does not choose a provider willing to provide services to that participant, The Department of Health Care Policy and Financing (the Department) expects the Community Centered Board (CCB) to work proactively to develop a service provider option for the participant. Case managers are required to inform the participant of all qualified providers without restriction to the CCB designated service area. Additionally, during annual Service Plan development, participants are again informed of their ability to select from any qualified Medicaid provider who agrees to provide them services.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The Department of Health Care Policy abd Financing (the Department) developed a web-based system called the Benefits Utilization System (BUS) that contains the long-term care assessment document (ULTC-100.2), the Service Plan, and the monthly case management log notes. The case manager is required to enter the Service Plan into the BUS in order to receive prior authorization of services. Community Centered Board (CCB) agencies are required to prepare Service Plans according to their contract with the Department and the Centers for Medicare and Medicaid Services (CMS) waiver requirements. The Department monitors the CCB agency annually for compliance. A sample of documentation including individual Service Plans are reviewed for accuracy, appropriateness, and compliance with regulations.

The Service Plan shall include the participant's assessed needs, goals, specific services, amount, duration and frequency of services, documentation of choice between waiver services and institutional care, and documentation of choice of providers. CCB agency monitoring by the Department includes a statistical sample of Service Plan reviews. During review, Service Plans and prior authorization request forms 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 Quality Improvement Strategy (QIS) for additional information about the Department's timelines for implementing additional procedures.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Specify the other schedule:

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

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

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

(a) Case managers are responsible for monitoring both implementation of the services plan and the health and welfare of the participant.

(b) Case managers are required to complete monitoring visits to all of the participant's provider sites (i.e., residence, day habilitation, or supported employment site, etc.), complete face-to-face visits, review written incident reports, written review of periodic (i.e. quarterly) progress reports from residential, day habilitation and supported employment providers, and document medical and dental exams and services. Case managers are required to document case management activities on the Benefits Utilization System(BUS). BUS documentation includes recording case management follow-up activities.

(c) Case Managers are required to visit each provider site at least once per year and to complete face-to-face monitoring with the participant at least once per quarter. Monitoring of other information related to health and welfare, and implementation of the Service Plan, is expected to be ongoing and commensurate to the needs of the participant. Such monitoring is also used to determine the effectiveness of back-up plans identified in the participant's service plan.

d) Case manager face-to-face monitoring and review of service written provider progress reports are used to review the participant's satisfaction with access to services identified in the Service Plan and the services provided to ensure the participant's needs are met by those services, and that if a back-up plan has been used, the effectiveness of that plan, and that the participant is accessing non-waiver services for the participant as identified in the Service Plan.

e) Case manager monitoring of the participant's free choice for the participant from among qualified providers is reviewed at the time of service plan development and on-going (please see section D 1 d above), and through the monitoring of the participant's satisfaction with the service provided for the participant in the Service Plan at the time of service site and face-to-face monitoring.

g) Case management agencies are responsible for monitoring the overall provision of services and support at the agency and local system level per rules 2 CCR 501-1 16.460, 16.210 and 16.560. Specifically, the case management agency is expected to review and analyze information from incident reports and complaint information to identify trends and problematic practices and to take appropriate corrective action. Much of the data that the case management agency uses in this process is provided through the provision of case management monitoring activities completed by case managers. This 'second level' of monitoring, data aggregation and analysis is intended to improve service provider practice and to prevent problematic practices. Compliance with the above listed requirements is reviewed the time of on-site reviews of Community Centered Board (CCB) administration and case management, which are conducted at a minimum of every three years. If problems identified in case management monitoring cannot be resolved at a local level the case management agency is expected to file a complaint against the service provider with The Department of Health Care Policy and Financing.

b. Monitoring Safeguards. *Select one:*

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

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

The Department of Health Care Policy Financing (The Department) has established the following safeguards to potential conflicts of interest arising from Community Centered Boards (CCB) dual roles as targeted case management agencies and service provider agencies:

Separation of Case Management from Service Provision: rule 2-CCR 503-1 16.410 requires case management to be the responsibility of the executive level of the CCB and to be separately administered from the delivery of services. Additionally, this rule also requires each CCB to adopt policies and procedures to address safeguards necessary to avoid conflicts of interest between case management and service provision.

Standardized Documentation of Case Management Activities- All case managers are required to document case management activities, including monitoring, through case management notes on the Benefits Utilization System (BUS).

Client Satisfaction Survey- Per 2 CCR 503-116.622 all agencies are required to conduct an evaluation of participant satisfaction no less than once every three years. This is monitored during on site program quality surveys.

Participant Interviews- Participant and family member/guardian interviews are conducting at the time of on-site program quality surveys of CCB administration and case management.

Complaint Response- The Department receives complaints from participants, family members/guardians, authorized representatives, and guardians regarding satisfaction with targeted case management services.

On-site Program Quality Surveys- Every three years the Department staff complete surveys of CCBs and review specifically separation of case management from service delivery, implementation of the Service Plan, case management monitoring, and follow-up to problems identified through monitoring. The on-site survey process also includes interview with participants and guardians regarding Service Plan development and choice form among qualified providers.

When restraints are used or plan to be used, when a suspension of the rights of a participant is to be implemented, or when psychoactive medications are to be used, the participant's Service Plan/developmental disabilities section must document the reasons such actions are to be taken and why. Both service provider agency and CCB compliance with requirements for Human Rights Committee (HRC) review and follow-up to HRC recommendations are reviewed at the time of on-site surveys of all service provider agencies and CCBs.

Incident Management- The Department has implemented several processes related to incident management to ensure case managers and CCB administration detect and respond to specific types of critical incidents and allegations of mistreatment, abuse, neglect and exploitation. The procedures are detailed in Appendix G. Pertinent to this section of Appendix D are the following requirements: Reporting Mistreatment, Abuse Neglect and Exploitation- CCB and program approved service agency staff must report a crime committed against a participant to local law enforcement and any allegation of mistreatment, abuse or neglect to county departments of social services/adult protection units. Additionally, CCBs are required to report critical incidents to The Department via the web-based critical incident reporting system monitored by the contracting agency for program quality review the Department of Public Health and Environment (DPHE). Any allegations of mistreatment, abuse, neglect or exploitation meeting the definition of a critical incident that involves the service agency or provider operated by the CCB is given additional scrutiny by The Department. This includes that all written investigation of such incidents are reviewed by The Department's contracted entity for program quality reviews (DPHE).

Local HRC Reviews- As described in Appendix G and H, each CCB must convene a Human Rights Committee to review all responses to allegations of mistreatment, abuse, neglect and exploitation. Local HRCs are also responsible for reviewing the use of restraints, suspensions of a participant's rights, restrictive procedures and use of psychoactive medications.

Oversight by the Department- Ongoing monitoring by the Department of critical incident and complaints (as identified in Appendix G and H) are key to ensuring CCBs that also provide direct waiver services adequately monitor the health and welfare of participants and that identified problems are addressed. The Department also conducts desk reviews of case management service planning and case management contact notes to ensure case managers are monitoring Service Plan implementation.

Global Quality Improvement Strategy (QIS)- As part of the approved Global QIS the Department staff complete desk reviews of a representative sample of service plans of waiver participants from each CCB and review claims data to assess if participants are receiving the type, amount and frequency of waiver services specified in their service plans.

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 Service Plans (SPs) address the needs identified in the ULTC assessment, through waiver and other non-waiver services. Numerator: Number of waiver participants in the sample whose SPs address the needs identified in the ULTC assessment. Denominator: Total number of waiver participants in the sample.

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of waiver participants in a representative sample whose SPs adequately address the waiver participant's goals. Numerator: Number of waiver participants in the sample whose SPs adequately 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 Tool

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

		95% with a 5% margin of error
☑ **Other** Specify: Case Management Agency	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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 contingency plan adequately addresses identified health and safety risks. Denominator: Total number of waiver participants in the sample.

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

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

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

Data Aggregation and Analysis:

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

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:
This sub-assurance has been removed from HCBS waiver requirements by the Centers for Medicaid and Medicare Services (CMS). The state continues to develop service plans in accordance with its policies and procedures but is no longer required to report evidenc of these practicies as part of its Quality Improvement Strategy.

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

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

Data Aggregation and Analysis:

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

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

Performance Measures

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

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

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

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

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

		Confidence Interval = + or - 5%
☑ **Other** Specify: Case Management Agency	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of existing, non-new, waiver participants in a representative sample where the SP start date is within one year of the prior SP start date. Numerator: Number of existing, non-new, waiver participants in the sample where the SP start date is within one year of the prior SP start date. Denominator: Total number of existing, non-new, waiver participants in the sample.

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

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

Data Aggregation and Analysis:

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

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 participants in a representative sample for whom 100% of waiver services were delivered in accordance with the service plan. Numerator: Number of waiver participants in the sample for whom the paid claims equal 100% of those services authorized by the service plan. Denominator: Total number of waiver participants in the sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Benefits Utilization System (BUS) and Medicaid Management Information System (MMIS) Data

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

Data Aggregation and Analysis:

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

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

Performance Measures

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

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

Performance Measure:
Number and percent of waiver participants in a representative sample whose SPs document a choice between/among HCBS waiver services and qualified waiver service providers. Numerator: Number of waiver participants in teh 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:
Benefits Utilzation System (BUS) Data

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

		☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% with a 5% margin of error
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of waiver participants in a representative sample provided a fact sheet with general information about HCBS and specific information about the range of services, types of providers, and contact information. Numerator: Number of waiver participants in th sample whose SP's 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 (BUS) Data

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

Data Aggregation and Analysis:

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

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

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 evalutions and Benefits Utilization (BUS) data as the primary methods for discovery. The Program Reveiw Tool is used to conduct standardized record reviews on statistically volid sample of waiver participants.

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 CMA adminstrator or director provides information about remediation in the 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 participant care file when appropriate.

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

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

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

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

Appendix E: Participant Direction of Services

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

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

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

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

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

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

Notification Upon Enrollment for Waiver Services- Participants are provided with written information in a consumer friendly brochure entitled "A Guide to Getting a Fair Medicaid Hearing". The brochure describes the Fair Hearing process, when the process may be used and how to request a Fair Hearing. Additionally, it provides the name of the community agency to contact if the participant wants assistance in the Fair Hearing process.

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 Community Centered Board (CCB) is required to generate the LTC 803 Form utilizing the Benefits Utilization System (BUS) and mail it to the participant at least ten days before the date of the intended action. Participants are also provided a copy of the brochure A Guide to Getting a Fair Medicaid Hearing at the time notification is provided. The Department of Health Care Policy and Financing (the Department) rules and regulations regarding notification are located at 10 CCR 2505-10 8.057.2.

When Notice is Provided- A waiver participant is notified of his/her right to a fair hearing upon enrollment in the waiver and when the CCB anticipates an adverse action will be taken (i.e. when the CCB is not providing the individual choice home and community based services an alternative to institutional services, is denying the individual choice in waiver services or choice in qualified providers, denying enrollment, or taking action to suspend, reduce or terminate services).

Location of Notice Records- Notices of adverse action and opportunity for a fair hearing are maintained in the BUS and referenced by the participant's State Medicaid identification number. Copies of participant requests for a fair hearing are maintained by the Colorado Office of Administrative Courts and in the participant's master record maintained by the CCB.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

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

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The State operates an additional dispute resolution process**

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

Operational Responsibility- The Department of Health Care Policy and Financing (the Department) is responsible for operating the additional dispute resolution process. Administrative rules describing the requirements for this process are located at 2 CCR 503-1 16.322 and apply to all persons receiving services for Individuals with Intellectual Disabilities, including waiver participants.

Process Description- A waiver participant may utilize the additional process to dispute specific actions taken by the Community Centered Board (CCB), Program Approved Service Agency (PASA), or other qualified provider. This additional dispute resolution process is not a pre-requisite or substitute for the Medicaid Fair Hearing process specified in Appendix F 1. The participant is informed of his/her rights associated with each process. The additional process is available when the CCB intends to take action based on a decision that: a) the applicant is not eligible or the participant is no longer eligible for services and supports in the intellectual and developmental disabilities system, b) the participant's services and supports are to be terminated or, c) services set forth in the participant's service plan are to be provided, or d) are to be changed, reduced, or denied. Additionally, the process is available when a qualified provider decides to change, reduce or terminate services or supports. Notification of the intended action shall be provided to the participant in writing at least 15 days prior to the effective date of the intended action. If the participant decides to contest the intended action, he/she may file a complaint with the agency intending to take the action. When a participant files a complaint the agency shall afford the participant access to the following procedures:

Local Informal Negotiations- Within 15 days of receipt of the complaint, the agency shall afford the participant and any of his/her representatives the opportunity to informally negotiate a resolution to the complaint. If both parties waive the opportunity for informal negotiations, or if such negotiations fail to resolve the complaint, the agency shall afford the participant an opportunity to present information and evidence to support his/her position to an impartial decision maker. The impartial decision maker may be the director of the agency taking the action or their designee. The impartial decision maker shall not have been directly involved in the specific decision at issue.

Meeting With an Impartial Decision Maker- The agency and participant shall be provided at least a 10-day notice of a meeting with the impartial decision maker. The impartial decision maker may be the director of the agency taking the action or their designee. Per 2 CCR 503-1 16.322 the impartial decision maker cannot have been directly involved in the specific decision at issue. The participant may bring a representative to the meeting and shall be provided with the opportunity to respond to or question the opposing position. A decision by the impartial decision maker shall be provided to both parties within 15 days of the meeting and shall include the reasons/rationale for the decision. If the complaint is not resolved, either party may object to the decision and request a review of the decision by the Department within 15 days of the postmark of the written decision.

Department Review of the Dispute Decision- The Department is responsible to review the dispute decision. When a complainant submits a request for review to the Department the party (agency or participant) responding to the complaint has 15 days to respond and submit additional documentation supporting their decision to the Department. The Department may request additional information from either party. The dispute resolution review by the Department is a de novo review of the dispute and a decision shall be rendered to the parties within 10 working days of submission of all relevant information. The decision rendered by the Department is considered to be the final

agency action on the dispute in relation to this specific process. This process and final agency action taken in the dispute is not a substitute or pre-requisite to the Medicaid Fair Hearing Process or any decision rendered in the process.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

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

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

The Department of Health Care Policy and Financing (the Department) is responsible for operating the state grievance/complaint system. Administrative rules describing the requirements for this process are located at 2 CCR 503-1 16.326 and apply to all persons receiving services for Individuals with Intellectual Disabilities through the Department, including waiver participants.

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

The Department of Health Care Policy and Financing (the Department) is responsible for operating the grievance complaint system. A waiver participant may file a grievance/complaint regarding any dissatisfaction with services and supports provided. All Community Centered Boards (CCB) and qualified provider agencies are required to have specific written procedures to address how grievances will be handled. The agencies' procedures shall identify who at the agency is to receive the grievance and who will support the participant in pursing his/her grievance, how the parties shall come together to resolve the grievance (including the use of mediation), the timelines for resolving the grievance and that the agency director considers the matter if the grievance cannot be resolved at a lower level. An agency is required to maintain documentation of grievances/complaints received and the resolution thereof. An agency shall provide information on its grievance/complaint procedure at the time a participant is enrolled into the waiver and anytime the participant indicates dissatisfaction with some aspect of the services and supports provided. Such information also states that the use of the grievance/complaint procedures is not a pre-requisite or substitute for the Medicaid Fair Hearing process specified in Appendix F 1. Participants have access to both processes.

Participants or his/her representatives may file a grievance with the Department via telephone, US mail or e-mail. The Department has written procedures for addressing grievances/complaints regarding services and supports provided in the intellectual and developmental disabilities services system (DDD Quality Management Manual June 2007). These procedures specify that the Department staff are to determine the level of involvement of state staff in resolving complaints including, where indicated, direct complaint investigation by the Department staff and requirements for documentation of results in the Department complaint log. All complaints received via voice mail or e-mail are to be responded to within one business day. Primary involvement by the Department staff in resolving the complaint is generally only implemented when local efforts to resolve the complaint have failed, or if the complainant has a valid reason for not contacting the local agency (e.g., previous efforts to resolve similar complaints have failed, complaint involves a manager at the agency, fear of retaliation, etc.) Timelines for resolving the complaint are to be commensurate with the seriousness of the complaint (e.g., a complaint regarding a health and welfare issue shall be resolved immediately, complaints regarding agency meal menu selection procedures should be resolved promptly, etc.). The Department staff are responsible for follow-up with the complainant regarding resolution of the complaint and for documenting the complaint and its resolution in the Department's Complaint Log. The Department staff are also responsible for maintaining a written record of all complaints investigated by the Department Staff.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*
  If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

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

Reporting to Law Enforcement and Adult Protection- All Program Approved Service Agencies (PASA) and Community Centered Boards (CCB) are required to report any incident in which a crime may have been committed to local law enforcement pursuant to Title 18-8-115, C.R.S. (Colorado Criminal Code -Duty To Report A Crime). The PASA and CCB also shall report any suspected incidents of abuse, neglect or self-neglect to county departments of social services adult protection units pursuant to Title 26-3.1-101, C.R.S. (At-Risk Adult Statute. Requirements for such reporting are included in DHS/DDD Rules located at 2 CCR 503-1 16.580 C.

Provider Reporting- The Department of Health Care Policy and Financing (the Department) requires all PASAs to report specific types of incidents to the CCB immediately upon detection via telephone, e-mail or facsimile but no more than 24 hours after the incident occurrence. These incidents include allegations of mistreatment, abuse, neglect and exploitation, medical crises requiring emergency treatment, death, victimization as a result of a serious crime, alleged perpetration of a serious crime and missing persons. Requirements for such reporting are located at 2 CCR 503-1 16.580. Subsequent to initial reporting, the agency must submit a written incident report to the CCB within 24 hours of discovery of the incident.

CCB Reporting- The Department operates a web-based critical incident reporting system and requires all CCBs to report a specific class of incidents, termed critical incidents, to the Department, as soon as possible after discovering the incident but no later than noon of the next business day. Critical incidents that require such reporting include allegations of mistreatment, abuse, neglect and exploitation that involve injury, death, adverse medical outcome, crime committed against a participant or by a participant, exploitation in excess of $300, police involvement, and allegations identified through trend analysis of incident data (e.g., pattern of suspicious bruising, multiple medication errors, etc.) Critical incidents are reported to the Department via the web-based Critical Incident Reporting System (CIRS) through a secure web portal. CCBs and waiver service providers may also fax a critical incident report to the Department when necessary. The definitions of critical incident categories are available in the Quick Guide to Critical Incidents (May 2007).

Licensed Community Group Home Reporting- All PASAs operating group homes licensed by the Colorado Department of Public Health and Environment (CDPHE) are required to report a specific class of incidents through the CDPHE Occurrence Reporting Program no later than the end of the next business day after discovery. A list and definition of critical incidents that must be reported to DPHE through the Occurrence Reporting Program are included in the Occurrence Reporting Manual (Amended August 2011) and include the following types of incidents: Physical abuse, sexual abuse, verbal abuse, neglect, brain injuries, burns, death, diverted drugs, life threatening complications due to anesthesia, transfusions, malfunction or misuse of medical equipment, misappropriation of resident property, missing persons and spinal cord injuries.

c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The Case Management Agency (CMA) provides information about mistreatment, abuse, neglect and exploitation to the participants, guardians, involved family members and authorized representatives at initial enrollment and annually thereafter. This will include information on the right to be free from mistreatment, abuse, neglect and exploitation, how to recognize signs of mistreatment, abuse, neglect and exploitation, and how to report mistreatment, abuse, neglect and exploitation.

Additionally, the information will include the requirements of service provider agencies and Targeted Case Management agencies for detecting and follow-up to suspicions and allegations of mistreatment, abuse, neglect and exploitation.

The Service Plan identifies concerns about abuse, neglect, mistreatment and exploitation that were identified in the participantÃƒÂ¢Ã‚Â€Ã‚Â™s level of care assessment. The intellectual and developmental disabilities section of the Service Plan has data fields to document the participantÃƒÂ¢Ã‚Â€Ã‚Â™s response to whether he/she feels safe in the home and whether he/she would like to learn self-advocacy skills. When requested by the participant and/or guardian, individual services and support plans can be developed teach the participant how to protect him/herself to prevent and report abuse, neglect, mistreatment and exploitation.

d. **Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Monitoring - Community Centered Boards (CCB) and Program Approved Service Agencies (PASA) monitor services (e.g., incident reports, anecdotal data, interview, etc.) and are required to identify and report all critical incidents. The Department of Health Care Policy and Financing (The Department) identifies incidents of non-compliance through Program Quality on-site surveys, stakeholder complaints and review of the critical incident reporting system.

Response to Critical Incidents Reportable To Law Enforcement and Adult Protection- In general, all investigations by law enforcement agencies and county departments of Adult Protective Services (APS) take precedence over investigations conducted by the Department and/or Case Management Agencies (CMA). Such critical incidents include those in which a crime may have been committed against or by a waiver participant, and allegations of abuse, neglect or self-neglect of a waiver participant. However, when law enforcement or county APS has determined that additional follow-up to a reported critical incident under the agencyÃƒÂ¢Ã‚Â€Ã‚Â™s purview does not require follow-up or investigation by law enforcement or county APS, the CMA agency is responsible for follow-up action. Where appropriate, the CMA agency must conduct an investigation on any questions not resolved by a law enforcement or county APS investigation (e.g., provider training, program management supervision, etc.).

Response to Critical Incidents by The Department: All mandatory incident reports are reviewed by the Department through the Critical Incident Reporting System (CIRS), further described in Appendix G.1 b. The CCB enters the critical incident report into CIRS. The Department reviews the report and issues a directive to the CCB requesting specific follow-up action. The Department reviews written reports provided by the CCB and PASAs. When necessary the Department may conduct an investigation or on-site review to ensure thorough completion of follow-up by the CCB or PASA.

When the Department determines that an investigation by state staff is required the investigation is initiated within 24 hours. The Department determines the need for state level investigation based on:

1) The severity of the critical incident (e.g., hospitalization due to pneumonia versus physical abuse resulting in an injury, etc.);

2) The critical incident history of the waiver participant; and

3) The history of the CCB and PASAs regarding reporting and response to critical incidents.

Additionally, The Department conducts or closely monitors those investigations completed by CCBs in which there may be a direct conflict of interest when the investigating party is, or is part of, the investigated party. The Department reviews all complete, written critical incident and follow up investigation reports, in the event of abuse, neglect, or exploitation and if the incident involves staff or contractors of a PASA operated by the CCB providing case management services to the participant. This is to ensure the investigation is thorough, conclusions are based upon evidence, and that all investigative questions are addressed. Timelines for completion of follow-up and/or investigation of critical incidents depend upon the severity and complexity of the incident, but are generally within 30 days of the critical incident, unless a good cause for a delay exists (e.g., awaiting investigation by law enforcement, lack of access to witnesses or the victim for interviews, etc.). Investigations completed by the Department are conducted in accordance with the requirements and standards specified in The Investigations Manual (October 2006) and within the recommended standards of practice specified in the Conducting Serious Incident Investigations (2003) manual developed by Labor Relations Alternatives, Inc.

Response to Critical Incidents by CCBs - CCBs are to ensure the health and safety of waiver participants in all critical incidents and to complete follow-up actions to prevent future critical incidents. CCBs are required to investigate all allegations of mistreatment, abuse, neglect and exploitation pursuant to DHS/DDD Rule 2 CCR 503-1 16.580. All investigations completed by CCBs are to comply with the requirements and standards specified in The Investigations Manual (October 2006) and within the recommended standards of practice specified in the Conducting Serious Incident Investigations (2003) manual developed by Labor Relations Alternatives, Inc. The local Human Rights Committee (HRC) reviews all written investigation reports and, where appropriate, issues recommendations for follow-up actions by the provider agency and or the CCB.

Notification of Outcomes of Investigations - All investigations completed by the Department are documented in a written investigation report. When the target of the investigation is a staff person/host home provider or a PASA to which the allegations are against, the written investigation report is not shared with the target(s) of the investigation. When the CCB is not the target of the investigation, a summary is provided to inform them whether the allegation was substantiated, and any recommendations or directives including deficiencies requiring plans of correction. The Department will notify the participant, legal representative and/or his/her guardian of the findings of the investigation and any follow-up action required, within 5 working days of completing the written investigation report. Investigators are encouraged to keep participants, authorized representatives and guardians advised of the progress of the investigation, and to assist providers with putting victim supports into place.

Summary information regarding the findings and recommendations of all investigations are made available to PASAs, waiver participants, authorized representatives and/or guardians within five (5) days of local HRC review of the investigation. The information may be shared with the PASA prior to HRC review to prevent future incidents, address quality of care issues, or to provide victim supports.

Practices regarding notification of the outcomes of investigations completed by local law enforcement and child protective services agencies are under the purview of those agencies. Typically those agencies provide standard information on the outcomes of the investigation to victims of abuse, neglect or exploitation.

Upon completion of the investigation the CCBs will provide verbal and written information to the participant, and where appropriate guardian or authorized representatives, on the outcomes of the investigation. PASAs are also notified of the outcome of the investigation and, where appropriate, recommendations or directives to prevent future incidents and to provide support to the participant. PASAs are also expected to provide documentation of follow-up action to the investigation to the CCB for review and approval by the local HRC.

e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

Ongoing oversight of critical incidents is the responsibility of the Department of Health Care Policy and Financing (the Department). The Department reviews and evaluates each reported critical incident as soon as possible but no later than noon the next business day. Data on the total and type of critical incidents by service type, provider and Community Centered Board (CCB) are reviewed monthly by the Department to identify incident trends, problematic practices, and to follow-up with specific provider and/or CCBs. Reviews are conducted of any participant who has had more than one incident in 30 days, more than three incidents in six months, and more than five incidents in 12 months. All current sentinel events are reviewed during the monthly Incident Review Team (IRT) meetings to

determine if the Department needs to take additional follow-up action or if additional directives need to be issued to service provider or CCBs.

Program Quality On-site Surveys- The Department conducts on-site regulatory surveys of incident management practices of Program Approved Service Agencies (PASA)and CCBs. Program Quality on-site surveys are completed of PASAs at least every three years. Administrative review of CCBs will be conducted on an annual basis, as specified in the Global QIS.

Appendix G: Participant Safeguards

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

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

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

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

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

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

Seclusion- State law Title 27-10.5-115 (5) C.R.S. prohibits the use of seclusion. Monitoring by case managers, investigation of complaints made to Case Management Agencies (CMA) and the Department of Health Care Policy and Financing (the Department), and on-site program quality surveys conducted by the Department are used to detect the illegal use of seclusion and to prevent any future use of seclusion by a provider agency.

Restraints- Use of physical, mechanical and chemical restraints are not prohibited in state statutes or policies. However, state law Title 27-10.5-115 CRS prohibits the use of certain mechanical devices (e.g., posey vests, strait jackets, wrist and ankle restraints) and places specific restrictions on the use of physical and mechanical restraints. State law Title 26-20 CRS provides additional prohibitions and restrictions on the use of restraints.

Restraints may be used only in an emergency, after alternative procedures have been attempted and failed, and to protect the participant and others from injury. An "emergency" is defined as a serious, probable, imminent threat of bodily harm to self or others where there is the present ability to effect such bodily harm. Only trained Program Approved Service Agency (PASA) direct care service providers may use mechanical or physical restraints. PASAs are to use alternative methods of positive behavior support (e.g.,de-escalation techniques, positive reinforcement, verbal counseling, etc.) and/or the least restrictive alternative to bring the participant's behavior into control prior to the use of mechanical or physical restraints. PASAs and Community Centered Boards(CCBs) must ensure that all direct care service providers are trained in the use of restraints prior to use of restraint utilizing an approved technique. Approved techniques involve the use of positive behavioral interventions (e.g., de-escalation, redirection, and blocking techniques) and/or the least restrictive alternative to bring the participant's behavior into control prior to the use of mechanical or physical restraints.

Direct care service providers must be trained in general positive behavioral supports and in service and supports specific to individuals for which services are provided (e.g., Individual Service and Support

Plans to address behavior and individual's Safety Control Procedure). In addition, the PASA and CCB must have policies and procedures specific to the use of emergency control procedures (i.e., unanticipated use of restraint) and should include positive behavioral interventions in such procedures.

Requirements and safeguards for the use of mechanical and physical restraints are specified in DHS/DDD Rules located at 2 CCR 503-1 16.530 and 16.540, which also require the following:

The participant shall be released from physical or mechanical restraint as soon as the emergency condition no longer exists.

Physical or mechanical restraint cannot be a part of an Individual Service and Support Plan, as a substitute for behavior programming, and only can be used in accordance with rules and regulations.

No physical or mechanical restraint of a participant shall place excess pressure on the chest or back of that person or inhibit or impede the person's ability to breathe.

During physical restraint, the participant's breathing and circulation must be monitored to ensure that these are not compromised.

Each CCB and PASA must have written policies and procedures on the use of physical restraint exceeding 15 minutes. Such policies and procedures must allow for physical restraint exceeding 15 minutes only when absolutely necessary for safety reasons and provide for backup by appropriate professional and/or direct care service providers.

Relief periods of, at a minimum, 10 minutes every hour must be provided to a participant in mechanical restraint, except when the person is sleeping. A written record of relief periods must be maintained.

A participant placed in a mechanical restraint must be monitored at least every 15 minutes by direct care service providers trained in the use of mechanical restraint to ensure that the person's physical needs are met and the person's circulation is not restricted or airway obstructed. A written record of such monitoring must be maintained.

The use of restraints in a prone position is prohibited.

Mechanical restraints used for medical purposes following a medical procedure or injury must be authorized by a physician's order that must be renewed every 24 hours. Other requirements applicable to mechanical restraint also apply.

Mechanical or physical restraints used for a diagnostic or other medical procedures conducted under the control of the agency (e.g., drawing blood by an agency nurse) must be dually authorized by a licensed medical professional and agency administrator, and its use documented in the participant's record.

Monitoring- CCB and PASA staff and direct care service providers are responsible for monitoring incident reports to identify when restraints are not used in accordance with statutory and regulatory requirements. Use of restraints not conforming to those requirements meets the definition of abuse (unreasonable restraint), is required to be reported as an allegation of abuse, and is subject to the investigation of abuse requirements specified in DHS/DDD Rule 2-CCR 503-1 16.580. The use of physical, mechanical and chemical restraints is reviewed by a local Human Rights Committee, pursuant to DHS/DDD Rule 2-CCR 503-1 16.550 I , either prior to the planned use of restraints or after each incident in which restraint was used.

Emergency Control Procedures- Emergency Control Procedures are defined as the unanticipated use of a restrictive procedure or restraint in order to keep the participant and others safe. Each PASA is required to have written policies on the use of Emergency Control Procedures, the types of procedures that may be used, and requirements for direct care service provider training. Behaviors requiring Emergency Control Procedures are those that are infrequent and unpredictable. Emergency Control Procedures may not be employed as punishment, for the convenience of direct care service providers, or as a substitute for services, supports or instruction.

Within 24 hours after the use of an Emergency Control Procedure, the responsible direct support service provider must file a written incident report. The incident report must include the following information:

1) A description of the Emergency Control Procedure employed, including beginning and ending times;
2) An explanation of why the procedure was judged necessary; and,
3) An assessment of the likelihood that the behavior that prompted the use of the Emergency ControlProcedure will recur.

Within three days after use of an Emergency Control Procedure, the CCB/case manager, guardian, and authorized representative if within the scope of his or her duties, must be notified of the use of the mechanical or physical restraint.

Safety Control Procedure- Safety Control Procedure is defined as a written plan describing what procedures will be used to address emergencies that are anticipated and stating that physical or mechanical restraints are to be used to ensure safety of the participant or others when previously exhibited behavior is likely to occur again. The use of Safety Control Procedures must comply with the following:

Each CCB and PASA must have written policies on the use of Safety Control Procedures, the types of procedures that may be used, and requirements for staff training. When a Safety Control Procedure is used, the PASA must file an incident report within three days with the CCB/case manager for each use of a Safety Control Procedure. If the Safety Control Procedure is used more than three times within the previous 30 days, the participant's interdisciplinary team must meet to review the situation and to endorse the current plans or to prepare other strategies.

Chemical restraints may be used only in conformance with the requirements of state law Title 26 Section 20 CRS, only in an emergency and cannot be ordered or used on a PRN basis. Only a licensed physician that has directly observed the emergency can prescribe chemical restraints or he/she may order the use of the medication for an emergency via telephone if a licensed registered nurse has directly observed the participant and determined that an emergency exists. The licensed registered nurse must transcribe and sign the order at the time the order is received.

Subsequent to the administration of the chemical restraint, the physician or licensed registered nurse must observe the effects of the medication and record the effects in the record of the participant.

Within 24 hours, the responsible PASA direct care service provider must file a written incident report documenting the use of the chemical restraint with the CCB/case manager.

Training Requirements- All direct care service providers must receive training on the use of restraints, Emergency Control Procedures, and Safety Control Procedures prior to having unsupervised contact with waiver participants. Additionally, direct care service providers responsible for the use of restraints must receive specific training on the emergency procedures to be used with participants under their care.

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

State oversight of the use of restraints and seclusion is the responsibility of the Department of Health Care Policy and Financing (the Department). Such oversight is accomplished through the operation of the Critical Incident Reporing System (CIRS), quarterly review of Community Centered Board (CCB) incident data and Program Quality on-site surveys of Case Management Agencies (CMA) and Program Approved Service Agencies (PASA).

Critical Incdient Reporting System (CIRS) Monitoring- The web-based CIRS system operated by the Department includes a specific data field for recording if any critical incident involved the use of restraints. Therefore, any use of restraint in an allegation of serious abuse, medical crisis (i.e. needing emergency medical treatment), crime against a person or death is reported immediately to the Department. Such incidents receive additional scrutiny by the Department staff that includes review of the original written incident report to ensure restraint was used in compliance with statutory and

regulatory requirements. The CIRS monitoring operates on a daily/continuous basis.

Quarterly Data Review of CCB Incident Data- CCBs are required to provide a data summary of all incident reports and complaints received by case managers on a quarterly basis. Reportable incidents that are included in that summary are data on the use of restraints. As described in Appendix H.1.d., The Department's Incident Response Team (IRT) completes the quarterly review of CCB incident data to identify trends for PASAs and, where indicated, individual participants. Outcomes of the IRT reviews of quarterly data include action items for additional follow-up in the form of additional data collection and analysis, remediation and quality improvement plans. IRT meetings and reviews of CCB incident data are completed on a quarterly basis.

Program Quality On-site Surveys- The Department conducts on-site regulatory surveys of PASAs and CCBs that include a review of the agency's incident management practices, compliance with standards for incident reporting and review, and data analysis practices. Such surveys include a specific review of written incident reports documenting the use of restraints to ensure such reports contain the information required by DHS/DDD rule 2 CCR 503-1 16.530 and 16.540 and that restraints are used only within the requirements specified in DHS/DDD rule 2 CCR 503-1 16.500 et seq. The Department's on-site regulatory survey of PASAs also includes a specific review of the use of restrictive procedures (e.g., time-out, response-cost programs, etc.) to ensure the PASA's practices comply with the statutory and regulatory requirements specified in state law Title 27-10.5 CRS and DHS/DD rule 2 CCR 503-1 16.530 (e.g., granting of informed consent for the use of the restrictive procedures, behavior assessments, written programs, direct care service providers training, etc). Additionally, on-site surveys of CCBs include a specific review of the local HRC review activities, the composition of the participant's interdisciplinary team, and investigation of allegations of abuse related to unreasonable restraint. When non-compliant use of restrictive procedures, restraints, or any use of seclusion is detected, deficiencies are cited and the responsible agency is required to submit a plan of correction.

Seclusion- As noted above, the use of seclusion is specifically prohibited by state law Title 27-10.5 CRS. The oversight mechanisms described above in G.1.c. are employed when an incident involving seclusion is detected.

Waiver specific performance measures included in the Quality Improvement Strategy (QIS) regarding the use of restraints includes the "Number and percent of critical incident reports, by incident type, involving the use of restraints" and the "Number and percent of waiver providers reviewed that consistently met requirements for use of physical or mechanical restraints". Please see the Performance Measure section of this application for additional information. Please note that the review of these waiver specific performance measures will be subject to the same remediation, data aggregation, review and quality improvement processes specified in the Global QIS.

Appendix G: Participant Safeguards

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

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

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

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

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

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including

restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

The use of aversive or noxious stimuli are specifically prohibited by state law Title 27-10.5 115 CRS. Restrictive procedures may be used only when alternative non-restrictive behavior programs have been proven to be ineffective in changing the behavior. Additionally, a Developmental Disabilities Professional having specific knowledge and skills to develop and implement positive behavioral intervention strategies must supervise behavior change programs using restrictive procedures. Restraints may not be used as part of a behavior plan and can only be used as part of an Emergency or Safety Control Procedure, as described in G.2.a.i.

DHS/DDD rule 2 CCR 503-1 16.120 defines a Restrictive Procedures as "any of the following when the intent or plan is to bring the person's behavior into compliance: A. Limitations of an individual's movement or activity against his or her wishes; or, B. Interference with an individual's ability to acquire and/or retain rewarding items or engage in valued experiences". Additionally, this rule defines Challenging Behavior as "Behavior that puts the person at risk of exclusion from typical community settings, community services and supports, or presents a risk to the health and safety of the person or others or a significant risk to property".

DHS/DDD rule 2-CCR 503-1 16.520 provides specific requirements anytime a Restrictive Procedure is to be used as part of an individual service and support plan (ISSP).

The rights of participants may be removed or suspended only in accordance with state law Title 27-10.5 and DHS/DDD rules. A suspension of rights is authorized under the two following processes:

Legal Imposition of Disability- Pursuant to state law Title 27-10.5-110 any individual, including a case manager for a waiver participant, may petition the district court to issue an imposition of legal disability to remove a participant's legal right. Articles of this state law provide specific requirements for when such an imposition may be granted and that the imposition must be reviewed by the court every six months. All actions to remove a legal right require a court order.

Suspension of Rights- Pursuant to state law Title 27-10.5-112 the rights of a participant may be suspended only to protect the participant from endangering themselves, others, or property. Such rights may be suspended only by a Developmental Disabilities Professional, with subsequent review by the interdisciplinary team (IDT) and by the local Human Rights Committee (HRC) to ensure the suspension which will promote the least restriction on the participant's rights.

Safeguards in place to protect participant's rights are included in 2 CCR 503-1 16.311 and include the following:

All participants, guardians and authorized representatives must be provided a written and verbal explanation of the participant's rights at the time the person is determined eligible to receive developmental disability services, at the time of enrollment, and when substantive changes to services and supports are considered through the Service Plan development process. The information must be provided in an easy to understand format and in the participant's native language, or through other modes of communication as may be necessary to enhance understanding. Community Centered Board (CCB) and Program Approved Service Agencies (PASA) are required to provide assistance and ongoing instruction to participants in exercising their rights. No participant, his/her family members, guardian or authorized representatives, may be retaliated against in their receipt of services or supports or otherwise as a result of attempts to advocate on their own behalf. Direct care service providers are required to successfully complete training on and be knowledgeable of participant's rights and the procedural safeguards for protecting those rights.

When suspension of a participant's rights is under consideration, the rights must be specifically explained to the individual, with written notice of the proposed suspension given to the participant, and when appropriate his/her guardian.

At the time a right is suspended, such action shall be referred to the local HRC for review and recommendation. This review must include an opportunity for the participant, guardian or authorized

representative to present relevant information to the local HRC. If suspended, the suspension is documented in the participant's Service Plan. The participant's Service Plan must specify the services and supports required in order to assist the person to the point that suspension of rights is no longer needed.

When a right has been suspended, the continuing need for such suspension must be reviewed by the participant's IDT at a frequency decided by the team, but not less than every six months. The review must include the original reason for suspension, the participant's current circumstances, success or failure of programmatic intervention, and the need for continued suspension or modification. Affected rights must be restored as soon as circumstances justify. Case managers are responsible for monitoring that restrictive procedures and a suspension of rights are used only in compliance with these requirements. Additionally, local HRCs are responsible to ensure restrictive procedures and procedures to suspend rights are used only in compliance with the requirements of state law and DHS/DDD rules.

Safeguards for the Use of Restrictive Procedures- When a PASA and IDT recommend or plan to use a restrictive procedure to change a participant's challenging behavior the provider agency and IDT must: a) complete a comprehensive review of the participant's life situation, b) complete a functional analysis of the participant's challenging behavior, c) prepare a written ISSP with specific information defined in DHS/DDD rule 2-CCR 503-1 16.520 3, and d) obtain the informed consent of the participant, his/her guardian for the use of the restrictive procedure.

Documentation Requirements- The use of restrictive procedures must be included in the participant's Service Plan or Service Plan addendum. Copies of the comprehensive life review, functional analysis assessment, written ISSP and data documenting the use of the restrictive procedures must be maintained in the participant's records. Additionally, the CCB is responsible for providing the local HRC with copies of all pertinent documents and data for the HRC to complete its review, and must maintain documentation of the HRC's review and recommendations.

Direct Care Service Provider Requirements- Direct care service providers are required to be trained specifically on implementation of the ISSP with a restrictive procedure prior to its use. Documentation of training and a signed assurance that the direct care service provider has demonstrated competence in implementation of the ISSP with a restrictive procedure must be included on the written ISSP. (Direct care service providers responsible for supervising an ISSP with restrictive procedures and for implementing a suspension of rights must meet the qualifications of a Developmental Disabilities Professional, defined at in DHS/DDD rule 2-CCR 503-1 16.520 as person who has, at least, a Bachelors Degree and a minimum of two years experience in the field of developmental disabilities or a person with at least five years of experience in the field of developmental disabilities with competency in the following areas: a) Understanding of civil, legal and human rights; b) Understanding of the theory and practice of positive and non-aversive behavioral intervention strategies; c) Understanding of the theory and practice of non-violent crisis and behavioral intervention strategies.

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

State oversight of the use of restrictive interventions is the responsibility of the Department of Health Care Policy and Financing (The Department). Program Quality staff provide oversight by conducting on -site surveys of Community Centered Boards (CCB) and Program Approved Service Agencies (PASA) and by receipt and review of complaints regarding services and supports.

Program Quality On-site Surveys- On-site regulatory surveys of all PASAs includes a review of the agency's implementation of services and support to address needs identified in participants' service plans, including the Individual Services and Supports Plan (ISSP) development process and practices, and the use of restrictive interventions. Such surveys include a specific review of: a) written ISSPs with restrictive procedures; b) data indicating the implementation/outcomes of the ISSP with restrictive procedures; c) the qualifications of direct support service providers implementing and supervising the ISSP with restrictive procedures; and d) review of the success of the restrictive intervention. On-site surveys also review the suspension of rights of participants to ensure the suspension is allowable and that due process requirements required by rule are consistently implemented, including documentation of review by the Human Rights Committee (HRC) of all ISSPs with restrictive

procedures. Additionally, on-site surveys of CCBs include a specific examination of HRC reviews of the PASA's use of restrictive interventions, review of the restrictive intervention, and Service Plan activities of the participant's IDT.

Program Quality on-site surveys are completed of PASAs at least every three years. Administrative review of CCBs will be conducted on an annual basis, as specified in the Global Quality Improvement Strategy (QIS).

Complaints Regarding Service and Supports- Program Quality staff directly receive complaints from participants, guardians, authorized representatives and case managers regarding services and supports provided by PASAs. Complaints regarding the non-compliant use of restrictive interventions or rights suspensions are documented in the Complaint Log and receive follow-up action. Additionally, the Department receives quarterly complaint data from each CCB that includes any reported complaints regarding services and supports, including the non-compliant use of restrictive interventions and rights suspensions.

Appendix G: Participant Safeguards

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

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

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

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

- **The 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.

Program Approved Service Agencies (PASA) are responsible for ongoing medication management and follow-up. Requirements for direct support service provider training, assessment, administration, documentation and monitoring are set out at included in DHS/DDD rule 2 CCR 503-1 16.623. Monitoring the use of medications, including psychoactive medications, are the responsibility of case managers/Community Centered Boards (CCB).

Monitoring- On-site monitoring by PASAs of the provision of services and supports, including medication administration, is required by DHS/DDD rule 2 CCR 503-1 16.662. The frequency of monitoring for medication management is commensurate with the level of complexity of the participant's medication regimen. Additionally, case managers monitor to ensure that the participant is receives his/her medications in conformance with the physician's orders for the medication. Monitoring methods include inspecting medications for labeling, safe storage, completing pill counts, reviewing and reconciling the medication administration records, and interviews with direct support service providers and participants.

Psychoactive Medication- When PASA direct care service providers assist participants in the administration of medications to change or modify a participant's behavior or to treat his/her psychiatric symptoms the agency is subject to additional requirements. Specifically, the participant's Service Plan must document the use of psychoactive medications and the agency staff must document the effects of the medication. The participant's case manager is responsible for monitoring that such required actions are completed. When the PASA or case manager have concerns about the participant's use of psychoactive medications the service provider is required to make a referral to the local Human Rights Committee.

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

The Department of Health Care Policy and Financing (the Department) is responsible for state oversight of medication management. Program Quality staff conduct on-site surveys of service provider agencies. Specifically, Program Approved Service Agency (PASA) practices regarding the use of psychoactive medications are reviewed to ensure that such medications are only prescribed subsequent to a psychiatric evaluation recommending the use of the medication. Program Quality on-site surveys are completed of PASAa at least every three years. When the use of psychoactive medications in a manner that does not comply with requirements is discovered, deficiencies are cited and the agency is required to submit a plan of correction.

Appendix G: Participant Safeguards

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

c. **Medication Administration by Waiver Providers**

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

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

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

Medications may be administered by Program Approved Service Ageny (PASA) direct care service providers when done in conformance with the requirements of DHS/DDD rule 2 CCR 503-1 16.623 D. The following requirements must be met when medications are administered by direct care service providers:

Assessment- PASAs are required to assess each participant's need for support in medication management and administration. PASAs are required to provide sufficient support to the participant to ensure his/her safe use of medications.

Staff Administration- Unless the assessment indicates that the participant is independent in administering his/her medications, the PASA must provide direct care service providers who are legally authorized to administer medications. If the direct care service provider is non-licensed, he/she must have passed a medication administration training course and competency test approved by the Department of Public Health and Environment. A physician or dentist must prescribe all medications administered by direct support service providers. When medications are administered to a participant,the PASA must ensure that a written record of medication administration is maintained, including time and amount of medication taken by the person receiving services.

Overseeing Self-Administration- When assessment results indicate that the participant is capable of safely self administering his/her medications and does not require monitoring each time medication is taken, the PASA must provide sufficient, at minimum quarterly, monitoring or review of medications to determine that medications are taken correctly.

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

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

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

Medication errors meeting the criteria of a critical incident are reported to the Department of Health Care Policy and Financing (the Department) through the Critical Incident Reporting System (CIRS).

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

Medication errors must be recorded anytime an error was made in the dose, route, time, medication provided, or missed medication. Additionally, direct support service providers are required to complete a written incident report of any medication errors (including those not meeting the critical incident criteria), which must be reviewed by the Program Approved Service Agency and the participant's case manager.

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

Medication errors reported in the Critical Incident Reporting System (CIRS) are those resulting in an 1) Adverse health outcome, a medical crisis; 2) Death; 3) An allegation of neglect or abuse that results in an adverse medical/health outcome; or, 4) A pattern or trend of medication errors that indicate possible abuse or neglect.

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

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

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

The Department of Health Care Policy and Financing (the Department) is responsible for ongoing monitoring the performance of Program Approved Service Agencies (PASA) that administer medications. To identify problems in PASA performance, to support remediation, and to support quality improvement activities, the Department employs the following monitoring methods:

Monitoring Through the Critical Incident Reporting System (CIRS)- As identified in Appendix G.3.iii, specific types of medication errors are required to be reported as a critical incident in the web-based CIRS. Such reports are reviewed by the Department staff as soon as possible upon receipt but always before the end of the next business day and as part of monthly IRT meetings. The CIRS allows the Department staff to issue specific directives to the Community Centered Board (CCB) to ensure remediation of identified problems.

Quarterly Data Review of CCB Incident Data- All CCBs are required to provide to the Department a data summary of all incident reports, including incident reports documenting medication errors, received by case managers, on a quarterly basis. Data is reported by PASA, service type (e.g., day habilitation, individual residential services and supports, etc), and the number and type of incidents requiring follow-up by a medical professional.

Program Quality On-site Surveys- The Department's on-site regulatory surveys of all PASAs include a review of the agency's medication administration practices. These surveys evaluate the practices of the agency to ensure a) unlicensed direct support service providers have met state requirements for training and certification; b physician's orders for all medications; c) safe storage of medications; d) appropriate documentation of medication administration, refusals and errors; and e) that participants have a sufficient supply of medications.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. **Methods for Discovery: Health and Welfare**
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. **Sub-Assurances:**

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
Number and percent of critical incidents including Abuse, Neglect and Exploitation (ANE) and Death, in a representative sample reviewed by the Department withing required timeframes. Numerator: Number of ANE and Death critical incidents in the sample reviewed by the Department within the required timeframes. Denominator: Number of ANE and Death critical incidents within the sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Colorado Contracts Management System (CCMS) Date

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

Data Aggregation and Analysis:

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

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

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 in the representative sample reported within the required timeframe. Numerator: Number of critical incidents in the sample reported within the required timeframe. Denominator: Total number of critical incidents reported in the sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Colorado Contracts management System (CCMS)

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of annual trainings provided to Case Management Agencies (CMAs) and providers on preventative strategies related to identified trends in critical incidents. Numerator: Number of annual trainings provided. Denominator: Total number of annual trainings expected to be provided.

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of critical incidents in a representative sample involving restrictive interventions that are reviewed by the Department. Numerator: Number of critical incidents in the sample involving restrictive interventions reviewed by the Department. Denominator: Total number of critical incidents in the sample involving restrictive interventions.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Colorado Contracts management System (CCMS)

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

Data Aggregation and Analysis:

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

Performance Measure:
Number and percent of waiver participants who completed an annual physical.
Numerator: The number of participants who completed and annual physical.
Denominator: The total number of participants within the sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Colorado Contracts management System (CCMS)

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

		Confidence Interval = 95% with a 5% margin of error
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The Department uses information entered into the Contracts Management System (CCMS) as the primary method for discovery.

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.

Issues or problems identified during annual program evaluations will be directed to the Case Management Agency (CMA) administrator or director and reported in the individual's annual report of findings. CMAs deficient in completing accurate and required critical incident reports will receive technical assistance and/or training by Department staff. CMAs will be required to provide training and education on the process for reporting abuse, neglect, or exploitation to any participant whose record fails to document this requirement. In some cases, a plan of correction may be required.

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. Technical assistance may be provided to the CMA case manager, supervisor or administrator and a confidential report will be documented in the waiver recipient care file when appropriate.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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 created a Global Quality Improvement Strategy to improve compliance with the six waiver assurances. All performance measures have been updated to align with the new Improvement Strategy.

The Department operates eleven Home and Community Based Services (HCBS) waivers listed below. This Quality Strategy encompasses all services provided under these waivers. Waiver specific requirements and assurances have been included in the appendices for each waiver.
Brain Injury Ã¢Â€Â“ CO.0288

ChildrenÃ¢Â€Â™s Extensive Support Ã¢Â€Â“ CO.4180
ChildrenÃ¢Â€Â™s Home and Community Based Services Ã¢Â€Â“ CO.4157
ChildrenÃ¢Â€Â™s Home and Residential Program* Ã¢Â€Â“ CO.0305
Children with Autism Ã¢Â€Â“ CO.0434
Developmental Disabilities Ã¢Â€Â“ CO.0007
Elderly, Blind, and Disabled Ã¢Â€Â“ CO.0006
Community Mental Health Supports Ã¢Â€Â“ CO.0268
Children with Life Limiting Illness Ã¢Â€Â“ CO.0450
Supported Living Services Ã¢Â€Â“ CO.0239
Spinal Cord Injury Ã¢Â€Â“ CO.0961

*This waiver program is operated by the Colorado Department of Human Services (CDHS), 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, including data gathered from the Department of Public Health and Environment (DPHE), the DepartmentÃ¢Â€Â™s Critical Incident Reporting System (CIRS), annual programmatic and administrative evaluations, participant satisfaction surveys, and stakeholder input. The Department uses an interdisciplinary approach, engaging members of both the Waiver Operations Unit and the Quality Assurance and Audits Unit to monitor and review quality assurances to determine the need for design changes and system improvements. The GovernorÃ¢Â€Â™s Office of Information Technology (OIT) works closely with the Department to implement changes to the Benefits Utilization System (BUS). Work groups form as necessary to discuss prioritization and selection of system design changes.

The Department also uses standardized tools for critical incident reporting, service planning, and level of care (LOC) assessments for its HCBS waiver populations. Through use of the BUS, data that are generated from assessments, service plans, and critical incident reporting and concomitant follow-up, are electronically available at both the Case Management Agencies (CMA) and State level, allowing for effective access and use for clinical and administrative functions as well as for system improvement activities. This standardization and electronic availability provide for comparability across CMAs, waiver programs, and allow for on-going analysis.

The quality improvement reports are compiled and analyzed annually and provided to CMS through the 372 reports. In addition to the annual report, 1) critical incident reports are reviewed and follow up is completed at the time the critical incident is submitted, 2) the Program Quality staff continuously monitors the performance of individual agencies through on-site audits, 3) the Quality and Risk Management team conducts on going utilization reviews, and 4) the Quality and Risk Management team conduct National Core Indicator surveys to monitor consumer satisfaction.

Trending: The Department will use waiver-specific performance measures to monitor program performance. There are no HCBS national performances standards to which the State can compare performance, therefore, the Department will use its performance results to establish baseline data and to trend and analyze over time. The DepartmentÃ¢Â€Â™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 the Colorado Department of Public Health and Environment (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 among program administrators and the HCBS quality oversight specialist at quarterly HCBS Oversight Committee (HOC) meetings. Results will also be shared with CMA representatives during quarterly CMA meetings. The Department will utilize these meetings to identify areas for opportunity and to implement additional improvement.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The Department holds the 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, Case Management Agencies (CMAs), and other stakeholders.

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

The Department reviews 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. Relevance of the strategy with current practices.
5. 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).

Some Case Management Agencies (CMAs) may be subject to the independent audit requirements established by the Single Audit Act of 1984. To ensure compliance with components detailed in the Office of Management and Budget (OMB) Circular A-133 and Compliance Supplement, those CMAs contract with external Certified Public Accountant (CPA) firms to conduct financial and compliance audit.

Per Section 205(i) the OMB Circular A-133, Medicaid payments to a sub-recipient for providing patient care services to Medicaid eligible individuals are not considered Federal awards expended under this part unless a State requires the funds to be treated as Federal awards expended because reimbursement is on a cost-reimbursement basis. Therefore, the Department of Health Care and Policy Financing (the Department) does not require an independent audit of waiver service providers.

The Department maintains documentation of provider qualifications to furnish specific waiver services. This documentation includes copies of the Medicaid Provider Agreement, copies of the Medicaid certification, verification of applicable State licenses, and any other documentation necessary to demonstrate compliance with the established provider qualification standards.

Title XIX of the Social Security Act, the Colorado Medicaid State Plan, state regulations, and contracts establish financial record maintenance and retention requirements. A case record/medical record or file must be developed and maintained for each waiver participant. Providers are required to retain records that verify claims and substantiate payment for a period of six years. Records may be maintained for a period longer than six years when necessary for the resolution of any pending matters such an audit or litigation.

Claims are submitted to the Department's fiscal agent for reimbursement. Billing claims and payment warrant registers are maintained through the Medicaid Management Information System (MMIS). The MMIS is designed to meet federal certification requirements for claims processing. Waiver Services are reimbursed only according to the PAR and Service Plan.

Each month, a random sample of approximately 0.2% to 0.35% of the total monthly claims is chosen through the MMIS, and Explanation of Medicaid Benefits (EOMB) reports are sent to Medicaid participants identified within the sample. This percentage has remained unchanged for over ten years and was likely determined due to funding constraints at the time of contract negotiation. This methodology is not intended to be a representative sample, but is meant to be a supplemental, random method for validating provider billings. The Department may also send EOMB reports to an additional, targeted population when patterns of suspicious activity have been identified.

Participants in receipt of EOMB reports are asked to confirm that the services were rendered by means of an enclosed response document. All returned EOMBs are forwarded to the Department's fiscal agent. The fiscal agent reviews and investigates discrepancies between provider claims and participant responses.

The Department engages in a post-payment review of claims in order to ensure that provider documentation and timekeeping records substantiate claims for reimbursement. An Enterprise Surveillance Utilization Reporting System (ESURS) is used to create a peer group for each provider type and to identify all providers whose utilization is two standard deviations or more from the norm. Each month, these providers are referred to the Recovery Audit Contractor (RAC) or to Department staff for a desk audit. These desk audits involve a review of prior authorizations, service plans, provider documentation for each date of service billed, case management notes, supervisory visits, provider training, agency licensure, and complaint surveys.

Generally, desk audits begin with an initial investigation of three years of claims data to ensure that services are documented prior to the submission of a claim and that those claims are equivalent to the services rendered. Should suspicious trends be identified, the audits may be expanded to include of up to six years of claims data and could result in referrals to law enforcement for further investigations. Any overpayments identified are recovered.

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

prosecution and/or civil litigation. The Department'™s SOPs for case selection and recovery of overpayments are available upon request.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. **Methods for Discovery: Financial Accountability**
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*
   i. **Sub-Assurances:**

      a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
Number and percent of waiver claim lines paid using the correct code as specified in the Provider Bulletin and Billing Manual in a representative sample of participants. Numerator: Number of waiver claim lines paid using the correct code as specified in the Provider Bulletin and Billing Manual in the sample. Denominator: Total number of waiver claim lines in the sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Medicaid Management Information System (MMIS) Claims Data

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

		95% with a 5% margin of error
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of waiver paid claims in a representative sample of participants adhering to the limits set forth in the Prior Authorization Request (PAR). Numerator: Number of paid waiver claims in the sample adhering to the limits set forth in the PAR. Denominator: Total number of paid waiver claims in the sample

Data Source (Select one):
Other
If 'Other' is selected, specify:
Medicaid Management Information System (MMIS) Claims Data

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of waiver codes that adhere to the approved reimbursement methodology. Numerator: Number of waiver codes listed in the HCPF Billing

Manual that adhere to reimbursement methodology Denominator: Total number of waiver codes listed in the HCPF Billing Manual

Data Source (Select one):
Other
If 'Other' is selected, specify:
Review of billing manual compared to defined reimbursement methodology

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

Data Aggregation and Analysis:

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

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

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 waiver claims in the sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Medicaid Management Information System (MMIS) Claims Data

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of waiver 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 waiver claims in the sample

Data Source (Select one):
Other
If 'Other' is selected, specify:
Medicaid Management Information System (MMIS) Claims Data

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

☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% with a 5% margin of error
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The information gathered for the annual reporting of the performance measures serves as the Department's primary method of discovery. The CMA independent audit results and the post payment reviews administered by the Department's Program Intergrity 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.
Waiver administrators coordinate with the Department's Claims Systems and Operations Division staff to initiate any edits to the 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 Program Integrity section for investigation as detailed
in Appendix I- 1 of the application.

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

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

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).

All HCBS-DD services are reimbursed on a fee-for-service basis. The rate-setting model for waiver services provider payment was developed in 2007 by the Department in conjunction with the Human Services Research Institute (HSRI) and Navigant Consulting. The development process included the formation of a Technical Advisory Group (TAG), which included membership from providers and advocates. The TAG was used to provide

opportunity for public comment and to establish and refine the assumptions built into the model. Additional community participation was obtained through targeted cost and wage surveys, supplemental survey questions, provider agency discussions, and two statewide teleconference presentations. Rates determined using this model have not been re-based since its development; however, these rates have been modified to accommodate percentage-based rate adjustments mandated by the Colorado General Assembly.

The model is designed to standardize rates, recognize reasonable and necessary provider costs, reflect participant needs, increase transparency, and facilitate regular updates. The model employs assumptions regarding non-direct cost allocations; the intensity of the service; staffing ratios; the types of employees; and employee salaries, wages, and benefits. Data derived from the targeted provider cost and wage surveys, the Bureau of Labor Statistics (national and statewide), and industry standards were integrated into the model's assumptions.

The following rates were determined by the rate-setting model and are reimbursed at standard, fee-for service basis that does not vary based upon Support Levels or any other factor:

Supported Employment: Job Coaching (Individual)
Supported Employment: Job Development (Group)
Non-Medical Transportation (Not To/From a Day Program)
Behavioral Services: Behavioral Line Staff
Behavioral Services: Behavioral Consultation
Behavioral Services: Behavioral Counseling (Individual or Group)
Behavioral Services: Behavioral Plan Assessment

The following services are reimbursed on a standard, fee-for service basis but were not determined by the rate-setting model described above:

Dental Services
Vision Services
Residential Habilitation: Group Residential Services and Supports (Regional Center)

Dental services are reimbursed according to a specialized fee schedule. The rate for each dental procedure is based upon the mean rate identified by the American Dental Association's 2011 Survey of Dental Fees. Vision services are reimbursed according to the Colorado Medicaid Fee Schedule for State Plan and Early Periodic Screening, Diagnosis, and Treatment (EPSDT) vision services.

Group Residential Services and Supports (GRSS) delivered at the Regional Centers in Grand Junction and Pueblo are provided by the Colorado Department of Human Services (CDHS). Regional Center admission is limited to only those with complex mental health and/or behavioral needs, a history of sex offense, and/or those who are medically fragile. A standard, per-diem rate was negotiated by the Department and the CDHS Division for Regional Center Operations in order to recognize the specialized needs of this higher risk population. As indicated in Appendix I-3.e of this waiver renewal application, no public provider receives payments that, in aggregate, exceed its reasonable costs of providing waiver services. These costs are determined by audited cost reports. A new cost-based rate for each Regional Center will be in place by July 1, 2014 through a retroactive rate setting method.

Tiered rates are used to reimburse for those services for which the level of provider effort and the intensity of service are variable based upon the differing support needs of individuals. Difficulty of care factors been incorporated into the rate-setting model for rates. The Department contracted with HRSI to develop a methodology for the classification of individuals into Support Levels and to develop a uniform rate model that builds provider payment rates based upon those Support Levels and other underlying cost components.

Through an analysis of data compiled from the Supports Intensity Scales (SIS), historical funding consumption patterns, and other sources, HSRI developed a methodology that groups individuals into six Support Levels. These Support Levels are reflective of similar adaptive skills, behavioral and medical support needs, and the presence of safety risk factors individuals present to themselves or to the community. The SIS is a nationally recognized, norm-referenced, and statistically valid assessment tool endorsed and published by the American Association on Intellectual and Developmental Disabilities (AAIDD).

Participants may change Support Levels based upon changing needs and/or circumstances, and Support Level determinations may be disputed. Participants may submit a request for Support Level re-determination to the CCB at

any time. A Department-convened review panel considers the request – along with copies of the completed SIS Interview and Profile Form, the Support Level Calculation form, the Uniform Long-Term Care 100.2 assessment, the service plan, the Level of Need (LON) checklist, and any supplemental documentation asserting that the participant's Support Level should be re-determined. The review panel is comprised of at least three individuals with working knowledge of the SIS and of waiver services. A final decision is rendered at the conclusion of the review panel meeting. The review panel may decide that the current Support Level is appropriate, re-assign the participant to another Support Level, or request the re-administration of the SIS Interview and/or safety risk factors.

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

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

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

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

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

When the determination of a standard or tiered rate is difficult due to the variable nature of the service, the Community Centered Boards (CCBs) are authorized by the Department to negotiate reimbursement. The following services are reimbursed at a negotiated, fee-for-service basis:

Supported Employment: Job Placement (Individual or Group)
Non-Medical Transportation: Public Conveyance
Specialized Medical Equipment and Supplies (Disposable Supplies or Equipment)

In order to ensure that payments are consistent with the provisions of §1902(a)(30)(A) of the Social Security Act and 42 CFR §447.200-205, the Department has developed standards for reimbursements negotiated by CCBs. These standards are detailed at 10 CCR 2505-10 §8.500.100.F.

Supported Employment: Job Placement, Non-Medical Transportation: Public Conveyance, and Professional Services: Recreational Facility Fees/Passes are authorized by case managers at or below the rates available to members of the general public.

Specialized Medical Equipment and Supplies are reimbursed at the lower of the submitted charges or the total allowable cost listed on the Colorado Medicaid Fee Schedule for services provided through the State Plan Durable Medical Equipment (DME) benefit. Items not included or listed as manually priced on the DME fee schedule are authorized at the lower of the following:
1. Submitted charges;
2. Manufacturer's Suggested Retail Price (MSRP) less 21.43 percent; or
3. Actual invoiced acquisition cost plus 13.56 percent when no MSRP is available.

Provider payment rate development details for each service, including assumption descriptions, are available upon

request. The standard and tiered reimbursement rates and the Support Levels are uniform statewide and cannot be appealed.

Changes to provider payment rates are published in the Colorado Register in accordance with 42 CFR §447.205. Rate information is also communicated through provider bulletins and billing manuals available on the Department's website. Case managers provide rate information to the participant during service plan development or at any other time a participant requests the information.

Room and Board payments are excluded from the Residential Habilitation Services and Supports as outlined in section 5b. of Appendix I.

In order to incorporate the new units of service, programming staff from the Governor's Office of Information Technology have given an initial estimate of nine months to complete systems changes to the Benefits Utilization System (BUS). The Department believes the necessary systems, operational, and administrative changes as well as service provider and case management agency trainings can be completed by March 31, 2015.

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

Payments for all waiver services are made directly to providers through the Department's approved Medicaid Management Information System (MMIS). Waiver services may be rendered by qualified providers enrolled directly with the Department via an executed Medicaid provider agreement. Providers submit claims and are reimbursed directly through the MMIS for services rendered.

Waiver services may also be rendered by qualified providers acting under an Organized Health Care Delivery System (OHCDS) agreement. Waiver services delivered under such an agreement may be rendered by employees or contractors of the OHCDS agency. The OHCDS agency must ensure that its employees and contractors meet the provider qualifications detailed in Appendix C of the waiver application. The OHCDS agencies submit claims and are reimbursed directly through the MMIS for services rendered. Providers may also choose to contract with an Organized Health Care Delivery System (OHCDS) agencies. These providers submit documentation of service provision to and are reimbursed by the OHCDS. The OHCDS submits claims to the MMIS. Payments to qualified providers under contract with the CCBS are negotiated between the CCBs and those contractors. The Department does not reimburse for claims processing fees.

Providers may use the OHCDS arrangement for all HCBS-DD services.

The flow of billing is the same regardless of the type of service or if the service is provided by a family caregiver.

Appendix I: Financial Accountability

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

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

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

***Select at least one*:**

- [ ] **Certified Public Expenditures (CPE) of State Public Agencies.**

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

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

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

Appendix I: Financial Accountability

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

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

All waiver services included in the participant's service plan must be prior authorized by case managers. Approved Prior Authorization Requests (PARs) are electronically uploaded into the MMIS.

(a) 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 (CBMS) is a unified system for data collection and eligibility. It allows for improved access to public assistance and medical benefits by permitting faster eligibility determinations, and allowing for higher accuracy and consistency in eligibility determinations statewide. The electronic files from CBMS are regularly downloaded into the MMIS in order to ensure updated verification of eligibility for dates of service claimed.

(b) The MMIS system validates the prior authorization of submitted claims. Claims submitted without prior authorization are denied.

(c) A claim is a statement by the provider that the services were rendered. The audit process and post payment review processes review claims for accuracy. Case managers monitor service provision through Targeted Case Management to ensure that services are being provided according to the service plan. Should a discrepancy between a provider's claim and what the client reports occur, or should the client report that the provider is not providing services according to the service plan; the case manager reports the information to the Department for investigation. If the provider's client records do not match the claims filed, a payment recovery occurs.

Each month, a random sample of approximately 0.2% to 0.35% of the total monthly claims is chosen through the MMIS, and Explanation of Medicaid Benefits (EOMB) reports are sent to Medicaid participants identified within the sample. This percentage has remained unchanged for over ten years and was likely determined due to funding constraints at the time of contract negotiation. This methodology is not intended to be a representative sample, but is meant to be a supplemental, random method for validating provider billings. The Department may also send EOMB reports to an additional, targeted population when patterns of suspicious activity have been identified.

Participants in receipt of EOMB reports are asked to confirm that the services were rendered by means of an enclosed response document. All returned EOMBs are forwarded to the Department's fiscal agent. The fiscal agent reviews and investigates discrepancies between provider claims and participant responses.

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

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

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

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

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

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

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

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

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

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

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

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

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

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

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

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

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

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

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

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

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

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

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

The 3 State operated Regional Centers, Wheat Ridge Regional Center, Grand Junction Regional Center, and Pueblo Regional Center provide Residential Habilitation, Day Habilitation, Supported Employement, Behavioral and Transportation services.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

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

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

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

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

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

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

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

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

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

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

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

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

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

Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.

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

(a) Each Community Centered Board (CCB) is designated as an OHCDS. Agencies must be approved to provide Targeted Case Management services for this designation.

(b) Providers may enroll directly with the Department by submitting an application. Included in the application is a Claims Submission Method Form. On this form, providers elect to enroll directly with the Department or to contract with an OHCDS. Additional information on provider enrollment is available on the Department'™s website.

(c) Department regulations require that case managers provide participants, guardians, and/or authorized representatives a listing of all qualified providers in the area. The Department's website also contains a statewide list of qualified providers for waiver services.

(d) The Department maintains documentation of qualifications for all providers. This documentation includes copies of the Medicaid Provider Agreement, copies of the Medicaid certification, verification of applicable State licenses, and any other documentation necessary to demonstrate compliance with the established provider qualification standards.

(e) The OHCDS agencies subcontract with providers certified by the Department to provide specific waiver services or with independent contractors which have been verified by the OHCDS to have met all applicable licensing and/or established provider qualification standards. The Department assures provider qualifications are met by OHCDS subcontractors through administrative monitoring. Verifying and monitoring the service delivery of enrolled participants receiving a defined service from a qualified provider is the responsibility of the OHCDS. These standards are detailed at 10 CCR 2505-10 8.500.111.

(f) Financial accountability is assured for services delivered in the OHCDS arrangement through the same methods and processes used for services delivered in a direct service provider arrangement and as described in Appendix I-1 and Appendix I-2.d of this application.

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:

The rate setting methodology approved by Health Care Policy and Financing (the Department) that establishes the residential habilitation payment excludes all costs associated with room and board. All individuals receiving Residential Habilitation services are required to utilize their income to pay the provider the amount established by the Department to cover room and board. Each year when the new Supplemental Security Income (SSI) standard is issued, the Department issues a room and board Advisory Notice to all providers and case management agencies identifying the dollar amount the individual may keep for personal needs and the amount required to pay for room and board. Case managers are responsible to provide this information to individuals already enrolled in the waiver and to each new individual being enrolled. The Department provides technical assistance and training on personal needs funds, which includes information regarding the individual's responsibility to pay for his or her room and board. The Department's rules specifically exclude the costs of room and board.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.*Select one:*

- (●) **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ( ) **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C -3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- (●) **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ( ) **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. **Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] **Nominal deductible**
- [ ] **Coinsurance**
- [ ] **Co-Payment**
- [ ] **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. **Co-Payment Requirements.**

ii. **Participants Subject to Co-pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	64599.81	8306.00	72905.81	239844.00	65461.00	305305.00	232399.19
2	65184.67	8443.00	73627.67	250340.00	66554.00	316894.00	243266.33

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)
3	65353.41	8582.00	73935.41	261296.00	67665.00	328961.00	255025.59
4	66426.11	8723.00	75149.11	272731.00	68794.00	341525.00	266375.89
5	67181.22	8867.00	76048.22	284667.00	69943.00	354610.00	278561.78

Appendix J: Cost Neutrality Demonstration

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

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

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/IID
Year 1	4818	4818
Year 2	4843	4843
Year 3	4868	4868
Year 4	4893	4893
Year 5	4918	4918

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 Average Length Of Stay (ALOS) is calculated by dividing the number of enrolled days by the number of unduplicated participants. The Department reviewed Medicaid Management Information System (MMIS) historical claims data for the fiscal years ending June 30, 2008 through June 30, 2013. This is the same claims data used to generate the annual CMS 372(S) reports. The ALOS varied by 2% or less each year during that time period. The Department estimated the ALOS for the forecasted years using an average of the annual ALOS figures in the MMIS Claims data.

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 considered the number clients utilizing each service, the number of units per user, the average cost per unit and the total cost of the service. The Department examined historical growth rates, the fraction of the total population that utilized each service and graphical trends. Once the historical data was analyzed, the Department selected trend factors to forecast, the number of clients utilizing each service, the number of units per user and the average cost per unit. The Department notes that overall expenditures have declined over the past several years, but are beginning to show slight increases. At the same time, specific service trends vary widely. The Department believes that the delivery of services is

reaching a point of homeostasis and that client growth with continue along normal trend lines. The Department assumes rates will remain unchanged after several years of rate reductions followed by a recent increase due to an end of recent fiscal belt-tightening and a return to mild economic recovery. The numbers were then multiplied together to calculate the total expenditure for each service and added to derive Factor D. A 4% increase was applied to FY 2013-14 Cost Per Unit to account for a 4% rate increase authorized by the state. The FY 2013-14 Cost Per Unit is then Fixed for the remainder of the forecast, while clients utilization and units per client are trended with using historical growth rates.

ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

To calculate State Plan services costs associated with DD Waiver clients, the Department analyzed historical D' values. D' has been increasing fairly steadily since FY 2008. The Department has chosen the average cost per client growth rate FY 2007-08 to FY 22012-13 which is 1.65%.

The claims information used to derive the Factor D' does not contain costs for prescribed drugs for those dually eligible for Medicare and Medicaid as those claims are not tracked in the MMIS system.

The factor DÃƒÂƒÃ‚,ÂƒÃƒÂ‚,Ã‚,Â¢ÃƒÂƒÃ‚,Â‚ÃƒÂ‚,Ã‚,Â€ÃƒÂƒÃ‚,Â‚ÃƒÂ‚,Ã‚,Â™ estimates were calculated to include the Targeted Case Management (TCM) expenditures, and the Behavioral Health Organization (BHO) and other pre-paid health plan premiums.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

To calculate ICF/IID costs, the Department examined utilization and average per user ICF/IID costs. The Department trended expenditure using the average growth rate from FY 2007-08 to FY 2012-13 of 4.38%.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

When determining the state plan costs for ICF/IID clients, the Department reviewed 6 years of historical data and chose 1.67% which was the growth in per capita costs from FY 2007-08 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 Department and for the selected population.

The claims information used to derive the Factor G' does not contain costs for prescribed drugs for those dually eligible for Medicare and Medicaid as those claims are not tracked in the MMIS system.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services	
Day Habilitation	
Prevocational Services	
Residential Habilitation	
Supported Employment	
Dental Services	
Vision Services	
Behavioral Services	
Non Medical Transportation	
Specialized Medical Equipment and Supplies	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						**50527035.50**
Supported Community Connections	15 min	2949	1850.00	4.10	**22368165.00**	
Specialized Habilitation	15 min	2963	2290.00	4.15	**28158870.50**	
Prevocational Services Total:						**5569742.88**
Prevocational Services	15 min	678	2633.00	3.12	**5569742.88**	
Residential Habilitation Total:						**229507310.20**
Group Residential Services and Supports	Day	1102	322.00	191.10	**67810688.40**	
Individual Residential Services and Supports	Day	1070	299.00	125.86	**40266389.80**	
Individual Residential Services and Supports/ Host Home	Day	2744	330.00	134.10	**121430232.00**	
Supported Employment Total:						**8208906.66**
Supported Employment Job Development	15 min	13	31.00	12.80	**5158.40**	
Supported Employment - Job Coaching	15 min	1154	1533.00	4.63	**8190849.66**	
Supported Employment Job Placement	Item	22	1.00	586.30	**12898.60**	
Dental Services Total:						**2592529.97**
Preventative-Basic	Office Visit	3996	3.00	166.38	**1994563.44**	
Major	Office Visit	427	1.00	1400.39	**597966.53**	
Vision Services Total:						**510676.08**
Vision Services	Item	1842	1.00	277.24	**510676.08**	
				GRAND TOTAL:		**311241875.76**
				Total Estimated Unduplicated Participants:		**4818**
				Factor D (Divide total by number of participants):		**64599.81**
				Average Length of Stay on the Waiver:		350

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Behavioral Services Total:						**3910074.77**
Line Services	15 min	68	272.00	6.52	**120593.92**	
Behavioral Consultation	15 min	1176	35.00	25.32	**1042171.20**	
Behavioral Counseling	15 min	1177	85.00	21.94	**2194987.30**	
Behavioral Plan Assessment	15 min	867	31.00	20.55	**552322.35**	
Non Medical Transportation Total:						**10046543.10**
Public Conveyance	Item	789	1.00	1166.38	**920273.82**	
Mileage Band	trip	3642	318.00	7.88	**9126269.28**	
Specialized Medical Equipment and Supplies Total:						**369056.60**
Disposable Supplies	Item	942	5.00	56.89	**267951.90**	
Equipment	Item	127	1.00	796.10	**101104.70**	
				GRAND TOTAL:		**311241875.76**
				Total Estimated Unduplicated Participants:		**4818**
				Factor D (Divide total by number of participants):		**64599.81**
				Average Length of Stay on the Waiver:		350

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						**51177872.10**
Supported Community Connections	15 min	2980	1861.00	4.10	**22737698.00**	
Specialized Habilitation	15 min	2977	2302.00	4.15	**28440174.10**	
				GRAND TOTAL:		**315689356.09**
				Total Estimated Unduplicated Participants:		**4843**
				Factor D (Divide total by number of participants):		**65184.67**
				Average Length of Stay on the Waiver:		350

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Prevocational Services Total:						**6277780.08**
Prevocational Services	15 min	759	2651.00	3.12	**6277780.08**	
Residential Habilitation Total:						**231965147.40**
Group Residential Services and Supports	Day	1088	323.00	191.10	**67157126.40**	
Individual Residential Services and Supports	Day	1075	300.00	125.86	**40589850.00**	
Individual Residential Services and Supports/ Host Home	Day	2807	330.00	134.10	**124218171.00**	
Supported Employment Total:						**8372566.70**
Supported Employment Job Development	15 min	14	33.00	12.80	**5913.60**	
Supported Employment - Job Coaching	15 min	1170	1542.00	4.63	**8353168.20**	
Supported Employment Job Placement	Item	23	1.00	586.30	**13484.90**	
Dental Services Total:						**2640766.48**
Preventative-Basic	Office Visit	4073	3.00	166.38	**2032997.22**	
Major	Office Visit	434	1.00	1400.39	**607769.26**	
Vision Services Total:						**560517.36**
Vision Services	Item	1898	1.00	295.32	**560517.36**	
Behavioral Services Total:						**4083328.28**
Line Services	15 min	63	228.00	6.52	**93653.28**	
Behavioral Consultation	15 min	1220	33.00	25.32	**1019383.20**	
Behavioral Counseling	15 min	1238	85.00	21.94	**2308746.20**	
Behavioral Plan Assessment	15 min	1006	32.00	20.55	**661545.60**	
Non Medical Transportation Total:						**10168764.84**
Public Conveyance	Item	810	1.00	1166.38	**944767.80**	
Mileage Band	Trip	3681	318.00	7.88	**9223997.04**	
				GRAND TOTAL:		**315689356.09**
				Total Estimated Unduplicated Participants:		**4843**
				Factor D (Divide total by number of participants):		**65184.67**
				Average Length of Stay on the Waiver:		350

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Medical Equipment and Supplies Total:						**442612.85**
Disposable Supplies	Item	1181	5.00	56.89	**335935.45**	
Equipment	Item	134	1.00	796.10	**106677.40**	
				GRAND TOTAL:		**315689356.09**
				Total Estimated Unduplicated Participants:		**4843**
				Factor D (Divide total by number of participants):		**65184.67**
				Average Length of Stay on the Waiver:		350

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						**51842502.40**
Supported Community Connections	15 min	3011	1872.00	4.10	**23110027.20**	
Specialized Habilitation	15 min	2992	2314.00	4.15	**28732475.20**	
Prevocational Services Total:						**7078188.00**
Prevocational Services	15 min	850	2669.00	3.12	**7078188.00**	
Residential Habilitation Total:						**234463145.40**
Group Residential Services and Supports	Day	1074	324.00	191.10	**66498213.60**	
Individual Residential Services and Supports	Day	1080	301.00	125.86	**40914568.80**	
Individual Residential Services and Supports/ Host Home	Day	2871	330.00	134.10	**127050363.00**	
Supported Employment Total:						**6341139.38**
Supported Employment Job Development	15 min	15	35.00	12.80	**6720.00**	
				GRAND TOTAL:		**318140399.64**
				Total Estimated Unduplicated Participants:		**4868**
				Factor D (Divide total by number of participants):		**65353.41**
				Average Length of Stay on the Waiver:		350

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Employment - Job Coaching	15 min	1186	1151.00	4.63	6320348.18	
Supported Employment Job Placement	Item	24	1.00	586.30	14071.20	
Dental Services Total:						2689502.13
Preventative-Basic	Office Visit	4151	3.00	166.38	2071930.14	
Major	Office Visit	441	1.00	1400.39	617571.99	
Vision Services Total:						615298.92
Vision Services	Item	1956	1.00	314.57	615298.92	
Behavioral Services Total:						4286116.28
Line Services	15 min	58	191.00	6.52	72228.56	
Behavioral Consultation	15 min	1266	31.00	25.32	993708.72	
Behavioral Counseling	15 min	1302	85.00	21.94	2428099.80	
Behavioral Plan Assessment	15 min	1168	33.00	20.55	792079.20	
Non Medical Transportation Total:						10290986.58
Public Conveyance	Item	831	1.00	1166.38	969261.78	
Mileage Band	trip	3720	318.00	7.88	9321724.80	
Specialized Medical Equipment and Supplies Total:						533520.55
Disposable Supplies	Item	1481	5.00	56.89	421270.45	
Equipment	Item	141	1.00	796.10	112250.10	
				GRAND TOTAL:		318140399.64
				Total Estimated Unduplicated Participants:		4868
				Factor D (Divide total by number of participants):		65353.41
				Average Length of Stay on the Waiver:		350

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						**52519143.20**
Supported Community Connections	15 min	3043	1883.00	4.10	**23492872.90**	
Specialized Habilitation	15 min	3007	2326.00	4.15	**29026270.30**	
Prevocational Services Total:						**7981034.88**
Prevocational Services	15 min	952	2687.00	3.12	**7981034.88**	
Residential Habilitation Total:						**237045557.20**
Group Residential Services and Supports	Day	1060	325.00	191.10	**65833950.00**	
Individual Residential Services and Supports	Day	1085	302.00	125.86	**41240546.20**	
Individual Residential Services and Supports/ Host Home	Day	2937	330.00	134.10	**129971061.00**	
Supported Employment Total:						**8704245.50**
Supported Employment Job Development	15 min	16	38.00	12.80	**7782.40**	
Supported Employment - Job Coaching	15 min	1202	1560.00	4.63	**8681805.60**	
Supported Employment Job Placement	Item	25	1.00	586.30	**14657.50**	
Dental Services Total:						**2739236.06**
Preventative-Basic	Office Visit	4231	3.00	166.38	**2111861.34**	
Major	Office Visit	448	1.00	1400.39	**627374.72**	
Vision Services Total:						**675521.28**
Vision Services	Item	2016	1.00	335.08	**675521.28**	
Behavioral Services Total:						**4522483.72**
Line Services	15 min	53	160.00	6.52	**55289.60**	
Behavioral Consultation	15 min	1314	29.00	25.32	**964843.92**	
Behavioral Counseling	15 min	1370	85.00	21.94	**2554913.00**	
				GRAND TOTAL:		**325022969.63**
				Total Estimated Unduplicated Participants:		**4893**
				Factor D (Divide total by number of participants):		**66426.11**
				Average Length of Stay on the Waiver:		350

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Behavioral Plan Assessment	15 min	1356	34.00	20.55	947437.20	
Non Medical Transportation Total:						10189701.34
Public Conveyance	Item	853	1.00	1166.38	994922.14	
Mileage Band	trip	3760	318.00	7.69	9194779.20	
Specialized Medical Equipment and Supplies Total:						646046.45
Disposable Supplies	Item	1857	5.00	56.89	528223.65	
Equipment	Item	148	1.00	796.10	117822.80	
				GRAND TOTAL:		325022969.63
				Total Estimated Unduplicated Participants:		4893
				Factor D (Divide total by number of participants):		66426.11
				Average Length of Stay on the Waiver:		350

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						53200164.40
Supported Community Connections	15 min	3075	1894.00	4.10	23878605.00	
Specialized Habilitation	15 min	3022	2338.00	4.15	29321559.40	
Prevocational Services Total:						8999939.52
Prevocational Services	15 min	1066	2706.00	3.12	8999939.52	
Residential Habilitation Total:						239668129.80
Group Residential Services and Supports	Day	1046	326.00	191.10	65164335.60	
					41567782.20	
				GRAND TOTAL:		330397259.47
				Total Estimated Unduplicated Participants:		4918
				Factor D (Divide total by number of participants):		67181.22
				Average Length of Stay on the Waiver:		305

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Individual Residential Services and Supports	Day	1090	303.00	125.86		
Individual Residential Services and Supports/ Host Home	Day	3004	330.00	134.10	132936012.00	
Supported Employment Total:						8872289.86
Supported Employment Job Development	15 min	17	41.00	12.80	8921.60	
Supported Employment - Job Coaching	15 min	1218	1569.00	4.63	8848124.46	
Supported Employment Job Placement	Item	26	1.00	586.30	15243.80	
Dental Services Total:						2790869.52
Preventative-Basic	Office Visit	4312	3.00	166.38	2152291.68	
Major	Office Visit	456	1.00	1400.39	638577.84	
Vision Services Total:						741700.54
Vision Services	Item	2078	1.00	356.93	741700.54	
Behavioral Services Total:						4794715.68
Line Services	15 min	49	134.00	6.52	42810.32	
Behavioral Consultation	15 min	1364	27.00	25.32	932484.96	
Behavioral Counseling	15 min	1441	85.00	21.94	2687320.90	
Behavioral Plan Assessment	15 min	1574	35.00	20.55	1132099.50	
Non Medical Transportation Total:						10542774.50
Public Conveyance	Item	875	1.00	1166.38	1020582.50	
Mileage Band	trip	3800	318.00	7.88	9522192.00	
Specialized Medical Equipment and Supplies Total:						786675.65
Disposable Supplies	Item	2329	5.00	56.89	662484.05	
Equipment	Item	156	1.00	796.10	124191.60	

GRAND TOTAL:	330397259.47
Total Estimated Unduplicated Participants:	4918
Factor D (Divide total by number of participants):	67181.22
Average Length of Stay on the Waiver:	305