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

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

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

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

1. Request Information

A. The **State** of **Colorado** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.
B. **Program Title:**
Persons with Spinal Cord Injury
C. **Waiver Number:CO.0961**
D. **Amendment Number:CO.0961.R00.02**
E. **Proposed Effective Date:** *(mm/dd/yy)*
07/01/14
Approved Effective Date of Waiver being Amended: 07/01/12

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
The purpose of this amendment to the home and community based services- Spinal Cord Injury (HCBS-SCI) waiver is to update the waiting list procedure, update cost projections in Appendix J, add Hospital Level of Care.

Waiting List Procedure: On November 5, 2013 the waiver reached its 67 client capacity limit. Currently, there is a broad waiting list procedure; this amendment would allow the department to formalize the process it intends to use in managing the waiting list. This amendment will not change any services or eligibility requirements for clients on the waiver or for applicants.

Updated Cost Projections:On July 1, 2014 the General Assembly approved a 2% rate increase to HCBS services which has been applied to Appendix J, Year 3. Home Modification did not receive a rate increase as this rate is $10,000 per the lifetime of a client.

Hospital Level of Care: This amendment would expand the waiver's eligibility requirements to include both Hospital and Nursing Facility level of care. Clients with a Spinal Cord Injury may require more intensive and acute care than would normally be available in a Nursing Facility and instead would be comparable to the care received in a hospital. The inclusion of Hospital level of care would enable the Department to accurately assess if individuals that would be at risk of institutionalization in either a nursing facility or a hospital if not enrolled on the waiver.

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
☑ Waiver Application	6-I Attachments
☐ Appendix A – Waiver Administration and Operation	
☑ Appendix B – Participant Access and Eligibility	1-b 3-f
☑ Appendix C – Participant Services	C-5
☐ Appendix D – Participant Centered Service Planning and Delivery	
☐ Appendix E – Participant Direction of Services	
☐ Appendix F – Participant Rights	
☐ Appendix G – Participant Safeguards	
☐ Appendix H	
☐ Appendix I – Financial Accountability	
☑ Appendix J – Cost-Neutrality Demonstration	1, 2-d-i

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

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

  Specify:
  Update the Department procedures for the waiting list and update rates.

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*):
Persons with Spinal Cord Injury

C. **Type of Request: amendment**

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

◉ **3 years** ○ **5 years**

Waiver Number:CO.0961.R00.02
Draft ID: CO.019.00.01

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

Model Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/12
Approved Effective Date of Waiver being Amended: 07/01/12

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:
The State does not limit this waiver to subcategories of 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:
The State does not limit this 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 Home and Community Based Services waiver for persons with Spinal Cord Injury (HCBS-SCI) provides assistance to individuals with spinal cord injuries that require long term supports and services in order to remain in a community setting.

Eligibility is limited to individuals age 18 and older residing in the Denver Metro Area (as defined in section 4-C of this application) who have been diagnosed with a spinal cord injury as specified by the International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) codes 952 through 954.9. Individuals must have been determined to have a significant functional impairment as identified by a comprehensive assessment using the Universal Long Term Care (ULTC) assessment tool, and must require long term support services at a level comparable to services typically provided in a nursing facility.

The Department of Health Care Policy and Financing (the Department) has defined a range of community-based services designed to support individuals and their families. These services include:

Adult Day Health
Alternative Therapies
Consumer Directed Attendant Support Services (CDASS)
Home Modification
Homemaker
In Home Support Services (IHSS)
Supplies, Equipment, & Medication Management
Non Medical Transportation
Personal Care
Personal Emergency Response Systems (PERS)
Respite

The Department has also included the use of Alternative Therapies (chiropractic, acupuncture, and/or massage) in the HCBS -SCI Waiver for the treatment of conditions or symptoms related to the individual's spinal cord injury. The Department does not require the use of Alternative Therapies by particpants of this waiver program.

The Department will also use this waiver program as an opportunity to study the effectiveness of alternative therapies and the impact the provision of this service may have on the utilization of other waiver and/or acute care services. An independent evaluation will be conducted in year three of the program. The results of this evaluation may merit the future expansion of these services to clients residing outside the geographic limitation and/or target populations served by other waiver programs.

HCBS-SCI waiver services are geographically limited to eligible clients in the Denver Metro Area as identified by residence in one of the following counties: Adams, Arapahoe, Denver, Douglas, and Jefferson. This limitation is necessary for the additional monitoring and oversight responsibilities of the Alternative Therapies service. The Department does not request a phase-in schedule for the effective period of this waiver application.

In addition to these waiver services, participants also have access to all Medicaid State Plan benefits.

The Department contracts with local and non-state Case Management Agencies (CMA) to perform case management functions for individuals enrolled in the HCBS-SCI waiver. CMA functions include: intake/screening/referral, assessment of client needs, determination of functional and program targeting criteria eligibility, service plan development, ongoing case management, and monitoring to assure participant protections and quality assurance. Participants assist the case manager, through a client-centered service planning process, to identify those services and supports needed to prevent institutionalization.

IHSS and CDASS provide HCBS-SCI waiver participants opportunities for participant directed service delivery of personal care, homemaker, and health maintenance activities. The participant and/or authorized representative may choose to direct these services or choose to have comparable services delivered by a traditional Medicaid provider agency.

Participants choosing CDASS in lieu of traditional personal care, homemaker, and home health care services have these services administered through a Financial Management Services (FMS) organization. The FMS is responsible for providing appropriate and timely personnel and financial management services and training to individuals and/or authorized representatives.

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:

HCBS-SCI waiver services are geographically limited to eligible clients in the Denver Metro Area as identified by residence in one of the following counties: Adams, Arapahoe, Denver, Douglas, and Jefferson. This limitation is necessary for the additional monitoring and oversight responsibilities of the alternative therapies. The Department does not request a phase-in schedule for the effective period of this waiver application.

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

Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

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

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

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

I. Public Input. Describe how the State secures public input into the development of the waiver:
The Department delivered a notice of opportunity for consultation to the Tribal Governments, Indian Health Services agencies, and Urban Indian Organizations on February 3rd, 2014 for the update in the waiting list procedure and the updating of rates. The Department also met with the Medical Advisory Committee on February 26th, 2014 to present the update to the waiting list procedure.

The Department delivered a notice of opportunity for consultation to the Tribal Governments, Indian Health Services agencies, and Urban Indian Organizations on October 2, 2014 for the addition of hospital level of care. No response was received from Tribal Governments. The Department also sent notice of public comment to the LTSS Stakeholder list serve regarding hospital level of care. The Department received seven comments from members of that list; four of the comments were members in support of the addition of hospital level of care; two were comments were regarding other aspects of the waiver; one asked questions regarding hospital level of care as well as other questions regarding the waiver. All comments were answered individually via email and logged in the SCI Listening Log. The Department also met with the Medical Advisory Committee on October 22, 2014 to present the addition of hospital level of care.

The entire waiver was posted to the Department’s website on February 20, 2015 with a request for all public comment to be submitted by March 24, 2015. Notice of the full waiver being posted was distributed to the LTSS Stakeholder list, SCI Advisory Committee and SCI Stakeholder list. During the public comment period, the

Department received four comments; one question about contact information, one question about the rate increase and the effective date, one question about buy-in, and one individual requested a full waiver via postal mail. All comments were answered individually via email and logged in the SCI Listening Log. The Department mailed the requesting individual a full copy of the waiver on March 3, 2015.

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

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

7. Contact Person(s)

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

Last Name: Martinez

First Name: Jennifer

Title: HCBS Supervisor

Agency: Colorado Department of Health Care Policy and Financing

Address: 1570 Grant Street

Address 2:

City: Denver

State: **Colorado**

Zip: 80203

Phone: (303) 866-4294 **Ext:** ☐ **TTY**

Fax: (303) 866-2786

E-mail: Jennifer.Martinez@state.co.us

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Colorado**

Zip:

Phone: **Ext:** ☐ **TTY**

Fax:

E-mail:

8. Authorizing Signature

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

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name: Gretchen

First Name: Hammer

Title:

Medicaid Director

Agency:

Department of Health Care Policy and Financing

Address:

1570 Grant Street

Address 2:

City:

Denver

State: **Colorado**

Zip:

80203

Phone:

(303) 866-3058 **Ext:** ☐ **TTY**

Fax:

(303) 866-2786

E-mail:

Gretchen.Hammer@state.co.us

Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

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:
   Long Term Care Benefits Division
   (Do not complete item A-2)

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

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

   (Complete item A-2-a).

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

   Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

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

Appendix A: Waiver Administration and Operation

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

   Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).
   Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
   The Department of Health Care Policy and Financing (the Department) maintains an Interagency Agreement with the Department of Public Health and Environment (DPHE). This agreement allows DPHE to survey and investigate complaints against the following HCBS providers: Personal Care, Homemaker, IHSS, Alternative Care Facilities, and Adult Day Services. Once the DPHE survey has been completed, the provider is referred to the Department to obtain Medicaid Certification.

   The Department contracts annually with 23 Case Management Agencies serving 25 districts throughout Colorado. Of the 23 CMAs, 20 are local/regional non-state public agencies. These governmental subdivisions are made up of County Departments of Human and Social Services, County Departments of Public Health, County Area Agencies on Aging or County and District Nursing Services. The remaining three CMAs are private, non-profit agencies. This waiver utilizes 2 of the 23 CMAs as HCBS-SCI waiver services are geographically limited to eligible clients in the Denver Metro Area as identified by residence in one of the following counties: Adams, Arapahoe, Denver, Douglas, and Jefferson.

   CMAs are contracted with the Department to provide case management services for clients participating in HCBS. These services include HCBS waiver operational and administrative services, general case management, functional and level of care assessment, service planning, referral care coordination, utilization review, the prior authorization of waiver services within limits, and service monitoring, reporting, and follow up. All CMAs are selected through a competitive bid process.

   The Department contracts with a Fiscal Management Services (FMS) organization to aid in the administration of Consumer Directed Attendant Support Services (CDASS). The FMS acts as the legal employer-of-record for participant attendants. The participant and/or authorized representative is delegated the authority to the hire, train, terminate, set wages and supervise the day-to-day activities of attendants. The FMS provides mandatory training to CDASS participants and/or authorized representatives. Please refer to Appendix E for additional detail on the FMS responsibilities.

   The Department contracts with a Fiscal Agent to maintain the Medicaid Management Information System

(MMIS), process claims, assist in the provider enrollment/application process, prior authorization data entry, maintain a call center, respond to provider questions and complaints, and produce reports.

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

Appendix A: Waiver Administration and Operation

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

- **Not applicable**
- **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:
  - **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

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

    The Department contracts with 20 non-state public agencies to act as Case Management Agencies to perform HCBS waiver operational and administrative services, case management, utilization review, and prior authorization of waiver services. These agencies are selected through a competitive bid process.
  - **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

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

Appendix A: Waiver Administration and Operation

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

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
   The Department provides on-going oversight of the Interagency Agreement with the Department of Public Health and Environment (DPHE) through regular meetings and reports. Issues which impact the agreement, problems discovered at specific agencies or widespread issues and solutions are discussed. In addition, the Department is provided with monthly and annual reports detailing the number of agencies that have been surveyed, the number of agencies that have deficiencies, the number of complaints received, complaints investigated, and complaints that have been substantiated. The Interagency Agreement Contract 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. Should the investigation result in a CDPHE recommendation to decertify a provider agency, the Department terminates the provider agency and coordinates with the CMA to ensure the continuity of care and transition of clients to other provider agencies. Further information about the relationship between DPHE and the Department is provided in Appendix G of the waiver application.

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

The administrative evaluation is used to monitor compliance with agency operations and functions as outlined in waiver and department contract requirements. The Department reviews documents used by the CMA 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 and other community service coordination. Should the monitors find that a CMA is not in compliance with policy or regulations; the agency is required to take corrective action. Technical assistance is provided to CMAs via phone and e-mail. The Department conducts follow-up monitoring to assure corrective action implementation and ongoing compliance. If a compliance issue extends to multiple CMAs the Department provides clarification through Dear Administrator Letters (DAL), formal training, or both.

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

The contract for the Fiscal Management Services (FMS) organization was established through a competitive bid process. It is monitored by the Department on an ongoing basis. The Department has an established Consumer Directed Advisory Committee that meets at least on quarterly basis. The committee is comprised of clients, family members, Department staff, FMS staff, advocates and other community stakeholders. The committee discusses a variety of issues that impact participant directed services. Issues that require quick action are resolved through the use of work groups comprised of volunteers from the committee. In addition, Department staff have monthly and ad hoc meetings with FMS contractor to resolve issues and maintain open and on-going communication. Additional information about CDASS operations is provided in Appendix E of the 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	☑	☐	☐

Function	Medicaid Agency	Contracted Entity	Local Non-State Entity
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 CMAs that performed delegated functions as identified in the Administrative Tool. Numerator = Number of CMAs that performed delegated functions as identified in the Administrative Tool Denominator = Total number of CMAs serving waiver participants

Data Source (Select one):
Operating agency performance monitoring
If 'Other' is selected, specify:

Using the Administrative Tool

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

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of data reports as specified in the Interagency Agreement (IA) between CDPHE and the Department that were submitted on time and in the correct format. Numerator = Number of data reports, as specified in the IA, that were submitted on time and in the correct format. Denominator = Number of data reports specified in the IA

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

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

Data Aggregation and Analysis:

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

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

Data Source (Select one):
Operating agency performance monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **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: On-site monitoring occurs annually. CMAs are visited based on a 4 year cycle.

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. The Administrative Tool used to evaluate CMA operations provides for reportable data to be used in Department 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.
The Department has an interagency agreement with DPHE to manage aspects of provider qualifications, surveys and complaints/critical incidents; and with the CMAs to perform operative services, case management, utilization review and prior authorization. Delegated responsibilities of these contracted entities is monitored, corrected and remediated by the Department's Long Term Care Division.

During routine annual evaluation or by notice of an occurrence, the Department works with the contracted agencies to provide technical assistance or some other appropriate 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 remediation has occurred.

The Department will maintain administrative authority over the HCBS-SCI program in its contract with sister agencies. The Department will have access and will review all required documentation and communication regarding this authority.

The Department will also monitor the reports generated by its fiscal agent. The Long Term Care Division will review and coordinate with the Program Integrity section to track and trend payment (claims) reviews.

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

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

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**	65		☑
	☑	**Disabled (Physical)**	18	64	
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
Intellectual Disability or Developmental Disability, or Both					
		Autism			
		Developmental Disability			
		Intellectual Disability			
Mental Illness					
		Mental Illness			
		Serious Emotional Disturbance			

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

Eligibility is limited to individuals age 18 and older residing in the Denver Metro Area (as defined in Section 4-C of this application) who have been diagnosed with a spinal cord injury as specified by the International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) codes 952 through 954.9. Individuals must have been determined to have a significant functional impairment as identified by a comprehensive assessment using the Universal Long Term Care (ULTC) assessment tool, and must require long term support services at a level comparable to services typically provided in a nursing facility or hospital.

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:

The waiver does not have a maximum age limit. When an individual with spinal cord injury turns 65 they are also considered aged.

Appendix B: Participant Access and Eligibility

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

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

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

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

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

  Specify the percentage:

- ○ **Other**

  Specify:

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

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

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

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

The following dollar amount:

Specify dollar amount:

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

Upon a change in the client's condition the case manager assesses the client to determine if the client's health and welfare can be assured in the community. If the case manager determines the client's health and welfare can be assured, the case manager is authorized by the Department to approve home health or health maintenance activities and HCBS waiver services up to the cost of the home health daily limit.

Should the combined costs for waiver services and/or Long Term Home Health exceed the cost of the home health daily limit, the Department will review the request to determine if it is appropriate and justifiable based on the client's condition. While the Department is reviewing the request, the client's existing services remain intact until the request for additional services is approved or denied. In the event that the request is denied, the client is provided with appeal rights, as well as being offered additional options of having their needs met such as, but not limited to nursing facility placement.

☐ **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	67
Year 2	67
Year 3	67

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

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

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

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

e. **Allocation of Waiver Capacity.**

Select one:

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

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

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

Individuals are enrolled on the HCBS-SCI Waiver upon the case manager's verification of Medicaid eligibility and certification that the individual meets the functional-level of care, and additional program criteria specified in this application.

Individuals who have been determined eligible for the waiver and cannot be served within the capacity limits of the waiver shall be eligible for placement on a waiting list. The waiting list shall be maintained by the Department and enrollment from the waiting list to the waiver shall be based on a first come first served basis utilizing the date the individual met all of the eligibility requirements for the waiver, as verified by their case manager.

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 7)

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

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

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☐ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses *spousal* post-eligibility rules under §1924 of the Act.** *Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.*

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

Select one:

○ **SSI standard**
○ **Optional State supplement standard**
○ **Medically needy income standard**
◉ **The special income level for institutionalized persons**

(*select one*):

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

Specify the percentage:

A dollar amount which is less than 300%.

Specify dollar amount:

A percentage of the Federal poverty level

Specify percentage:

Other standard included under the State Plan

Specify:

The following dollar amount

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

The following formula is used to determine the needs allowance:

Specify:

Other

Specify:

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

Not Applicable

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

Specify:

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

SSI standard

Optional State supplement standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

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

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

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

  Specify:
- ○ **Other**

  Specify:

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

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

Select one:

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

  Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

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

  Specify percentage:

- ○ **The following dollar amount:**

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

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

  Specify formula:

- ○ **Other**

  Specify:

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

Select one:

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

Explanation of difference:

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

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

Select one:

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

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

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

   i. **Minimum number of services.**

   The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

   ii. **Frequency of services.** The State requires (select one):

   - (selected) **The provision of waiver services at least monthly**
   - (not selected) **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*):

- (not selected) **Directly by the Medicaid agency**
- (not selected) **By the operating agency specified in Appendix A**
- (selected) **By an entity under contract with the Medicaid agency.**

Specify the entity:

Case Management Agencies

- (not selected) **Other**

Specify:

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

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

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

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

d. **Level of Care Criteria.**Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

The case manager completes a comprehensive assessment utilizing the Uniform Long Term Care (ULTC) instrument. The ULTC includes a functional assessment and professional Medical Information Page (PMIP). The functional assessment measures 6 defined Activities of Daily Living (ADL) and the need for supervision for behavioral or cognitive dysfunction. ADLs include bathing, eating, mobility, toileting, transferring, and dressing. The case manager sends the PMIP to the client's medical professional for completion. The medical professional verifies the client's need for institutional level of care.

Additional information is documented using the Instrumental Activities of Daily Living (IADL) information page. This supplemental assessment considers a client's independence level for activities such as money management, medication management, household maintenance, transportation, meal preparation, hygiene, shopping, and accessing resources.

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:

Clients are referred to the CMA for an HCBS eligibility assessment. The CMA screens the referrals to determine if an assessment is appropriate.

Should the CMA determine that an assessment is not appropriate; the CMA provides information and referral to other agencies as needed. The client is informed of the right to request an assessment if the client disagrees with the CMA's determination.

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

The determination of the applicant's financial eligibility is completed by the county department of social services for the county in which the applicant resides.

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

The CMA is required to complete a reevaluation of clients within 12 months of the initial or previous assessment. A reevaluation may be completed sooner if there is a significant change in the client's condition or if required by program criteria.

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):*

CMAs are required to maintain a tracking system to assure that reevaluations are completed on a timely basis. The Department monitors CMAs annually to ensure compliance through record reviews and reports electronically generated by the Benefits Utilization System (BUS). The BUS is utilized by every CMA and contains electronic client records and the timeframes for evaluation and reevaluation. The annual program evaluation includes review of a random sample to ensure assessments are being completed correctly and timely.

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

CMAs are required to keep documentation retrievable electronically in the BUS. The BUS database is located at the Department, and the documentation is accessible electronically to monitoring staff and program administrators. CMAs are monitored annually for compliance with appropriate record maintenance.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

a. **Methods for Discovery: Level of Care Assurance/Sub-assurances**

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. **Sub-Assurances:**

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

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

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

Performance Measure:
Number and percent of new waiver enrollees with a level of care assessment indicating a need for institutional level of 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:
Benefit 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:

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

Performance Measures

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

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

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

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

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

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

Performance Measures

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

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

Performance Measure:
Number and percentage of waiver participants in a representative sample assessed with the ULTC assessment tool to determine eligibility. Numerator = Number of wavier participants in the sample assessed with the ULTC assessment tool Denominator = Total number of waiver participants in the sample certified to receive 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 = 95% with a +/- 5% margin of error
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
 # and percent of waiver participants in a representative sample for whom a Professional Medical Information Page (PMIP)was completed and signed by a licensed medical professional according to Department regulation. Numerator = # of participants in the sample for whom a PMIP was completed as required Denominator = total # of participants in the sample certified to receive waiver services

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 = 95% with a +/- 5% margin of error
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
		☐ **Other**

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

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The Department uses information gathered by the CMA annual program evaluations as the primary method for discovery. The Program Review Tool is used to evaluate a statistically valid sample of waiver applicants and recipients. The sample evaluates level of care determinations and service planning. It provides reportable data to used to identify waiver program trends.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Department contract managers and program administrators remediate problems as they arise based on the severity of the problem or by nature of the compliance issues in addition to annual data collection and analysis.

The Department delegates responsibility to 23 CMAs to perform waiver operative functions including case management, utilization review and prior authorization.

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

receiving an increase in complaints.

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

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

ii. **Remediation Data Aggregation**

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: As warrented by nature of discovery and/or severity of incident.

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).

   During the initial and assessment and care planning process, eligible individuals and/or legal representatives are informed of feasible service alternatives provided by the waiver and the choice of either institutional or home and community based services. This information is also presented at reassessment.

   The ULTC assessment and the client-centered care planning process assist the case manager in identifying the client's needs and supports. Based on this assessment and discussion, a long term service plan is developed. Case managers complete a long term care service plan information and summary form that is reviewed with the client. Case managers also provide a choice of providers.

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

   Both written and electronically retrievable facsimiles of freedom of choice documentation are maintained by the CMA and in the 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):
CMAs employ several methods to assure meaningful access to waiver services by Limited English Proficient persons. Documents include a written statement in Spanish instructing clients how to obtain assistance with translation. Documents are orally translated for clients who speak other languages by a language translator.

CMAs may employ case management staff to provide translation to clients. For languages in which there is not an available translator employed by the CMA, the case manager first attempts to have a family member translate. If family members are unavailable or unable to translate, the CMA may align with specific language or ethnic centers, and/or use a telephone translation service.

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	Adult Day Health		
Statutory Service	Homemaker		
Statutory Service	Personal Care		
Statutory Service	Respite		
Other Service	Alternative Therapies		
Other Service	Consumer Directed Attendant Support Services (CDASS)		
Other Service	Home Modification		
Other Service	In Home Support Services (IHSS)		
Other Service	Non Medical Transportation		
Other Service	Personal Emergency Response Systems (PERS)		
Other Service	Supplies, Equipment, & Medication Management		

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:

Adult Day Health

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope)*:

Services furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to assure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a ÃƒÂ,Ã,Â“full nutritional regimenÃƒÂ,Ã,Â” (3 meals per day). Physical, occupational and speech therapies indicated in the individualÃƒÂ,Ã,Â’s plan of care would be furnished as component parts of this service if such services are not being provided in the participantÃƒÂ,Ã,Â’s home.

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

Adult Day Health services offered in this waiver are limited based on the clientÃƒÂ,Ã,Â’s assessed need for services, physicianÃƒÂ,Ã,Â’s orders and prior authorization by case managers up to the cost containment parameters as defined in 10 CCR 2505-10, Section 8.485.50(J).

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	Adult Day Care Center

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Health

Provider Category:
Agency
Provider Type:
Adult Day Care Center
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:
Certification as a Medicaid provider of Adult Day Care C.R.S: 10 C.C.R. 2505-10, Section 8.491
Other Standard *(specify)*:

Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Public Health and Environment, Health Facilities and Emergency Section Division
Frequency of Verification:
The Certification cycle shall be 9-15 months until a Risk-Based Survey Schedule is developed. The Risk-Based Survey schedule shall be implemented no later than 12 months after adoption of appropriate Medicaid regulations.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
Services that consist of the performance of general household tasks (e.g. meal preparation and routine household care) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Relatives shall not be reimbursed to provide homemaker services. The service is limited based on the clientÃ‚Â's assessed need for services and prior authorization by case managers up to the cost containment parameters as defined in 10 CCR 2505-10, Section 8.485.50(J). Clients that choose to have homemaker services delivered by an agency shall have no duplication of these services by an IHSS agency or CDASS. There shall be no duplication of housekeeping chores that are incidental to and reimbursed as personal care.

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**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency
Agency	Personal Care / Homemaker Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:
Agency
Provider Type:
Home Health Agency
Provider Qualifications
License *(specify):*
Home Care Agency, Class A or B
Certificate *(specify):*
Medicare/Medicaid Certified as a Home Health Agency and Certified as a Medicaid provider of Home and Community Based Services C.R.S (2005); 10 C.C.R. 2505-10, Section 8.490
Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Providers are surveyed every 9-15 months for the first three years of their Medicaid certification until eligibility for a Risk Based Survey can be established. Once a Risk Base is established providers survey schedules are modified to a 9 to 36 month risk based survey cycle. Providers that have deficiencies in areas of staff training/ supervision, or client care are surveyed every 9-15 months according to the number and severity of the deficiencies. Providers that have administrative deficiencies due to errors in paperwork are surveyed every 15 to 24 months. Providers that have no deficiencies are surveyed every 24 to 36 months. In addition, if DPHE receives a complaint involving client care, the findings of the investigation may be grounds for DPHE to initiate a full survey of the provider agency regardless of the date of the last survey.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Agency

Provider Type:

Personal Care / Homemaker Agency

Provider Qualifications

License *(specify)*:

Home Care Agency, Class A or B

Certificate *(specify)*:

Certified as a Medicaid provider of Home and Community Based Services C.R.S; 10 C.C.R. 2505-10, Sections 8.489 and 8.490

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Providers are surveyed every 9-15 months for the first three years of their Medicaid certification until eligibility for a Risk Based Survey can be established. Once a Risk Base is established providers survey schedules are modified to a 9 to 36 month risk based survey cycle. Providers that have deficiencies in areas of staff training/ supervision, or client care are surveyed every 9-15 months according to the number and severity of the deficiencies. Providers that have administrative deficiencies due to errors in paperwork are surveyed every 15 to 24 months. Providers that have no deficiencies are surveyed every 24 to 36 months. In addition, if DPHE receives a complaint involving client care, the findings of the investigation may be grounds for DPHE to initiate a full survey of the provider agency regardless of the date of the last survey.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope)*:

Personal care includes assistance with eating, bathing, dressing, personal hygiene, and activities of daily living. When specified in the service plan, this service may also include only such light housekeeping chores as meal preparation, bed making, dusting, and vacuuming that are incidental to the care furnished.

This service may include assistance with preparation of meals, but does not include the cost of the meals themselves.

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

Relatives, other than a spouse, that are related to the individual receiving services by virtue of blood, marriage, adoption, or Colorado common law may be employed by a personal care/homemaker or home health agency to provide personal care services. Relatives employed by an agency shall meet the same experience and qualification standards required of all agency employees.

Per 25.5-6-310, C.R.S., the number of Medicaid personal care units provided by relatives shall not exceed the equivalent of 444 hours per annual certification.

Personal care services are limited based on the clientÃ‚Â's assessed need for services and prior authorization by case managers up to the cost containment parameters as defined in 10 CCR 2505-10, Section 8.485.50(J).

Clients that choose to have personal care services delivered by an agency shall have no duplication of these services by an IHSS agency or by CDASS. There shall be no duplication of the light housekeeping chores that are incidental to personal care and the services reimbursed under the homemaker benefit.

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	Personal Care / Homemaker Agency
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:
Agency
Provider Type:
Personal Care / Homemaker Agency
Provider Qualifications
License *(specify):*
Home Care Agency, Class A or B
Certificate *(specify):*
Certification as a Medicaid provider of Home and Community Based Services. 26-4-601, C.R.S; 10 C.C.R. 2505-10, Section 8.489 and 8.490.
Other Standard *(specify):*

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care

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

Home Care Agency, Class A or B
Certificate *(specify):*
Certified as a Medicaid provider of of Home and Community Based Services C.R.S; 10 C.C.R. 2505 -10, Section 8.489
Other Standard *(specify):*

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope)*:
Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
An individual client shall be authorized for no more than 30 days of respite care in each certification period.

Relatives, other than a spouse, that are related to the individual receiving services by virtue of blood, marriage, adoption, or common law may be employed by a personal care/homemaker or home health agency to provide respite services. Relatives employed by an agency shall meet the same experience and qualification standards required of all agency employees.

Relatives shall be employed by an agency and shall not be the same persons normally providing care. There shall be no duplication of this service and the personal care, homemaker, IHSS, and CDASS benefits.

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	Nursing Facility
Agency	Home Health Agency
Agency	Personal Care / Homemaker Agency
Agency	Alternative Care Facility

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Nursing Facility
Provider Qualifications
License *(specify)*:
Long Term Care Facility
Certificate *(specify)*:
Medicaid certified nursing facility. Certification as a Medicaid Nursing Facility. 10 C.C.R. 2505-10, Section 8.430
Other Standard *(specify)*:

Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Public Health and Environment, Health Facilities and Emergency Section Division.
Department of Public Safety, Fire Prevention and Control Division.

Frequency of Verification:
Every nursing facility is surveyed by DPHE every 9-15 months. The Department of Public Safety is responsible for the Building, Fire and Life Safety Code enforcement and certification of inspection.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Home Health Agency
Provider Qualifications
License *(specify):*
Home Care Agency, Class A or B
Certificate *(specify):*
Medicaid certified Personal care provider. Certification as a Medicaid provider of Home and Community Based Services. 10 C.C.R. 2505-10, Sections 8.489 and 8.490.
Other Standard *(specify):*

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Personal Care / Homemaker Agency
Provider Qualifications
License *(specify):*
Home Care Agency, Class A or B
Certificate *(specify):*
Medicaid certified Personal care agency Certification as a Medicaid provider of Home and Community Based Services C.R.S; 10 C.C.R. 2505-10, Sections 8.489 and 8.490.
Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Providers are surveyed every 9-15 months for the first three years of their Medicaid certification until eligibility for a Risk Based Survey can be established. Once a Risk Base is established providers survey schedules are modified to a 9 to 36 month risk based survey cycle. Providers that have deficiencies in areas of staff training/ supervision, or client care are surveyed every 9-15 months according to the number and severity of the deficiencies. Providers that have administrative deficiencies due to errors in paperwork are surveyed every 15 to 24 months. Providers that have no deficiencies are surveyed every 24 to 36 months. In addition, if DPHE receives a complaint involving client care, the findings of the investigation may be grounds for DPHE to initiate a full survey of the provider agency regardless of the date of the last survey.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Alternative Care Facility

Provider Qualifications

License *(specify):*

Assisted Living Residence

Certificate *(specify):*

Medicaid certified alternative care facility. Certification as a Medicaid Alternative Care Facility. 10 C.C.R. 2505-10 Section 8.495

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Environment, Health Facilities and Emergency Section Division. Department of Public Safety, Fire Prevention and Control Division.

Frequency of Verification:

Alternative Care Facility (ACF) providers are surveyed every 18 to 26 months until eligibility for the extended survey cycle can be established. Thereafter, ACF providers eligible for the extended survey cycle may be surveyed up to every 36 months. ACF providers are eligible for the extended survey cycle if they have been licensed for three years, have not had enforcement activity, and do not have a pattern of deficient practice or a substantiated complaint resulting in a deficiency cited at a level of actual harm or life threatening situation. If Department of Public Health and Environment receives a complaint involving abuse, neglect or substandard care, the findings of the investigation may be grounds to conduct a survey regardless of the date of the last survey.

The Department of Public Safety is responsible for the Building, Fire and Life Safety Code enforcement and certification of inspection.

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:

Alternative Therapies

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*

Alternative therapies are are limited to acupuncture, chiropractic care, and massage therapy as defined below. Services are to be delivered in an outpatient setting under the supervision of a physician.

Acupuncture means the stimulation of anatomical points on the body by penetrating the skin with thin, solid, metallic, single-use needles that are manipulated by the hands or by electrical stimulation for the purpose of bringing about physiologic and /or psychological changes.

Chiropractic care means the use of manual adjustments (manipulation or mobilization) of the spine or other parts of the body with the goal of correcting alignment and other musculoskeletal problems.

Massage therapy means the systematic manipulation of the soft tissues of the body, (including manual techniques of gliding, percussion, compression, vibration, and gentle stretching) for the purpose of bringing about physiologic, mechanical, and/or psychological changes to achieve higher levels of mobility, self-sufficiency, and satisfaction with life in order to increase an individuals level of engagement both at home and within their community.

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

The utilization of alternative therapies may typically begin at a higher frequency and is expected to decrease as the client progresses. Authorization and payment for the alternative therapies service is limited as follows:

During the first 90 days of the initial alternative therapies Care plan, the schedule of services recommended by the supervising physician shall not exceed 15 visits for any one modality or 30 visits for any combination of modalities. After the first 90 days of the initial alternative therapies care plan and in all subsequent alternative therapies care plans, the schedule of services recommended by the supervising physician shall not exceed 12 visits for any one modality or 24 visits for any combination of modalities per 90 day period.

Services are limited based on the client's assessed need for services, physician's orders, and prior

authorization by case managers up to the cost containment parameters as defined in 10 CCR 2505-10, Section 8.485.50(J).

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	Alternative Therapies Center

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Alternative Therapies

Provider Category:
Agency
Provider Type:
Alternative Therapies Center
Provider Qualifications
License *(specify)*:
Services must be provided by licensed, certified, and/or registered individuals operating within the applicable scope of practice and under the supervision of a physician.

Acupuncturists must be licensed by the Department of Regulatory Agencies, Division of Registrations as required by the Acupuncturists Practice Act (C.R.S. 12-29.5-101).

Chiropractors must be licensed by the State Board of Chiropractic Examiners as required by the Chiropractors Practice Act (C.R.S. 12-33-101).

Massage Therapists must be registered by the Department of Regulatory Agencies, Division of Registrations as required by the Massage Therapy Practice Act (C.R.S. 12-35.3-101)
Certificate *(specify)*:
Certification as an approved Medicaid provider of Alternative Therapies
Other Standard *(specify)*:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Consumer Directed Attendant Support Services (CDASS)

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope)*:

Services that assist an individual in accomplishing activities of daily living including health maintenance, personal care, homemaker activities, and protective oversight.

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

Personal Care services are those routine and repetitive activities of daily living which require non-skilled assistance for health and normal bodily functioning and which would be carried out by an individual with a disability if he or she were physically/cognitively able. Personal Care includes accompanying the client outside the home when associated with the delivery of a personal care task.

Homemaker services are general household activities provided in the home of an eligible client to maintain a healthy and safe home environment for a client, when the person ordinarily responsible for these activities is absent or unable to manage these tasks.

Protective oversight is supervision of the client to prevent at risk behavior that may result in harm to the client. These services are provided by an attendant under the supervision of the client or the clientÂ's authorized representative.

The client, or the authorized representative, is responsible for hiring, training, recruiting, setting wages, scheduling, and in other ways managing the attendant.

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

Consumer Directed Attendant Support Services offered in this waiver are limited based on the clientÂ's assessed need for services and prior authorization by case managers up to cost containment parameters as

defined in 10 CCR 2505-10, Section 8.485.50(J). In addition, spouses, guardians and family members are limited to providing CDASS under the guidelines described in Appendix C-2, d and e.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Attendant employed by the Financial Management Serivices (FMS) organization

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consumer Directed Attendant Support Services (CDASS)

Provider Category:
Individual
Provider Type:
Attendant employed by the Financial Management Serivices (FMS) organization
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
At minimum, attendants must be at least 16 years of age, trained to perform appropriate tasks to meet the client's needs, and demonstrate the ability to provide support to the client and/or the authorized representative as defined in the client's Attendant Support Management Plan and Hiring Agreement.
Sections 12-38-103 (8), 12-38-103 (11), 12-38-123 (1) (a), 12-38.1-102 (5) and 12-38.1-117 (1)(b) C.R.S (2007) shall not apply to Attendants employed through CDASS and who are acting within the scope of such employment.
However, such person may not represent him or herself to the public as a licensed nurse, certified nurse aide, a licensed practical or professional nurse, a registered nurse or a registered professional nurse. This exclusion shall not apply to any person who has his or her license as a nurse or certification as a nurse aide suspended or revoked or his or her application for such license or certification denied.

Verification of Provider Qualifications
Entity Responsible for Verification:
Financial Management Service (FMS) organization and the Department of Health Care Policy and Financing, Community Based Long Term Care Section
Frequency of Verification:
The FMS shall ensure that the attendant's initial training certification is on file prior to the provision of CDASS services and is updated on a continual basis when there is a change in services listed on the Attendant Support Management Plan.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home Modification

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope)*:

Those physical adaptations to the home, required by the individualÃ‚Â's plan of care, which are necessary to assure the health, welfare, and safety of the individual, or which enable the individual to function with greater independence in the home, and without which the individual would require institutionalization. Such adaptations may include the installation of ramps and grab bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual.

Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State and local building codes.

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

Home Modifications are limited based on the clients assessed need for services. There is a lifetime cap of $10,000 per home modification client. Home Modifications shall not be made to provider-owned housing. The client and case manager may request Department approval to exceed the $10,000 cap if additional modifications to ensure health and welfare of the individual are required.

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	Licensed Building Contractor
Agency	Contractor Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Modification

Provider Category:
Individual
Provider Type:
Licensed Building Contractor
Provider Qualifications
License *(specify)*:
As required by State and local laws
Certificate *(specify)*:
Certification as a Medicaid Home Modification Provider 10 C.C.R. 2505-10 Section 8.493.12.
Meets Uniform Building Codes as adopted by the State of Colorado, and meets local building codes.
Other Standard *(specify)*:

Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Health Care Policy and Financing
Frequency of Verification:
The Department currently reviews the provider qualifications at the time of initial application and on an annual basis.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Modification

Provider Category:
Agency
Provider Type:
Contractor Agency
Provider Qualifications
License *(specify)*:
As required by State and local law.
Certificate *(specify)*:
Certification as a Medicaid Home Modification Provider 10 C.C.R. 2505-10 Section 8.493.12.
Meets Uniform Building Codes as adopted by the State of Colorado, and meets local building codes.
Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Health Care Policy and Financing

Frequency of Verification:
The Department currently reviews the provider qualifications at the time of initial application and on an annual basis.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
In Home Support Services (IHSS)

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
Services that are provided by an attendant and include health maintenance activities support for activities of daily living or instrumental activities of daily living, personal care services, and homemaker services. Such services are provided under the direction of the client, or an authorized representative who is designated by the client.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
In Home Support Services offered in this waiver are limited based on the clientÃ‚Â's assessed need for services and prior authorization by case managers up to cost containment parameters as defined in 10 CCR 2505-10, Section 8.485.50(J).

All IHSS attendants must be employed by an agency certified by the Department to provide this service.

Payment will not be made for services furnished to a client by the personÃ‚Â's spouse. Family members may be

reimbursed up to the limitations established in Appendix C-2-d&e of the waiver application.

Clients and/or authorized representatives choosing IHSS shall have no duplication of Personal Care services, Homemaker services and/or Health Maintenance Activities through CDASS, Personal Care agency, Homemaker agency or Home Health Agency.

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

- [x] **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	Personal Care Agency - Certified to provide In Home Support Services
Agency	Home Health Agency - Certified to provide In Home Support Services
Agency	In Home Support Services Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: In Home Support Services (IHSS)

Provider Category:
Agency
Provider Type:
Personal Care Agency - Certified to provide In Home Support Services
Provider Qualifications
License *(specify)*:
Home Care Agency, Class A or B
Certificate *(specify)*:
Certified to provide IHSS. Certification as a Medicaid provider of In Home Support Services. 10 C.C.R. 2505-10, Section 8.487 and 8.552.7
Other Standard *(specify)*:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: In Home Support Services (IHSS)

Provider Category:
Agency
Provider Type:
Home Health Agency - Certified to provide In Home Support Services
Provider Qualifications
License *(specify):*
Home Care Agency, Class A or B
Certificate *(specify):*
Certified to provide IHSS. Certification as a Medicaid provider of In Home Support Services. 10 C.C.R. 2505-10, Section 8.487 and 8.552.7
Other Standard *(specify):*

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: In Home Support Services (IHSS)

Provider Category:
Agency
Provider Type:
In Home Support Services Agency
Provider Qualifications
License *(specify):*
Home Care Agency, Class A or B
Certificate *(specify):*
Certified as an IHSS agency. Certification as a Medicaid provider of In Home Support Services. 10 C.C.R. 2505-10, Section 8.487 and 8.552.7
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Public Health and Environment, Health Facilities and Emergency Section Division

Frequency of Verification:
Providers are surveyed every 9-15 months for the first three years of their Medicaid certification until eligibility for a Risk Based Survey can be established. Once a Risk Base is established providers survey schedules are modified to a 9 to 36 month risk based survey cycle. Providers that have deficiencies in areas of staff training/ supervision, or client care are surveyed every 9-15 months according to the number and severity of the deficiencies. Providers that have administrative deficiencies due to errors in paperwork are surveyed every 15 to 24 months. Providers that have no deficiencies are surveyed every 24 to 36 months. In addition, if DPHE receives a complaint involving client care, the findings of the investigation may be grounds for DPHE to initiate a full survey of the provider agency regardless of the date of the last survey.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Definition *(Scope):*
Service offered in order to enable individuals served on the waiver to gain access to waiver and other community services, activities and resources, specified by the service plan. 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 shall not replace them. Transportation services under the waiver shall be offered in accordance with the individualÃ‚Â's service plan. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge will be utilized.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Excluding transportation to Adult Day facilities, a client may not receive more than the eqiuivalent of four one-way trip services per week, or 104 round trip (two, one-way trips) per annual certification period, unless otherwise authorized by the Department. Non-medical transportation services offered in this waiver are limited

based on the clientÃ‚Â's assessed need for services, physicianÃ‚Â's orders and prior authorization by case managers up to the cost containment parameters as defined in 10 CCR 2505-10, Section 8.485.50(J).

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	Non- Medical Transportation Provider

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:
Non- Medical Transportation Provider
Provider Qualifications
License *(specify)*:
As required by State law.
Certificate *(specify)*:
Medicaid certified. Certification as a Medicaid provider of Non-medical transportation provider 10 C.C.R. 2505-10, Section 8.494: All drivers shall possess a valid Colorado drivers license, shall be free of physical or mental impairment that would adversely affect driving performance, and have not had two or more convictions or chargeable accidents within the past two years. All vehicles and related auxiliary equipment shall meet all applicable federal, state and local safety inspection and maintenance requirements, and shall be in compliance with state automobile insurance requirements.
Other Standard *(specify)*:

Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Health Care Policy and Financing
Frequency of Verification:
The Department currently reviews the provider qualifications at the time of initial application and on an annual basis.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Personal Emergency Response Systems (PERS)

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope)*:

PERS is an electronic device, which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable Â“helpÂ” button to allow for mobility. The system is connected to the personÂ’s phone and programmed to signal a response center once a Â“helpÂ” button is activated. Monitoring of the device is included in the PERS service. The response center is staffed by trained professionals.

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

PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time and who would otherwise require routine supervision.

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	Personal Alert Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response Systems (PERS)

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

Certificate *(specify)*:
Certification as a Medicaid provider of Electronic Monitoring services. C.R.S (2005); 10 C.C.R. 2505-10, Section 8.488
Other Standard *(specify)*:

Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Health Care Policy and Financing
Frequency of Verification:
The Department currently reviews the provider qualifications at the time of initial application and on an annual basis.

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:
Supplies, Equipment, & Medication Management

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
The devices, controls, or appliances which enable an individual at high risk of institutionalization to increase their abilities to perform activities of daily living, such as medication administration. Medication Reminders shall include devices or items that remind or signal the client to take perscribed medications or other devices necessary for the proper functioning of such items, and durable and non-durable medical equipment not available as a State plan benefit. Medication Reminders shall be considered a benefit only when reasonable and necessary for the treatment of an individual'Ã‚Â's illness, impairment, or disability as documented on the ULTC 100.2 and service plan.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Items reimbursed as Medication Reminder shall be in addition to any medical equipment and supplies furnished under the Medicaid State plan. Medication Reminder shall be authorized only for individuals who have the physical and mental capacity to utilize the particular system requested for that client. Medicaition Reminder shall be authorized only if they are in accordance with current accepted standards of medical practice in the treatment of the client's condition without excess or extreme function or expense beyond which is necessary.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Specialized Medical Equipment and Supplies Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supplies, Equipment, & Medication Management

Provider Category:
Agency
Provider Type:
Specialized Medical Equipment and Supplies Provider
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Certification as a Medicaid provider of durable and non-durable medical equipment and supplies. 10 C.C.R. 2505-10, Section 8.590 et seq.
Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health Care Policy and Financing

Frequency of Verification:

The Department currently reviews the provider qualifications at the time of initial application and on an annual basis.

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:

The Department contracts annually with 23 Case Management Agencies serving 25 districts throughout Colorado to perform Home and Community Based Services waiver operational and administrative services, case management, utilization review, and prior authorization of waiver 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):

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

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

HCBS-SCI clients may utilize Nursing Facilities (NF) and Alternative Care Facilities (ACF) for respite services. Owners and administrators along with any staff or volunteers that have personal contact with residents at these facilities are required to submit to a CBI criminal history check. When making employment decisions, it is the responsibility of an ACF and NF to determine whether prospective staff or volunteers have been convicted of a felony or misdemeanor that could pose a risk to the health, safety and welfare of the residents. During regular surveys, DPHE reviews employment records to ensure ACFs and NFs are completing required criminal background checks.

State approved educational programs for Certified Nurse Aides also require CBI criminal history checks upon admission to the education program.

For clients who choose CDASS, the FMS performs CBI criminal history checks on perspective attendants. Employment decisions are made at the discretion the FMS and of the clients and/or authorized representatives.

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

Chiropractors are required to be licensed by the State Board of Chiropractic Examiners (SBCE). This license requires that chiropractors report to the SBCE any of the following events within 90 days: the conviction of a felony under the laws of any state or of the United States, or a crime related to the practice of chiropractic; a disciplinary action imposed by another jurisdiction that registers or licenses chiropractors; the revocation or suspension by another state board, municipality, federal or state agency of any health services related license or registration.

Acupuncturists are required to be licensed by the Department of Regulatory Agencies, Division of Registrations. The license requires acupuncturists report to the Division of Registrations Director any of the following events that within 30 days: the conviction of the licensee of a felony under the laws of any state or of the United States; a disciplinary action imposed upon the licensee by another jurisdiction that licenses acupuncturists; the revocation or suspension by another state board, municipality, federal or state agency of any health services related license; any judgment, award or settlement of a civil action or arbitration in which there was a final judgment or settlement against the licensee for malpractice of acupuncture.

Massage Therapists are required to be registered with Department of Regulatory Agencies, Division of Registrations. The registration requires a CBI criminal history record check and that massage therapists report to the Division of Registrations Director any of the following events within 90 days: the conviction of the registrant of a felony under the laws of any state or of the United States; a disciplinary action imposed upon the registrant by another jurisdiction that registers or licenses massage therapists; the revocation or suspension by another state board, municipality, federal or state agency of any health services related license or registration; any judgment, award or settlement of a civil action or arbitration in which there was a final judgment or settlement against the registrant for malpractice of massage therapy.

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

Adult day services providers are not licensed in the State of Colorado. CDPHE surveys these providers on a risk -based survey schedule to ensure compliance with the certification standards detailed in program regulation. Currently, this regulation does not require criminal background investigations though many providers complete

the investigations voluntarily. The adult day services regulation is currently under review, and the Department will consider adding criminal background investigations as a requirement.

Background checks are not required on any other HCBS-SCI waiver service providers, though many providers complete the checks on staff voluntarily. The Department does not require an abuse registry screening, because the State does not have such a registry.

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

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

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

Appendix C: Participant Services

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

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

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

Appendix C: Participant Services

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

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

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

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

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

A spouse may be paid to furnish extraordinary care through CDASS. Extraordinary care is determined by assessing whether an individual who is the same age without a disability needs the requested level of care, the activity is one that a spouse would not normally provide as part of a normal household routine and the activity is one that a spouse is not legally responsible to provide. A spouse may not provide more than 40 hours of CDASS in a seven day period. A client and/or authorized representative must provide a planned work schedule to the FMS a minimum of two weeks in advance of beginning CDASS, and variations to the schedule must be noted and supplied to the fiscal agent when billing.

An individual must be offered a choice of providers. If clients or his/her authorized representative chooses a spouse as a care provider, it must be documented on the Attendant Support Management Plan. In addition to case management, monitoring and reporting activities required for all waiver services, the following additional requirements are employed when a spouse is paid as a care provider:

a. At least quarterly reviews of expenditures, and health, safety and welfare status of the client by the case manager.
b. Monthly reviews by the fiscal agent of hours billed for spouse provided care.
c. A spouse who is a client's authorized representative may not also be paid to be the client's attendant.

Under no circumstance may a client's spouse be employed or reimbursed by a personal care or IHSS agency to provide personal care or IHSS to his/her spouse.

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

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

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

For the purpose of this section family members and relatives shall be defined as all persons related to the client by virtue of blood, marriage, adoption, or Colorado common law.

Family members other than spouses may be employed to provide Personal Care, IHSS, or CDASS based on the limitations described below:

1. Relatives employed by a Personal Care agency may provide up to 444 hours of personal care to their family member per each annual certification for HCBS-SCI.
OR
2. Relatives employed by an IHSS agency care may provide up to 40 hours of attendant care in a seven day period. However, a family member who is an individual's authorized representative may not be reimbursed for the provision of IHSS.

Family members may also be employed by the FMS to provide CDASS subject to the conditions below:
1. The family member providing CDASS shall meet the following requirements for employment by:
a. Being employed by the FMS and supervised by the client and/or authorized representative if providing CDASS.
b. A family member who is an individual's authorized representative may not be reimbursed for the provision of CDASS.
2. The family member employed by the FMS may provide up to 40 hours of CDASS in a seven day period.
3. Client and/or authorized representative must provide a planned work schedule to the FMS two weeks in advance of beginning CDASS, and variations to the schedule must be noted and supplied to the fiscal agent

when billing.
4. Clients and/or authorized representatives who choose to hire a family member as a care provider in CDASS must document their choice on the Attendant Support Management Plan.

In addition to case management, monitoring, and reporting activities required for all waiver services, the following additional requirements are employed when a family member is paid as a care provider for CDASS clients:

a. At least quarterly reviews of expenditures, and health, safety and welfare status of the client.

b. Monthly reviews by the fiscal agent of hours billed for family member provided care.

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

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

Other policy.

Specify:

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

Providers interested in providing services to Colorado Medicaid clients must first obtain certification from the Department. Certification is obtained by a provider after undergoing a survey by DPHE. DPHE will recommend a provider for Medicaid certification after the provider has successfully completed a survey. The Department will review the recommendation by DPHE and either certify the provider or ask that the provider improve the conformance to rules and/or regulations before certifying the provider.

Additional provider agencies will likely be notified of this new waiver through the CMAs that are contractually obligated to assist in the development of local community resources. Information about waivers can be distributed by CMA staff attending local community meetings.

The alternative therapies service will require the enrollment of providers that are not likely to be enrolled to serve Medicaid clients. The Department has worked in collaboration with alternative therapy practitioners and professional associations in the development of this service and its regulation. Through this process, the Department has identified a group of providers that are likely to apply for provider certification.

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

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

The enrollment application is designed to address requirements for providers who render specific types of services. Providers who have questions about how to complete the application may contact the fiscal agent for technical assistance. The fiscal agent processes applications and sends written notification of the action to the provider within ten days of receipt of the application.

Providers whose applications are approved will be sent a provider number and information to help the provider to begin to submit claims. Incomplete applications are delayed in processing, but the provider will be sent a letter identifying the missing information or incomplete documents. Providers whose applications are denied will be advised of the reason for denial.

DPHE does not survey providers of the following services: Medication Reminders, PERS, CDASS, home modification and non-medical transportation. Providers of these services obtain Medicaid certification from the Department by completing the Medicaid provider enrollment process through the fiscal agent prior to serving Medicaid clients.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. **Methods for Discovery: Qualified Providers**

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. **Sub-Assurances:**

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

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

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

Performance Measure:
Number and percent of waiver providers enrolled within the performance period, by type, that have the required license or certification prior to serving waiver participants. Numerator = Number of newly enrolled waiver providers, by type, that have the required license or certification prior to serving waiver participants Denominator = Total number of newly enrolled waiver providers, by type

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

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

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

Data Aggregation and Analysis:

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

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

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

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

Data Aggregation and Analysis:

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

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

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

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

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

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

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

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 non-licensed/non-certified waiver providers, by type, that continually meet waiver provider qualifications. Numerator = Number of non-licensed/non-certified waiver providers that continually meet waiver provider qualifications Denominator = Total number of enrolled non-licensed/non-certified waiver providers

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

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 CDASS attendants deemed eligible for hire by the Financial Management Services (FMS) agency based on background and registry screening prior to providing services. Numberator = Number of CDASS attendants deemed eligible for hire by the FMS agency based on background and registry screening prior to providing services Denominator = Total number of CDASS attendants

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

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: FMS 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:

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

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

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

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

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

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

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The Department contracts with DPHE to manage aspects of provider qualifications, survey, and complaints/critical incidents. DPHE surveys all providers interested in providing services to Colorado Medicaid clients including Home and Community Services. Providers who have obtained a satisfactory survey are referred to the Department for certification as a Medicaid provider. Each certified provider is re-surveyed according to the DPHE schedule to ensure ongoing compliance.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Providers who are not in compliance with DPHE and other state standards receive deficient practice citations. Depending on the risk to the health and welfare of clients, the deficiency will require at minimum a plan of correction to DPHE. Providers that are unable to correct deficient practices are recommended for termination by DPHE and are terminated by the Department.

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

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

The second method the Department uses to remediate/fix problem with providers that are not surveyed by DPHE is an informal complaint/grievance process that includes direct contact with clients. Clients, family members and/or advocates who have concerns or complaints about providers may contact the Department

directly. If the Department receives a complaint the program administrator or HCBS provider manager investigates the complaint and remediates the issue.

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

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

☑ **Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

The Department's contract with the Case Management Agencies (CMAs) includes service plan development. The same qualifications detailed in Appendix B-6-c of this application apply to CMA employees responsible for service plan development.

☐ **Social Worker**

Specify qualifications:

☐ **Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

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

The Department may grant a waiver to a CMA to provide direct services provided that the agency can document a least one of the following:

1. The service is not otherwise available within the CMA district or within a sub-region of the district; and/ or

2. The service can be provided more cost effectively by the CMA, as documented in a detailed comparison of its proposed service with all other service providers in the district or sub-region of the district.

When a CMA submits a waiver request to the Department the CMA must provide the Department with the following information:

1. Specific service that is lacking in the CMA District. (10 C.C.R. 2505-10, Section 8.393.61 A. 1.)

2. Number of other providers available in the CMA District for this service.

3. Number of Medicaid clients being served by the CMA for this service.

4. If the lack of service is in a particular area, indicate the area and the number of clients being served in that area.

5. Efforts the CMA has made to develop the service that is lacking. (10 C.C.R. 2505-10, Section 8.393.61 C.)

6. Procedure the CMA follows to ensure client has been offered a choice of providers. (10 C.C.R. 2505-10, Section 8.393.61 E.)

7. Procedure the CMA uses to avoid any possible bias of using only the CMA when the service may be available from another provider agency.

8. Written documentation indicating Direct Service Provider functions and CMA functions are being administered separately. (10 C.C.R. 2505-10, Section 8.393.61 D.)

9. Any other information the CMA may feel is pertinent to obtaining a waiver.

The Department reviews the above information to ensure that the CMA's waiver is in compliance with State laws regulations and policies in reference to service provision at 10 C.C.R. 2505-10, Section 8.393.6 prior to granting a waiver.

The Department acknowledges that problems such as "self-referral" may arise when a CMA also furnishes waiver services. Therefore the Department has developed the following safeguards to ensure that service plans are developed in the best interest of the client. The following safeguards shall be implemented by the Department and incorporated into the contracts for CMAs as specified in the Global QIS.

1. CMAs that are granted a waiver to provide services must provide written notification to the client and/or guardian about the potential influence the CMA has on the service planning process (such as, exercising free choice of providers, controlling the content of service plan, including assessment of risk, services, frequency and duration, and informing the client of their rights).

2. The CMA must also provide the client and/or guardian written information about how to file a provider agency complaint as well as how to make a complaint against the CMA.

3. Upon client and/or guardian request the CMA must provide an option for the client and/or guardian to choose a different entity or individual to develop the service plan. The CMA must also provide an option for the service plan to be monitored by a different CMA entity or individual.

The Department requires that all CMAs provide information about the full range of waiver services to eligible clients and/or guardians. The Department does not establish rules about how the information is to be provided. The Department requires the use of a universal service plan be used by all HCBS case managers. The universal service plan includes a list of all service available to the client provided in the HCBS-SCI waiver. In addition to the list of waiver services provided by the service plan, CMAs may choose to provide the information to clients in a format that best meets the client's needs. For example, many CMAs prepare a comprehensive list of qualified HCBS providers in their area that is provided to clients during the care planning process.

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.

CMAs are contractually obligated to provide information to clients about the potential services, supports and resources that are available to long term care clients. CMAs are located throughout the State, as such; some services or options that are available in one part of the state may not be available in other areas of the State. For this reason, the Department has opted not to mandate that CMAs use a specific form or method to inform clients about all of the supports available to clients.

In 2007, the Department implemented an improved monitoring system to better collect administrative data from CMAs. This new monitoring system will assist the Department in not only assuring CMAs are providing meaningful information and supports to clients, but also identify a "Best Practice" approach to provide clients and/ or family members with meaningful information and supports to actively engage in and direct the process.

In addition, the Department has taken steps to improve access to information using the Departments website. Information continues to be added in order to assist the client and/or family members to make informed decisions about waiver services, informal supports, and State Plan benefits.

When scheduling to meet with the client, the case manager makes reasonable attempts to schedule meeting times that are convenient for the client. In addition, a waiver client and/or authorized representative have the authority to select and invite individuals of their choice to actively participate in the service planning process.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

The client and/or legal guardian have the authority to select and invite individuals of their choice to actively participate in the assessment process. The client and the client's chosen group provide the case manager with information about the client's needs, preferences, and goals. In addition, the case manager obtains diagnostic and health status information from the client's medical provider, and determines the client's functional capacity using the Uniform Long Term Care (ULTC) assessment tool.

The case manager also determines if services provided by a caregiver living in the home are above and beyond the workload of a normal family/household routine. The case manager works with the client and/or the group of representatives to identify risk factors and addresses risk factors with appropriate parties.

Once the service plan is developed, options for services and providers are explained to the client and/or legal guardian by the case manager. Before accessing waiver benefits, clients must access services through other available sources such as State Plan and EPSDT benefits. The case manager arranges and coordinates services documented in the service plan.

Referrals are made to the appropriate providers of the client's and/or legal representative's choice when services requiring a skilled assessment, such as skilled nursing or home health aide (Certified Nursing Aide) are determined appropriate.

The service plan defines the type of services, frequency, and duration of the services needed. The service plan also documents that the client and/or legal guardian have been informed of the choice of providers and the choice to have services provided in the community or in a nursing facility. The client may contact the case manager for on-going case management such as assistance in coordinating services, conflict resolution or crisis intervention.

The case manager reviews the ULTC form and service plan with the client every six months. The review is conducted over the telephone, at the client's place of residence, place of service, or other appropriate setting as determined by the client's needs. This review includes obtaining information concerning the client's satisfaction with the services, effectiveness of services being provided, an informal assessment of changes in client's function, service appropriateness, and service cost effectiveness.

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

This complaint log is reviewed by the Department on a quarterly basis. Department contract managers are able to

identify trends or discern if a particular case manager or CMA is receiving an unusual number or increase in complaints and remediate accordingly.

The client may also contact the case manager's supervisor or the Department if they do not feel comfortable contacting the case manager directly. The contact information for the case manager, case manager's supervisor, the CMA administrator, and the Department is included on the copy of the service plan that is provided to the client. The client also has the option of lodging an anonymous complaint to case manager, CMA, or the Department.

Client's, family members, and/or advocates who have concerns or complaints may contact the case manager, case manager's supervisor, CMA administrator, or Department directly. If the Department receives a complaint, the program administrator of HCBS provider manager investigates the complaint and remediates the issue.

The case manager is required to complete a face-to-face reassessment at the client's residence within twelve months of the initial client assessment or previous assessment. A reassessment shall be completed sooner if the client's condition changes or as needed by program requirements. Upon Department approval, the annual assessment and/or development of the service plan may be completed by the case manager at an alternate location or via the telephone. Such approval may be granted for situations in which there is a documented safety risk to the case manager or client (e.g. natural disaster, pandemic, etc.)

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

Risks are assessed as part of the service planning process during a face-to face interview in the client's home and are documented in the client's electronic record. Case managers are required to provide clients with all of the choices available to the client for Long Term Care. These choices include continuing to live in the client's home or choosing to live in a Nursing Facility.

The case manager discusses the possible risks associated with the client's choice of living arrangement with the client and/or guardian. The case manager and the client then develop strategies for reducing these risks. Strategies for reducing these risks include developing back-up plans. Back-up plans are designed to be client centered and often include relying on the client's choice of family, friends, or neighbors to care for the client if a provider is unable to do so, or for life or limb emergencies, clients are instructed to call his/her emergency number (i.e. 911).

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.

CMAs are obligated to provide clients with a choice of qualified providers. CMAs are located throughout the state, as such; some services and/or providers that are available in one part of the State may not be available in other areas of the State. CMAs have developed individual methods for providing choice to their clients.

The Department has also developed an informational tool in coordination with the Department of Public Health and Environment to assist clients in selecting a service agency. The Department has provided all CMAs with this informational tool. In addition, the guide is available on the DPHE website.

In an effort to better monitor CMA compliance with this requirement the Department has developed a client survey/questionnaire that is administered to clients as specified in the QIS. The survey identifies client satisfaction with waiver services, case management services, Medicaid and other medical services, etc. The survey also inquires

whether or not clients were provided choices, including but not limited to: a choice in waiver services, LTC service delivery (HCBS or NF), qualified providers, participation in service planning, etc. Clients are also asked if they have received a list of client rights and responsibilities, complaint procedures, critical incident reporting guidelines and contingency options.

Survey results are analyzed, tracked and trended each year according to program area and CMA. Improvements based on the data collected from this tool will be implemented as specified in the QIS.

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):

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Specify the other schedule:

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

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

Specify:

Written copies are maintained at the CMA and are also available electronically to both the clients' CMA and the State Medicaid agency via the BUS.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

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

Participant's exercise of free choice of providers:

Each CMA is obligated to provide clients with a free choice of qualified providers. Some services and/or providers that are available in one part of the State may not be available in other areas of the State. CMAs have developed individual methods for providing choice to their clients. In order to ensure that clients continue to exercise a free choice of providers the Department has added a signature section to the service plan that allows clients to indicate whether they have been provided with free choice of providers.

In an effort to better monitor CMA compliance with this requirement the Department has developed a client survey/questionnaire that is administered to clients as specified in the QIS. The survey identifies client satisfaction with waiver services, case management services, Medicaid and other medical services, etc. The survey also inquires whether or not clients were provided choices, including but not limited to: a choice in waiver services, LTC service delivery (HCBS or NF), qualified providers, participation in service planning, etc. Clients are also asked if they have received a list of client rights and responsibilities, complaint procedures, critical incident reporting guidelines and contingency options. Survey results are analyzed, tracked and trended each year according to program area and CMA. Improvements based on the data collected from this tool will be implemented as specified in the QIS.

Participant access to non-waiver services in service plan, including health services:

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

Methods for prompt follow-up and remediation of identified problems:

Clients are provided with this information during the initial and annual service planning process using the "Client Roles and Responsibilities" and the Case Mangers "Roles and Responsibilities" form. The form provides information to the client about the following, but not limited to, case management responsibilities:

• Assists with coordination of needed services.
• Communicate with the service providers regarding service delivery and concerns
• Review and revise services, as necessary
• Notifying clients regarding a change in services

The form also states that clients are responsible for notifying their case manager of any changes in the clients care needs and/or problems with services. If a case manger is notified about an issue that requires prompt follow up and/or remediation the case manger is required to assist the client. Case managers document the issue and the follow up in the BUS.

Methods for systematic collection of information about monitoring results that are compiled, including how problems indentified during monitoring are reported to the state:

CMAs are contractually obligated to conduct annual internal programmatic reviews. As specified in the QIS, the Department will require the CMA to conduct their internal programmatic reviews using the Department prescribed "Programmatic Tool". The tool is a standardized form with waiver specific components to assist the Department to measure whether or not CMAs remain in compliance with Department rules, regulations, contractual agreements and

waiver specific policies. The Department requires that each CMA complete a specified number of client reviews as determined by the sampling methodology detailed in the QIS.

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

In addition, the Department audits each CMA for administrative functions including: qualifications of the individuals performing the assessment and service planning, process regarding evaluation of need, service planning, client monitoring (contact), case reviews, complaint procedures, provision of client choice, waiver expenditures, etc. This information is compared with the programmatic review for each agency. This information is also reviewed and analyzed in aggregate to track and illustrate state trends and will be the basis for future remediation.

The Department also has a Program Integrity section responsible for an on-going review of sample cases to reconcile services rendered compared to costs. Cases under review are those referred to Program Integrity through various sources such as Department staff, DPHE, and client complaints. The policies and procedures Program Integrity employs in this review are available from the Department.

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

b. Monitoring Safeguards. *Select one:*

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

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

The Department may grant a waiver to a CMA to provide direct services provided that the agency can document a least one of the following:

1. The service is not otherwise available within the CMA district or within a sub-region of the district; and/ or

2. The service can be provided more cost effectively by the CMA, as documented in a detailed comparison of its proposed service with all other service providers in the district or sub-region of the district.

State laws regulations and policies in reference to service provision are available at 10 C.C.R. 2505-10, Section 8.393.6.

The Department provides an evaluation of the service planning process for all CMAs during the annual monitoring. This monitoring includes an Administrative Review in which the monitor completes an investigation into how the case managers coordinate care for the client (i.e. selecting providers) and how case managers determine the amount of services a client requires. The monitor reviews a representative sample of client files to assure compliance that clients are provided representation in the assessment and care planning process, freedom of choice for providers, waiver services, and that the clients and/or guardians have been provided written/printed notification of these safeguards.

In addition to the safeguards noted in Appendix D-1-b of this waiver application, the Department coordinates with DPHE to monitor the activities of CMAs that have been granted a waiver. Copies of complaints filed by clients and/or guardians that allege an instance of conflict of interest or limiting the client's freedom of choice are reviewed. The department reviews the complaint with the CMA to ensure it is handled appropriately, an appropriate resolution was reached, and that the complaint is not indicative of widespread issues related to conflict of interest and/or limiting freedom of choice.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. **Methods for Discovery: Service Plan Assurance/Sub-assurances**

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. **Sub-Assurances:**

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

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

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

Performance Measure:
 # and % of waiver participants in a representative sample whose Service Plans (SPs) address the needs identified in the ULTC assessment, through waiver and other non-waiver services. Numerator = # of participants in the sample whose SPs address the needs identified in the ULTC assessment, through waiver and other non-waiver services Denominator = Total # of waiver participants in the sample

Data Source (Select one):
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 = 95% with a +/- 5% margin of error
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of waiver participants in a representative sample whose SPs adequately address the waiver participant's desired goals as identified in the Personal Goals, as appropriate. 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 Review Tool

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

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

Data Aggregation and Analysis:

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

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

Data Source (Select one):
Record reviews, on-site

If 'Other' is selected, specify:

Program Review Tool

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

Data Aggregation and Analysis:

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

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

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

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

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

Performance Measure:
Number and percent of waiver participants in a representative sample whose SPs were developed according to the Department's SP policies and procedures.
Numerator = Number of waiver participants in the sample whose SPs demonstrate that the Department's policies and procedures were followed
Denominator = Total number of waiver participants in the sample

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

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

Data Aggregation and Analysis:

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

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 Service Plans are updated prior to the 12 month certification period. Numerator = Number of waiver participants in the sample whose service plans are updated prior to the 12 month certification period Denominator = Total number of waiver participants in the sample

Data Source (Select one):
Other

If 'Other' is selected, specify:

Benefits Utilization System (Data)

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

Data Aggregation and Analysis:

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

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

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

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

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

Data Aggregation and Analysis:

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

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

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

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

Performance Measure:
Number and percent of waiver participants in a representative sample for whom at least 90% of waiver services were delivered in accordance with the service plan. Numerator = # of waiver participants in a representative sample for whom the paid claims equal at least 90% of those services authorized by the service plan Denominator = Total # of waiver participants in a representative sample

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS Claims Data and Benefit Utilization System (BUS) Data

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

		☑ **Representative Sample** Confidence Interval = 95% with a +/- 5% margin of error
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of waiver participant in a representative sample whose SPs document a choice: (1) of institutional care or HCB waiver services (2) of appropriate waiver services (3) of qualified waiver service providers. Numerator = Number of waiver participants in the sample whose SPs document these choices Denominator = Total number of waiver participants in the sample

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percent of waiver participant survey respondents reporting that they had a choice of services and providers. Numerator = Number of survey respondents reporting choice Denominator = Total number of survey respondents

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
% of waiver participants who are provided an fact sheet with general information about HCBS and specific information about the range of waiver services, types of providers and contact information. Numerator= # of waiver participants for whom BUS records indicate a fact sheet was provided to the participant at enrollment and annual reassessment Denominator = Total # of waiver participants

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

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

		95% with a +/- 5% margin of error
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The Department uses information gathered by the CMA monitor's annual program evaluations as the primary method for discovery. The Program Review Tool is used to evaluate a statistically valid sample of waiver applicants and recipients. The sample evaluates level of care determinations and service planning, providing reportable data to use in Department discover for specific waiver program trends.

Please see the QIS and work plan for more information on sampling frequency and responsible parties.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Department contract managers and program administrators remediate problems as they arise based on the severity of the problem or by nature of the compliance issues in addition to annual data collection and analysis.

The Department delegates responsibility to 23 CMAs to perform waiver operative functions including case management, utilization review and prior authorization.

Issues or problems identified during annual program evaluations will be directed to the CMA administrator or director and reported in the individual agency's annual report of findings. In some cases, a plan of correction may be required. For issues or problems that arise at any other time throughout the year, technical assistance may be provided to the CMA case manager, supervisor or administrator and a confidential report will be documented in the waiver recipient care file when appropriate.

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

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

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

◉ **No**

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

Appendix E: Participant Direction of Services

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

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

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

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

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

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

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

There are two participant directed service delivery options available to participants of this waiver program. The case manager provides information including service description, eligibility criteria, and required paperwork to potential and current HCBS-SCI clients. During the initial assessment and service planning process and at the time of reassessment, the case manager must also provide information to the client and/or legal guardian on the following participant directed options:

In Home Support Services (IHSS)
Consumer Directed Attendant Support Services (CDASS).

The client and/or legal guardian interested in participant direction must obtain a completed Physician Statement of Consumer Capability indicating that the client is of sound judgment and has the ability to direct his/her care; or the client requires the assistance of an authorized representative to direct care on his/her behalf. In order to ensure that the physicianÂ's judgment can be consistently applied, the Physician Statement of Consumer Capability is a Department approved form that includes definitions of the following: stable health, ability to manage the health aspects of his/her life, ability to direct his/her own care, and authorized representative.

If the physician indicates that the client is unable to direct his/her care, the case manager must ensure that the client or legal guardian designates an authorized representative. Clients that have been designated as able to direct his/her care may also elect to designate an authorized representative.

The authorized representative may not be the clientÂ's attendant. The authorized representative must submit an affidavit stating that he or she is at least 18 years of age; has known the client for at least two years; has not been convicted of any crime involving exploitation, abuse, or assault on another person; and does not have a mental, emotional, or physical condition that could result in harm to the client. The client and/or authorized representative works with the case manager who determines the level of care the client requires through the completion of a ULTC 100.2 and the development of the service plan. The case manager provides the client and/or authorized representative with a list of certified IHSS agencies or refers the CDASS client to the FMS.

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

The client and/or authorized representative may obtain support from the IHSS agency to hire the attendant(s) of his/her choice. The IHSS agency is required to provide the client and/or authorized representative with the following: a new client intake and orientation process, peer counseling, information and referrals, skills training, and individual and systems advocacy. The IHSS agency must also provide 24 hour backup attendant services when regularly scheduled attendants are unavailable, whether the attendantÂ's absence is anticipated or unforeseen.

CDASS is the most flexible option for participant directed care. Attendants are employed through a FMS, but are supervised in all other ways by the client and/or authorized representative. This program offers the client and/or authorized representative the ability to recruit, hire, train, schedule, and set wages within the limitations established by the Department. The case manager calculates the clientÂ's individual allocation based on the clientÂ's needs using the DepartmentÂ's guidelines and prescribed methods. The needs determined for allocation must reflect the needs identified by a comprehensive assessment using the ULTC and documented in the service plan. The case manager then refers the client and/or authorized representative to the FMS for training.

The FMS provides training to assure that clients and/or authorized representatives understand the philosophy and responsibilities of participant directed care. At minimum, this training includes: an overview of the program, client and/or authorized representative rights and responsibilities, planning and organizing attendant services, managing personnel issues, communication skills, recognizing and recruiting quality attendant support, managing health, allocation budgeting, accessing resources, safety and prevention strategies, managing emergencies, and working with the FMS. The FMS is required to monitor the clientÂ's and/or authorized representativeÂ's submittal of required information to determine that it is complete, accurate and timely; work with the case manager to address client performance problems; and provide monthly reports to the client and/or authorized representative for the purpose of financial reconciliation. The FMS must also provide personnel and financial management services for CDASS clients and/ or authorized representatives.

After the client and/or authorized representative complete the FMS training, an Attendant Support Management Plan and must be developed and submitted to the case manager for approval. The Attendant Support Management Plan must describe at least the following: the clientÂ's current health status; the clientÂ's consumer directed attendant support needs; a detailed listing of amount, scope, and duration of services to be provided; the clientÂ's plans for securing consumer attendant support services, utilizing the monthly allocation, and handling emergencies. If areas of concern are identified upon the case managerÂ's review of the Attendant Support Management Plan, the case manager assists the participant to further develop the plan. CDASS may not begin until the plan is approved by the case manager. Existing Medicaid-funded services continue until the conditions for CDASS have been met and the start date for CDASS services is set.

In order to assess the client and/or authorized representativeÂ's effectiveness in participant direction and satisfaction with the quality of services being provided; the case manager must contact the client and/or the authorized representative at least monthly for the first three months, quarterly for the remainder of the first year, and twice a year thereafter. If the client and/or authorized representative report a change in functioning which requires a modification to the clientÂ's Attendant Support Management Plan, the case manager performs a reassessment.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

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

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

- ☑ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**

☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**

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

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

○ **Waiver is designed to support only individuals who want to direct their services.**

○ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**

◉ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

1. Clients must be willing to participate in IHSS or CDASS; and

2. Obtain a statement from his or her primary care physician indicating that the person is in stable health, has sound judgment and the ability to direct his or her care or has an authorized representative who is able to direct the clientÂ's care on his or her behalf; and

3. Clients that choose CDASS must demonstrate the ability to handle the financial/budgeting aspects of self directed care and/or has an authorized representative who is able to handle financial/budgeting aspects of the eligible personÂ's care. The client and/or authorized representative demonstrate this ability by completing training and submitting an Attendant Support Management Plan to the case manager for approval.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

At intake and at the annual reassessment, the case manager is required to provide a client and/or the legal guardian with the service options that are available. These options may include traditional agency services and/or participant directed services. The case manger informs the client and/or the legal guardian about the potential benefits and risks for each service option as well as inform them about the client and/or authorized representative responsibilities.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

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

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

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

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

The client and/or legal guardian interested in participant direction must obtain a completed Physician Statement of Consumer Capability indicating that the client is of sound judgment and has the ability to direct his/her care; or the client requires the assistance of an authorized representative to direct care on his/her behalf. In order to ensure that the physicianÂ's judgment can be consistently applied, the Physician Statement of Consumer Capability is a Department approved form that includes definitions of the following: stable health, ability to manage the health aspects of his/her life, ability to direct his/her own care, and authorized representative.

If the physician indicates that the client is unable to direct his/her care, the case manager must ensure that the client or legal guardian designates an authorized representative. Clients that have been designated as able to direct his/her care may also elect to designate an authorized representative.

The authorized representative must have the judgment and ability to direct attendant support services and must complete the Authorized Representative Designation and Affidavit form. The authorized representative must assert on this form that the he/she does not receive compensation to care for the client; is at least eighteen years of age; has known the client for at least two years; has not been convicted of any crime involving exploitation, abuse, or assault on another person; and does not have a mental, emotional, or physical condition that could result in harm to the client. The form also requires that the authorized representative provide information about the relationship he/she has with the client and informs the authorized representative about the responsibilities of CDASS.

Authorized representatives may not receive compensation for providing representation nor attendant support services to the clients they have agreed to represent.

In order to assess the client and/or authorized representativeÂ's effectiveness in participant direction and satisfaction with the quality of services being provided; the case manager must contact the client and/or the authorized representative at least monthly for the first three months, quarterly for the remainder of the first year, and twice a year thereafter. During this contact the case manager assures that the authorized representative is acting in the best interests of the participant.

The case manager also reviews monthly statements provided by the FMS contractor and contacts the FMS and authorized representative if an issue with utilization of the monthly allocation has been identified.

Should the case manager determine that the authorized representative is not acting in the best interests of the participant or demonstrates an inability to direct the attendant support services; the case manager must take action in accordance with Department guidelines. These guidelines include the development of a plan for progressive action that may include: mandatory retraining, the designation of a new authorized representative, and/or the discontinuation of participant directed services.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

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

Waiver Service	Employer Authority	Budget Authority
In Home Support Services (IHSS)	☑	☐
Consumer Directed Attendant Support Services (CDASS)	☑	☑

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

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

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

☐ **Governmental entities**
☑ **Private entities**

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

◉ **FMS are provided as an administrative activity.**

Provide the following information

i. **Types of Entities:** Specify the types of entities that furnish FMS and the method of procuring these services:

The Department contracts with the FMS contractor(s) in accordance with the State of Colorado Procurement Code and Rules, 24-101-101 through 24-112-101-10. Criteria for the selection of the FMS contractor(s) will include the ability to provide appropriate and timely personnel, accounting, fiscal management services, and training to clients and/or authorized representatives.

ii. **Payment for FMS.** Specify how FMS entities are compensated for the administrative activities that they perform:

The Department employs an agency with choice model for FMS. The Department executed a contract amendment with the current FMS contractor on January 1, 2012. This contract amendment has replaced the percent-of-allocation payment methodology for FMS services with a flat Per Member Per Month (PMPM) amount. This contract amendment permanently severs the link between the clients allocation and the FMS payment amount.

Payments to FMS contractors are made in accordance with the State fiscal rules and managed by the Medicaid Management Information System. FMS performance is supervised by a contract manager.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- [x] **Assist participant in verifying support worker citizenship status**
- [x] **Collect and process timesheets of support workers**
- [x] **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- [x] **Other**

Specify:

Provides mandatory training to the participant and/or authorized representative.

Performs Colorado Bureau of Investigation criminal history and Board of Nursing checks.

Adopts any Federal and/or State statute, regulation, rule, or policy that requires the provision of health care insurance.

Ensures attendants meet the established minimum qualifications.

Supports furnished when the participant exercises budget authority:

- [x] **Maintain a separate account for each participant's participant-directed budget**
- [x] **Track and report participant funds, disbursements and the balance of participant funds**
- [x] **Process and pay invoices for goods and services approved in the service plan**
- [x] **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- [x] **Other services and supports**

Specify:

Provides mandatory training that must include budget training, to the participant and/or authorized representative.

Additional functions/activities:

- [x] **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- [x] **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- [x] **Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- [x] **Other**

Specify:

The FMS is the employer of record for all CDASS attendants.

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

Oversight of FMS entities is assured by the Department through the establishment and oversight of a contractual agreement. The contract is overseen by an administrator at the Department and performance is assessed quarterly. An on-site review is conducted at least annually.

The FMS must permit the Department and any other government agency to monitor all activities conducted by the FMS, pursuant to the terms of the contract. Monitoring consists of an internal evaluation of FMS procedures, review of reports, review of complaint logs, re-examination of program data, on-site review, formal audit examinations, and/or any other reasonable procedures.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

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

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

The case manager provides information including service description, eligibility criteria, and required paperwork to potential and current HCBS-SCI clients. During the initial assessment and service planning process and at the time of reassessment, the case manager must also provide information to the client and/or legal guardian on the participant directed options.

The client and/or legal guardian interested in participant direction must obtain a completed Physician Statement of Consumer Capability indicating that the client is of sound judgment and has the ability to direct his/her care; or the client requires the assistance of an authorized representative to direct care on his/her behalf. In order to ensure that the physician's judgment can be consistently applied, the Physician Statement of Consumer Capability is a Department approved form that includes definitions of the following: stable health, ability to manage the health aspects of his/her life, ability to direct his/her own care, and authorized representative.

Should the physician indicate that the client is unable to direct his/her care, the case manager must ensure that the client or legal guardian designates an authorized representative. Clients that have been designated as able to direct his/her care may also elect to designate an authorized representative.

The case manager assists with the completion of and reviews the required paperwork for completion. The case manager then determines the level of care the client requires through the completion of a comprehensive assessment including the functional assessment using the ULTC tool and collaborates with the client and/or authorized representative in the development of the service plan. The case manager provides clients and/or authorized representatives that choose participant direction a list of certified IHSS agencies or refers CDASS clients to the FMS for the required training.

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

CDASS is the most flexible option for participant directed care, and requires more case manager support. Attendants are employed through a FMS, but are supervised in all other ways by the client and/or authorized representative. This program offers the client and/or authorized representative the ability to recruit, hire, train, schedule, and set wages within the limitations established by the Department. The case manager calculates the client's individual allocation based on the client's needs using the Department's guidelines and prescribed methods. The needs determined for allocation must reflect the needs identified by a comprehensive assessment using the ULTC and documented in the service plan. The case manager then refers the client and/or authorized representative to the FMS for training.

The FMS provides training to assure that clients and/or authorized representatives understand the philosophy and responsibilities of participant directed care. At minimum, this training includes: an overview of the program, client and/or authorized representative rights and responsibilities, planning and organizing attendant services, managing personnel issues, communication skills, recognizing and recruiting quality attendant support, managing health, allocation budgeting, accessing resources, safety and prevention strategies, managing emergencies, and working with the FMS. The FMS is required to monitor the client's and/or authorized representative's submittal of required information to determine that it is complete, accurate and timely; work with the case manager to address client performance problems; and provide monthly reports to the client and/or authorized representative for the purpose of financial reconciliation. The FMS must also provide personnel and financial management services for CDASS clients and/ or authorized representatives.

After the client and/or authorized representative complete the FMS training, an Attendant Support Management Plan and must be developed and submitted to the case manager for approval. The Attendant Support Management Plan must describe at least the following: the client's current health status; the client's consumer directed attendant support needs; a detailed listing of amount, scope, and duration of services to be provided; the client's plans for securing consumer attendant support services, utilizing the monthly allocation, and handling emergencies. If areas of concern are identified upon the case manager's review of the Attendant Support Management Plan, the case manager assists the participant to further develop the plan. CDASS may not begin until the plan is approved by the case manager. Existing Medicaid-funded services continue until the conditions for CDASS have been met and the start date for CDASS services is set.

In order to assess the client and/or authorized representative's effectiveness in participant direction and satisfaction with the quality of services being provided; the case manager must contact the client and/or the authorized representative at least monthly for the first three months, quarterly for the remainder of the first year, and twice a year thereafter. If the client and/or authorized representative report a change in functioning which requires a modification to the client's Attendant Support Management Plan, the case manager performs a reassessment.

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

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Home Modification	☐
In Home Support Services (IHSS)	☐
Supplies, Equipment, & Medication Management	☐
Homemaker	☐
Non Medical Transportation	☐
Personal Emergency Response Systems (PERS)	☐
Adult Day Health	☐
Respite	☐
Personal Care	☐
Alternative Therapies	☐
Consumer Directed Attendant Support Services (CDASS)	☐

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

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

Client and/or legal guardians that choose IHSS are referred to certified IHSS agencies. The IHSS agency is responsible for the provision of functional skills training to assist the client and/or authorized representative in developing skills and resources to maximize independent living and personal management of heath care.

Clients and/or legal guardians that choose CDASS are referred to the FMS contractor(s) for mandatory training. The FMS provides training to assure that clients and/or authorized representatives understand the philosophy and responsibilities of participant directed care. At minimum, this training includes: an overview of the program, client and/or authorized representative rights and responsibilities, planning and organizing attendant services, managing personnel issues, communication skills, recognizing and recruiting quality attendant support, managing health, allocation budgeting, accessing resources, safety and prevention strategies, managing emergencies, and working with the FMS. The FMS is required to monitor the client's and/or authorized representative's submittal of required information to determine that it is complete, accurate and timely; work with the case manager to address client performance problems; and provide monthly reports to the client and/or authorized representative for the purpose of financial reconciliation. The FMS must also provide personnel and financial management services for CDASS clients and/ or authorized representatives.

Oversight of FMS entities is assured by the Department through the establishment and oversight of a contractual agreement. The contract is overseen by an administrator at the Department and performance is assessed quarterly. An on-site review is conducted at least annually.

The FMS must permit the Department and any other government agency to monitor all activities conducted by the FMS, pursuant to the terms of the contract. Monitoring consists of an internal evaluation of FMS procedures, review of reports, review of complaint logs, re-examination of program data, on-site review, formal audit examinations, and/or any other reasonable procedures.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one)*.

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

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

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

IHSS and CDASS are voluntary programs. A client may choose to withdraw at anytime. If the client and/or authorized representative choose to withdraw, he/she must contact the case manager. The case manager would then assist the client in transitioning to equivalent care in the community. A client may choose to return to participant directed services as long as the client remains eligible. Participant directed services continue while the transition to provider managed care is in process.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

The Department may involuntarily terminate the use of IHSS under the following the conditions: the client is no longer eligible for the HCBS-SCI waiver program, the client's medical condition deteriorates causing an unsafe situation as documented by the primary physician, and/or the client refuses to designate an authorized representative and the client is unable to direct his/her own care as documented by the primary physician. IHSS agencies may also discontinue services when the client has exhibited inappropriate behavior toward the attendant and the Department has determined that the IHSS agency has made adequate attempts at dispute resolution and dispute resolution has failed. Inappropriate behavior includes, but is not limited to, documented verbal, sexual and/or physical abuse. IHSS agencies must assure that equivalent care has been established prior to a discontinuation of services.

The Department may involuntarily terminate the use of CDASS under the following conditions: The client and/or authorized representative no longer meet program criteria due to deterioration in physical or cognitive health and refuses to designate a new authorized representative to direct services; the client and/or authorized representative demonstrate a consistent pattern of overspending the monthly allocation leading to the premature depletion of funds, and the Department has determined that adequate attempts to assist the client and/or authorized representative to resolve the overspending have failed; the client and/or authorized representative exhibit inappropriate behavior toward attendants, case managers, or the FMS, the Department has determined that the FMS has made adequate attempts to assist the client and/or authorized representative to resolve the inappropriate behavior, and those attempts have failed; there is documented misuse of the monthly allocation by the client and/or authorized representative; there has been intentional submission of fraudulent CDASS documents to case managers, the Department, or the FMS; and/or instances of convicted fraud and/or abuse. Termination may be initiated immediately for clients being involuntarily terminated. Clients who are involuntarily terminated according to the above provisions may not be re-enrolled in CDASS as a service delivery option. The case manager must ensure that equivalent services are secured to assure participant health and welfare.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		17
Year 2		17
Year 3		17

Appendix E: Participant Direction of Services

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

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

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

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

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

  FMS and IHSS providers act as agencies with choice. The IHSS agency acts as the legal employer of participant-hired attendants while delegating authority to clients and/or authorized representatives for hiring, firing, and scheduling of his or her attendants. The FMS acts as the legal employer of participant-hired attendants while delegating authority to clients and/or authorized representatives for hiring, firing, training, setting wages, and supervising the day-to-day activities of his or her attendants.
- [ ] **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. **Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

- [x] **Recruit staff**
- [x] **Refer staff to agency for hiring (co-employer)**
- [ ] **Select staff from worker registry**
- [ ] **Hire staff common law employer**
- [x] **Verify staff qualifications**
- [x] **Obtain criminal history and/or background investigation of staff**

  Specify how the costs of such investigations are compensated:

  IHSS agencies are licensed annually by the Department of Public Health and Environment (DPHE). This licensure requires that any individual seeking employment with the agency submit to a Colorado Bureau of Investigation (CBI) criminal history record check. The costs of the criminal history record checks are the responsibility of the IHSS agency.

  The FMS is compensated for the costs of the criminal history background checks through the FMS administration fee.
- [x] **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
- [x] **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- [x] **Determine staff wages and benefits subject to State limits**
- [x] **Schedule staff**
- [x] **Orient and instruct staff in duties**
- [x] **Supervise staff**
- [x] **Evaluate staff performance**
- [x] **Verify time worked by staff and approve time sheets**
- [ ] **Discharge staff (common law employer)**
- [x] **Discharge staff from providing services (co-employer)**
- [ ] **Other**

  Specify:

Appendix E: Participant Direction of Services

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

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

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

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

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

The needs determined for allocation must reflect the needs identified by a comprehensive assessment using the ULTC and documented in the service plan. The case manager calculates the client's individual allocation based on the client's needs using the Department's guidelines and prescribed methods. The established methods include the case manager's determination of the number of Personal Care, Homemaker, and Health Maintenance Activities hours needed on a weekly basis. A worksheet converts the service hours into an annual allocation amount based on the current fee for service rates for comparable services. This is the amount of the participant-directed budget for waiver services over which the participant has authority.

The Department makes a concerted effort to ensure that the process to determine a client's allocation is transparent to the client and/or family members. When a CDASS client and/ or authorized representative participate in CDASS training the FMS provides the client and/or authorized representative with basic information about how the allocation is derived. If clients and/or authorized representatives request more detailed information, the FMS refers the client to their case manager for an individualized explanation. In addition, the worksheets used to determine allocations are available to the public on the Department's website.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

Case managers provide the client and/or authorized representative written notification of the approved allocation to be used for CDASS. If there is a change in client condition or service needs, the client and/or authorized representative may request the case manager to perform a reassessment. Should the reassessment indicate that a change in need for attendant support is justified, the client and/or authorized representative must amend the Attendant Management Support Plan. The case manager must also complete a PAR revision indicating the change and submit it to the Department's fiscal agent and to the FMS.

In approving an increase in the allocation, the case manager will consider the following: any deterioration in the client's functioning or change in the natural support condition, the appropriateness of attendant wages as determined by Department's established rate for equivalent services, and the appropriate use and application of funds to CDASS services.

In approving a decrease in the allocation, the case manager will consider the following: any improvement of functional condition or changes in the available natural supports, inaccuracies or misrepresentation in previously reported condition or need for service, and the appropriate use and application of funds to CDASS services.

The case manager notifies the client or his/her legal representative when CDASS allocation is denied or reduced. Notice of client appeal rights is mailed using the Department approved Notice of Action form number 803 and/or prior authorization request (PAR) for services denial letter is generated by the BUS and includes the appeal rights and filing instructions.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

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

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

The case manager will review monthly reports provided by the FMS to monitor client spending patterns and service utilization to assure appropriate budgeting. If the case manager determines that the client's spending patterns indicate a premature depletion of the budget, the case manager will contact the client and/or authorized representative to determine the reason for overspending.

If the client requires an allocation increase the case manager will complete a reassessment. If the client requires further skills training, the case manager will refer the client and/or the authorized representative to the FMS for additional training.

If the client and/or authorized representative completes training and continues to spend in a manner indicating premature depletion of funds the client will be required to select another authorized representative. If he/she refuses, the client will be terminated from CDASS and the case manager will assist the client in transitioning to agency services.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

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

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

Appeal rights are also included on the Long Term Care Plan Information form. The case manager reviews this form with the applicant/client/ and/or authorized representative at time of initial assessment and reassessment. A copy of this form is provided to the client and/or authorized representative. During the annual on-site monitoring of the CMA by the Department CMA reviewers monitor a random sample of client records. Included in the record review is an examination of the Notice of Action form number 803 to ensure that each CMA is using the approved form to convey information to the client on fair hearing rights. The Department monitors also have access to the BUS which allows them to review 803 forms as reviewers receive individual complaints.

Client appeal rights are maintained on a Notice of Action (803) form in the BUS. Case managers are instructed to send a Notice of Action whenever there is a change or reduction in services or when a client has been denied HCBS services due to functional or financial ineligibility.

If a client submits an appeal within the required time frame, the client may choose to continue receiving HCBS waiver

services. The continuation of services is available under the condition that if the denial or reduction is upheld, the client may be financially liable for services rendered.

Clients who have not received HCBS services and are denied due to ineligibility are provided with appeal rights and referred to alternative community resources including: home health, and other state plan benefits, if applicable. The annual Administrative Review conducted by the Department requires CMAs to report their methods for community referrals.

Every Medicaid action that is appealed with the OAC is reviewed by the Department. When a client appeals a decision, the OAC notifies the Department of the appeal hearing and a case manager participates in the hearing. Following the hearing, the administrative law judge issues an Initial Decision and sends it to the Office of Appeals (OA). The OA distributes the Initial Decision to all parties, including the Department, to review.

All parties then have an opportunity to file exceptions to the administrative law judge's Initial Decision. The OA is responsible for reviewing all of the documents presented at the hearing, as well as subsequent filings of exceptions to ensure that the Initial Decision is in compliance with the Department's regulations. The OA then issues a Final Agency Decision, affirming, reversing, or remanding the administrative law judge's decision.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

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

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

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

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

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

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

CMAs are responsible for operating for an internal grievance system, the CMA grievance is overseen by the Department.

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

A Home Health Hotline is maintained by the Department of Public Health and Environment, Health Facilities and

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

The participant does not use either hotline to report complaints or grievances against the CMAs or case manager as CMAs are not licensed or surveyed by CDPHE.

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

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

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

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

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

In addition, CMAs maintain a log system for complaints and grievances and either resolve the problem themselves or refer to the appropriate oversight agency.

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

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

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

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

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

Critical incidents are those incidents involving abuse, neglect, or exploitation, unexpected death or disability and, misuse of personal property. Critical incidents are required to be reported by licensed home health care agencies, personal care agencies and homemaker agencies, and CMA and Department staff. Oversight is provided by the Department and/or the Departments of Public Health and Environment (DPHE) and Human Services (DHS).

Critical incidents are to be reported immediately by case managers to the protective services unit of the county department of social services in the individualÂ's county of residence and/or local law enforcement agency as required by 10 CCR 2505-10, Section 8.390.2. In addition, Critical incidents are required to be reported to the Department within 24 hours of incident by the case manager and/or home care agency depending on the nature of the incident. Case managers report critical incidents to Department staff using the Critical Incident Reporting System (CIRS) accessible through the BUS. Additionally, case managers make phone calls to protective services to report critical incidents. Department reviewers also examine log notes, complaint logs and the CIRS reporting feature to ensure that issues discovered by the case manager are provided with appropriate follow up.

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

The Legal Center for People with Disabilities and Older People administers the Office of the State Long Term Care Ombudsman under contract with DHS. A network of local ombudsman, under the auspices of the local Area Agencies on Aging, identify, investigate, and resolve complaints by residents of long term facilities. Ombudsmen have regular contact with ACF clients in order to ensure clients have access to advocacy.

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

As set forth in 10 CCR 2505-10, Section 8.393.2, case managers are responsible for follow up with appropriate individuals and/or agencies in the event any issues or complaints have been presented. Each client and/or legal guardian is informed at time of initial assessment and reassessment to notify the case manager if there are changes in the care needs and/or problems with services.

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

c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Clients and/or legal representatives are informed by the case manager about the CMAÂ's complaint policy and the availability of the Home Health Hotline, an 800 telephone number. Home health agencies are also required to provide to all clients with the Home Health Hotline number. Additionally, home health agencies are required to maintain an internal complaint log system under the condition of participation. DPHE reviews the complaint log during annual surveys.

Information and training are provided to In Home Support Services clients by the certified IHSS provider agency. The IHSS agency is responsible for providing the client and/or authorized representative with peer counseling; information and referral services; independent living skills training; and individual and systems advocacy. This requirement includes informing the client about the process for reporting abuse, neglect, and exploitation. Clients can notify the IHSS agency and/or the appropriate authority if the client has experienced abuse, neglect, or exploitation.

Information and training is provided to CDASS clients and/or his/her authorized representatives by the FMS. The training includes in depth instruction about recognizing and preventing abuse, neglect, and exploitation. During the training clients and/or authorized representatives are provided with a list of resources to use if they experience an incident involving abuse, neglect, or exploitation. The training also includes information how to safely terminate an attendant. CDASS clients will also be encouraged to contact the proper authorities if they have been subjected to abuse, neglect, or exploitation by an attendant.

The Department has developed Policies and Procedures for the Critical Incident Reporting System. Similar resources are also available to clients and case managers about emergency backup and safety and prevention strategies.

Case managers must indicate if abuse, neglect, or exploitation is suspected during the initial and annual assessment process. The client and/or the clientÂ's representative participate in the development of the service plan and are provided a copy of the completed document. In 2011, a new service plan was created to ensure that the case manager discusses issues of abuse, neglect, and exploitation with the client. The Department uses its case management system, the Benefits Utilization System (BUS), to track the provision of this information and training. The case manager must confirm within the service plan that the client and/or clientÂ's representative have been informed of and trained on the process for reporting critical incidents including abuse, neglect, and exploitation.

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

Clients will be encouraged to report critical incidents to their provider(s), case manager, APS, local ombudsman and/or any other client advocate. The information packet includes what types of incidents to report and to whom the incident should be reported.

d. **Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Oversight is provided by the Department, DPHE, and/or DHS. The response to a critical incident is unique to the type of incident and the parties involved. However, the Department reviews all critical incidents. Below is a list of possible incidents, as well as who is responsible for follow up.

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

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

Alternative Care Facilities that have deficiencies will be required to submit a plan of correction at a minimum and can be assessed fines for major deficiencies. The most severe deficiency may result in closure. Life threatening situations require actions to correct the situation at the time of survey.

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

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

Incidents involving providers not surveyed by DPHE must be reported and responded to by the Department.

Incidents involving CDASS must be reported to the FMS and/or the Department. The Department and/or the FMS will respond to the incident depending upon the nature of the incident and the parties involved. IHSS providers are surveyed and licensed by CDPHE. Critical events and incidents that are reported to IHSS agencies follow the same procedures as all agencies surveyed or licensed by CDPHE.

All incidents involving abuse, neglect, or exploitation must also be reported to the County Department of Social Services and are responded to by the county agency.

All other incidents are responded to by the Department.

Time frames for investigations vary by the type of incident and/or complaint. If the incident involves immediate or imminent risk to the clientÂ's health, safety and/or welfare the incident is required to be responded to by the responsible party with 24 hours of receipt of the incident.

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

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

If the investigation involves the case manager or CMA, the CIRS administrator will convey the results of the investigation to the client and/or clientÂ's representative.

Critical incidents reported to CDPHE are also posted for public view on CDPHEÂ's website.

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

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

e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The Department receives all critical incident reports for HCBS-SCI participants and monthly complaint reports from DPHE for licensed and surveyed agencies. The reports provide the Department with information about the type of compliant or occurrence, the source of the complaint or occurrence, when the complaint or occurrence will be investigated, and the investigation findings. From these reports, Department staff can trend critical incidence and/or request to see a copy of individual complaint or occurrence reports from DPHE.

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

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

Appendix G: Participant Safeguards

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

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

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

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

◉ **The 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).

The Department has provided clients safeguards concerning the use of restraints as set forth in 26-20-102, 26-20-103, 26-20-104, 26-20-106, 26-20-107, 26-20-108 and 26-20-109, C.R.S. The use of restraints and restrictive interventions is only permitted in the delivery of the respite service.

As set forth in 6 CCR 1011-1, Chapter VII, Part 1.106 et seq. and at 10 CCR 2505-10, Section 8.495, an Alternative Care Facility is prohibited from the use of restraints and seclusion. For an ACF to meet criteria for HCBS waiver participation, the setting must facilitate community integration; protect the health, welfare and safety of the client; and be home-like and person-centered. The use of interventions that restrict participant movement; participant access to other individuals, locations or activities; restrict participant rights; or employment of aversive methods to modify behavior are prohibited. Upon admission, clients provided respite care in an alternative care facility are provided a list of client rights indicating the prohibition against restraint procedures and seclusion. To detect any unauthorized use of restraints or seclusion, the Department has added a signature section to the service plan that allows clients to indicate that he/she was provided information regarding client rights, complaint procedures,

and who to contact to report critical incidents.

Nursing Facilities are subject to the following regulations: as set forth in 6 CCR 1011-1, Chapter V, Part 7.11 et seq. A Nursing Facility may only use a chemical, emergency, mechanical and/or physical restraints upon the order of a physician and only when necessary to prevent injury to the resident or others, based on a physical, functional, emotional, and medication assessment. Restraints shall not be used for disciplinary purposes, for staff convenience or to reduce the need for care of residents during periods of understaffing. Whenever restraints are used, a call signal switch or similar devise within reach or appropriate method of communication shall be provided to the resident. Restraints are initiated through the judgment of professional staff for a specified and limited period of time or on the written authorization of a physician. Restraints are authorized only when there is a documented danger of injury to self or others.

The nature of the emergency shall be documented on in the health record and a physicianÂ's order for the restraint shall be obtained as soon as practicable but in no event later than 24 hours after the restraint is first used.

Facilities are required to permit access during reasonable hours to the premises and residents by the State Ombudsman and the designated local long-term care ombudsman in accordance with the federal "Older Americans Act of 1965", pursuant to Section 25-27-104 (2) (d), C.R.S. Additionally, each facility is required to maintain a mechanism to address resident/resident family concerns. Facilities are also required to allow case managers and family members to contact residents.

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:

The Department of Public Health and Environment (DPHE) survey of Alternative Care Facilities (ACF) and Nursing Facilities (NF) includes an environmental tour of the facility in which surveyors tour the entire facility looking for the use of restraints or seclusions. This survey is conducted annually or more frequently if DPHE has received a complaint involving abuse, neglect or substandard care about the facility. The surveyors review the clients they have identified during the tour as having restraints or seclusions, or for larger facilities the surveyors review a random sample of clients who have restraints or seclusions.

The review involves interviewing client and/or legal guardian to determine if the client and/or legal guardian understand why the restraint or seclusion is being used and that he/she has chosen and/or given permission for the restraint or seclusion. After the interview has been conducted the surveyor reviews the client's care plan to assess that the client has been assessed for safety and looks to see that the use of less restrictive measures was documented as being unsuccessful. The client's file will also be reviewed to ensure that the restraint or seclusion has been developed with and based on a physician's order, and that the client and/or legal guardian has signed a form giving the facility the permission to use the restraint or seclusion. If problems or inconsistencies are noted the error is noted as a deficiency by DPHE.

The Department maintains an Interagency Agreement that delegates DPHE the authority to survey and investigate complaints against Alternative Care Facilities (ACFs). The Department of Public Safety is responsible for the Building, Fire and Life Safety Code enforcement and certification of inspection. DPHE will not issue a license or recommend certification until the agency conforms to all applicable statutes and regulations for both departments. Should it be found that an agency does not comply with the licensing or certification standards, DPHE requires the agency to submit a plan of correction within 30 days. DPHE has the discretion to approve, impose, modify, or reject a plan of correction.

Only after the plan of correction has been accepted will a license or recommendation for certification be issued. DPHE sends the survey and licensing information to the Department for review. The Department may certify the provider for Medicaid enrollment based on the DPHE recommendation and survey results. Agencies denied licensure or recommendation for certification by DPHE are not approved as Medicaid providers.

The Department has developed and implemented an additional survey tool that is administered by DPHE during its survey process to ensure that ACFs comply with the home-like and person centered environment requirements and support community integration. This tool is enclosed.

The Department relies on information from the survey completed by DPHE in order to certify or decertify/ revoke certification of these providers.

Appendix G: Participant Safeguards

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

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

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

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

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

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

The Department has provided clients safeguards concerning the use of restraints as set forth in 26-20-102, 26-20-103, 26-20-104, 26-20-106, 26-20-107, 26-20-108 and 26-20-109, 2010 C.R.S.

The Colorado Revised Statutes referenced above also apply to many restrictive interventions as restraint is defined as:

Â“Any method or device used to involuntarily limit freedom of movement, including but not limited to bodily physical force, mechanical devices, or chemicals.Â”

The client rights established in 6 CCR 1011-1, Chapter VII, Part 1.106 et seq. provide safeguards concerning the use of restrictive interventions. These rights include, but are not limited to:

Â•The right to privacy.
Â•The right not to be isolated or kept apart from other residents.
Â•The right not to be sexually, verbally, physically or emotionally abused, humiliated, intimidated, or punished.
Â•The right to live free from involuntary confinement, or financial exploitation and to be free from physical or chemical restraints.
Â•The right to full use of the facility common areas, in compliance with the documented house rules.
Â•The right to have visitors, in accordance with house rules, including the right to privacy during such visits.
Â•The right to make visits outside the facility in which case the administrator and the resident shall share responsibility for communicating with respect to scheduling.
Â•The right to exercise choice in attending and participating in religious activities.
Â•The right to choose to participate in social activities, in accordance with the care plan.

6 CCR 1011-1, Chapter VII, Part 104(3) (f) requires that the facility shall document the personnel have received all required trainings. Prior to providing direct care, the facility shall provide an orientation of the physical plant and adequate training including training specific to the particular needs of the

populations served and resident rights.

Clients being provided respite care in a nursing facility are subject to the following regulations: as set forth in 6 CCR 1011-1, Chapter V, Part 7.11 et seq. A Nursing Facility may only use a chemical, emergency, mechanical and/or physical restraints upon the order of a physician and only when necessary to prevent injury to the resident or others, based on a physical, functional, emotional, and medication assessment. Restraints shall not be used for disciplinary purposes, for staff convenience or to reduce the need for care of residents during periods of understaffing. Whenever restraints are used, a call signal switch or similar devise within reach or appropriate method of communication shall be provided to the resident. In an emergency when there is a documented danger of injury to self or others, a registered nurse or licensed practical nurse may order a physical restraint. The nature of the emergency shall be documented on in the health record and a physicianÂ's order for the restraint shall be obtained as soon as practicable but in no event later than 24 hours after the restraint is first used.

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

The DPHE survey of Alternative Care Facilities (ACF) and Nursing Facilities (NF) includes an environmental tour of the facility in which surveyors tour the entire facility looking for the use of restrictive interventions. This survey is conducted annually or more frequently if DPHE has received a complaint about the facility. The surveyors review the clients they have identified during the tour as having restraints or seclusions. For larger facilities, the surveyors review a random sample of clients who have restraints or seclusions.

The review involves interviewing client and/or legal guardian to determine if the client and/or legal guardian understand why the restrictive interventions is being used and that he/she has chosen and/or given permission for the restraint or seclusion. After the interview has been conducted the surveyor reviews the clientÂ's care plan to assess that the client has been assessed for safety and looks to see that the use of less restrictive measures was documented as being unsuccessful. The clientÂ's file will also be reviewed to ensure that the restrictive interventions has been developed with and based on a physicianÂ's order, and that the client and/or legal guardian has signed a form giving the facility the permission to use the restraint or seclusion. If problems or inconsistencies are noted the error is noted as a deficiency by DPHE.

Clients living in an ACF are subject to the following regulation (6 CCR 1011-1, Chapter VII, Part 1.107 (i) and (i) (B) in regard to the use of behavior modifying drugs:
(i) Any drugs used to affect or modify behavior, including psychotropic drugs may not be administered by unlicensed persons as a "PRN" or "as needed" medication, except:
(B) Where a resident understands the purpose of the medication, is capable of requesting the drug of his or her own volition and the facility has documentation from a licensed medical professional that the use of such drug in this manner is appropriate.

ACFs are monitored every 9-15 months by DPHE. DPHE has two teams of surveyors. One team is comprised of experts that survey the facility for Â"Life Safety CodeÂ" issues. The Life Safety code team tours facilities to ensure that the environment such as square footage, fire sprinklers, adequate bathrooms, etc. meet the standards set forth in the Life Safety Code. The second team is the Health Survey team. The Health Survey team is comprised of Health experts that survey the facility to ensure the care clientsÂ' are receiving is in compliance with ACF client health/care regulations such as medication administration, etc. The two survey teams rotate surveying each facility every other year which ensures that all ACFs are surveyed by one of the teams every 9 to 15 months. In addition, if DPHE receives a complaint about an ACF, the findings of the investigation may be grounds for DPHE to initiate a Life Safety survey, a Heath survey or both regardless of the date the ACFs was last surveyed.

The Department relies on information from the survey completed by DPHE in order to certify or decertify/revoke certification of these providers.

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.

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

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

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

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

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

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

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

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

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

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

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

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

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

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

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. **Methods for Discovery: Health and Welfare**
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. **Sub-Assurances:**

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent 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 in a representative sample investigated within the required timeframe. Numerator = Number of critical incidents in the sample that required investigation and were investigated within the required timeframe Denominator = Total number of critical incidents in the sample that required investigation

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

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

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

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

Data Aggregation and Analysis:

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

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

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

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

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.

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.

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The Department uses information entered into the Critical Incident Reporting System (CIRS) by case managers as the primary method for discovery. Annual waiver recipient surveys are used as a secondary method.

Annual review by the LTC Division in collaboration with the quality improvement specialist is used to compare critical incident reporting trends with accuracy of documentation in case files reviewed.
Please see the QIS and work plan for more information on sampling frequency and responsible parties.

b. Methods for Remediation/Fixing Individual Problems

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

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

For issues or problems that arise at any other time throughout the year, technical assistance may be provided to the CMA case manager, supervisor or administrator and a confidential report will be documented in the waiver recipient care file when appropriate.

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

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

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

- (selected) **No**
- **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and

received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

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

Waiver Name Ã‚Â– Waiver Control Number
Brain Injury Ã‚Â– 0288.R03.00
ChildrenÃ‚Â's Extensive Support Ã‚Â– *4180.R03.01
ChildrenÃ‚Â's Home and Community Based Services Ã‚Â–4157.R04.00
ChildrenÃ‚Â's Habilitation Residential Program - **0305.R03.00
Children with Autism Ã‚Â– 0434.R01.01
Developmentally Disabled - *0007.R0.01
Elderly, Blind and Disabled Ã‚Â– 0006.R06.01
Mental Illness Ã‚Â– 0268.90.02
Pediatric Hospice Ã‚Â– 0450.R01.00
Supported Living Services - *0293.R03.01

*These waiver programs are operated by the Department of Human Services (DHS), Division for Developmental Disabilities (DDD).
**This waiver program is operated by DHS, Division of Child Welfare.

Discovery and Remediation Information: The Department draws from multiple sources when determining the need for and methods to accomplish system design changes. Using data gathered from DPHE and CIRS reports, annual programmatic and administrative evaluations, waiver participant survey data and stakeholder input, the DepartmentÃ‚Â's Long Term Care (LTC) Division, in partnership with the quality improvement section and Office of Information Technology (OIT), uses an interdisciplinary approach to review and monitor the system to determine the need for design changes, including those to the Benefits Utilization System (BUS). Work groups form as necessary to discuss prioritization and selection of system design changes.

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

Trending: The Department will use waiver-specific performance measures to monitor program performance. There are no HCBS national performance measures to which the Department can compare results, therefore, the Department will use its performance results to establish baseline data and to trend and analyze over time. The DepartmentÃ‚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 additional to using information from annual reviews, analysis of performance measure data, and feedback from case managers, the Department factors in appropriation of funds, legislation and federal mandates. For changes to the Medicaid Management Information Systems (MMIS), the Department had developed a Priority and Change Board that convenes monthly to review and prioritize system modifications and enhancements. Change requests are presented to the Board, which discusses the merits and risks of each proposal, then ranks it according to several factors including implementation dates, level of effort, required resources, code contention, contracting requirements, and risk. Change requests are tabled, sent to the fiscal agent for an order of magnitude, or cancelled. If an order of magnitude is requested, it is reviewed at the next scheduled Board meeting. If selected for continuance, the Board decides where in the priority list the project is ranked.

Implementation: The Department continually works to enhance coordination with DPHE. The Department will engage in quarterly meetings with DPHE to maintain oversight of delegated responsibilities; report findings and analysis; provider licensure/certification and surveys; provider investigations, corrective actions and follow-up. Documentation of inter-agency meeting minutes, decisions and agreements will be maintained in accordance with state record maintenance protocol.
Quality improvement activities and results will be reviewed and analyzed amongst program administrators and the HCBS quality oversight specialist 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 process used to monitor the effectiveness of system design changes will include systematic reviews of baseline data, reviews of remediation efforts and analysis of results of performance measure data collected after remediation activities have been in place long enough to produce results. Targeted standards have not been identified but will be based on baseline data once the baseline data has been collected.

Roles and Responsibilities: The LTC Division and the quality improvement section hold primary responsibility for monitoring and assessing the effectiveness of system design changes to determine if the desired effect has been achieved. This includes incorporation of feedback from waiver recipients, advocates, CMAs, and other stakeholders.

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

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

The LTC Division HCBS quality oversight specialist will review the QIS and its deliverables with the management on a quarterly basis and will provide updates to CMS when appropriate. Evaluation of the QIS is the responsibility of HOC members and will take into account the following elements:
1. Compliance with federal and state regulations and protocols.
2. Effectiveness of the strategy in improving care processes and outcomes.
3. Effectiveness of the performance measures used for discovery.
4. Effectiveness of the projects undertaken for remediation.
5. Relevance of the strategy with current practices.
6. Budgetary considerations.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Case Management Agencies (CMA) are subject to an independent audit as required by the Single Audit Act of 1984. The Department contracts with external CPA firms to conduct an annual audit of each CMAÃƒÂ,Ã‚'s compliance with the requirements detailed in the Office of Management and Budget (OMB) Circular A-133 Compliance Supplement.

Per the OMB Circular A-133, the Department does not require an independent audit of waiver service providers. Section 205(i) of OMB Circular A-133 states that, ÃƒÂ,Ã‚"Medicaid payments to a subrecipient 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.ÃƒÂ,Ã‚"

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

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

The Department has a Program Integrity (PI) Section that engages in post payment review of claims. The Department utilizes an Enterprise Surveillance Utilization Reporting System (ESURS) to create a peer group for each provider type and to identify all providers whose utilization is two standard deviations or more from the norm. Each month, these providers are referred to the Recovery Audit Contractor (RAC) or internal PI staff for a desk audit of provider records. The desk audits involve a review of prior authorized services, care plans, documentation created by the caregiver for each date of service billed, case management notes, supervisory visits, caregiver training, agency licensure and a review of complaint surveys. Documentation must substantiate claims for reimbursement and the number of units

billed must match the time-in/time-out records for each visit. Generally, all desk audits start with an initial investigation of three years of claims data to ensure that services are documented prior to the submission of a claim and that those claims are equivalent to the services rendered. Should suspicious trends be identified, the audits may be expanded to include of up to six years of claims data and could result in referrals to law enforcement for further investigations. Any overpayments identified are recovered.

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

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

The DepartmentÃƒÂ,Ã,Â's SOPs for case selection and recovery of overpayments are available on request.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. **Methods for Discovery: Financial Accountability**
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*
   i. **Sub-Assurances:**

      a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
Number and percent of waiver claims in a representative sample paid using the correct code as specified in the Provider Bulletin and Billing Manual. Numerator = Number of waiver claims paid using the correct code as specified in the Provider Bulletin and Billing Manual Denominator = Total number of waiver claims

Data Source (Select one):

Other
If 'Other' is selected, specify:
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**

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

Performance Measure:
Number and percent of waiver paid claims in a representative sample adhering to the limits set forth in the Prior Authorization Request (PAR). Numerator = Number of paid waiver claims adhering to the limits set forth in the PAR Denominator = Total number of paid waiver claims

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **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 Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
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 = 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 as specified in the Provider Bulletin and Billing Manual. Numerator = Number of waiver claims paid using the correct rate as specified in the Provider Bulletin and Billing Manual Denominator = Total number of waiver claims

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

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

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

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.

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 PI 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 PI Section for investigation as detailed in Appendix I-1 of the application.

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

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: As needed based on severity of occurance or compliance issue.

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

- ◉ **No**
- ○ **Yes**

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

Appendix I: Financial Accountability

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

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

HCBS-SCI waiver rates are established by the Department. Opportunity for public comment during the rate setting process is available through the legislative process and the rule setting process at the Medical Services Board. Information about payment rates are communicated using provider bulletins. The provider bulletin is available to the public on the DepartmentÃƒÂ¢Ã‚Ã‚™s website. In addition, all HCBS services are approved using a PAR which includes a column indicating ÃƒÂ¢Ã‚Ã‚œcost per unit.ÃƒÂ¢Ã‚Ã‚ The case manager is required to provide all waiver clients with a copy of the approved PAR if requested.

The adult day health, alternative therapies, CDASS, homemaker, In Home Support Services (IHSS), personal care, and respite care benefits are reimbursed on a fee-for-service basis. Payment is based on a statewide fee schedule. The fee schedule for these services is reviewed annually and published in the provider billing manual available through the Fiscal AgentÃƒÂ¢Ã‚Ã‚™s web site. Department staff in the Rates Division is responsible for developing rates for these waivered services.

The rate for personal care and homemaker under IHSS does not vary from the stand alone services. Additionally, the rate for relative personal care is the same as personal care.

Non-medical transportation is reimbursed on a per-trip basis. Reimbursement per trip depends on the type of transportation. Taxi services are reimbursed up to a set dollar amount, not to exceed the rate determined by the Public Utilities Commission. Mobility vans and wheelchair vans are reimbursed at a set rate per trip, based on a fee schedule.

Some services are also subject to a prior authorization review process, as indicated.

Allowable expenditures for Home Modification are negotiated by the case management agency. Home Modification expenditures above $1,000 require competing bids and are subject to the prior authorization process. The scope and cost of a home modification project is variable depending on the participantÃƒÂ¢Ã‚Â€Ã‚Â™ÃƒÂ¢Ã‚Â€Ã‚Â™ needs and the type of physical adaptation that is required to assure the health, safety, and welfare of the individual. Home modifications estimated to cost $1,000 or more require at least two competing bids. The bids must include a detailed breakdown of the costs and are submitted to the Department for authorization. The Department reviews the bids for appropriateness based on the participantÃƒÂ¢Ã‚Â€Ã‚Â™ÃƒÂ¢Ã‚Â€Ã‚Â™ assessed condition, duplicate adaptations, new construction costs, unusual or uncustomary charges, and authorizes payment to the lowest bidder. Payments cannot exceed the lifetime maximum of $10,000 per client.

The PERS rate is negotiated by the case management agency based on competitive market pricing. When the determination of a standard or tiered rate is difficult due to the variable nature of the service, the Single Entry Points (SEP) are authorized by the Department to negotiate reimbursement. Electronic monitoring services including PERs are authorized only for individuals who live alone, or who are alone for significant parts of the day, or whose only companion for significant parts of the day is too impaired to assist in an emergency, and who would otherwise require extensive supervision.

Case managers must ensure that Personal Emergency Response System meet the standards that are outlined in detail in 10 CCR 2505-10 §8.488. The case managers determine the features required for each client regarding GPS location services, wireless network capability, traditional landline capability, etc. The case managers choose the most cost-effective system required to meet the needs of the client. Case managers must also document the systems and vendors considered and the justification for the system selected in the participant's service plan. The unit of reimbursement is one unit for non-recurring services (e.g. initial installation) or one unit per month for services recurring monthly.

Due to the broad definition of the service necessary to meet variation in client need, the rates for medication reminder services are not standardized, and instead are individualized to specific client need. The Department uses negotiated rates on a case by case basis as its rate methodology. Under that rate methodology, the case manager is responsible for negotiation of the rates, and the process for oversight and review of those rates. Case managers are required to review the services necessary to meet the unique support needs for each client. Based on the needs of the client and the services available to meet those needs the case manager works with available providers to authorize the most appropriate level of service.

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

All billing claims flow directly from providers to the MMIS.

Appendix I: Financial Accountability

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

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

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

***Select at least one*:**

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

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how

the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

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

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

Appendix I: Financial Accountability

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

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

All waiver services included in the client's service plan must be prior authorized by case managers and forwarded to the fiscal agent for data entry in the MMIS. The MMIS system validates authorization for services when claims are filed. The first edit in the MMIS system when a claim is filed ensures that the waiver client is eligible for Medicaid.

The Colorado Benefits Management System (CBMS) is a unified system for data collection and eligibility. It allows for improved access to public assistance and medical benefits by permitting faster eligibility determinations, and allowing for higher accuracy and consistency in eligibility determinations statewide. The electronic files from CBMS are downloaded in to the MMIS system regularly to ensure updated verification of eligibility for dates of service claimed.

The claim is a statement by the provider that the services were rendered. The audit process and post payment review processes review claims for accuracy. Case managers contact clients quarterly and the service providers regularly 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's Program Integrity Section for investigation. If the provider's client records do not match the claims filed a payment recovery occurs.

Additionally, a random sample of approximately 0.2% to 0.35% of the total monthly claims are chosen through the MMIS and Explanation of Medicaid Benefits (EOMB) reports are sent to the Medicaid clients identified within the sample by the Department's fiscal agent. 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.

Medicaid clients receiving EOMB reports are asked to confirm that the services were rendered by means of a response document enclosed. All returned EOMBs are forwarded to Program Integrity. Program Integrity reviews them and provides follow up when a discrepancy occurs between a provider claims and what the client reports. After July 1, 2006 the fiscal agent became responsible for reviewing returned EOMBs and to provide the Department with reports of the results.

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

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

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

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

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

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

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

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

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

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

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

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

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

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

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

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

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

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

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

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

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

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

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

Select County Departments of Public Health provide home health and personal care services for waiver clients. The amount of the payment to public providers does not differ from the amount paid to private providers of the same service.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

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

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

- (●) **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**

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

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

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

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

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

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. **Additional Payment Arrangements**

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

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

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

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

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

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

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

- (●) **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ( ) **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

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

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

- [ ] **Other State Level Source(s) of Funds.**

  Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. **Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

- (●) **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
- ( ) **Applicable**

Check each that applies:

- [ ] **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

- [ ] **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. **Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- ( ) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- (●) **The following source(s) are used**

Check each that applies:

- [ ] **Health care-related taxes or fees**
- [x] **Provider-related donations**
- [ ] **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

The donated funds came from the Chanda Foundation. The corresponding legislation (HB09-1047) that mandated the pilot program for alternative care for people with spinal cord injuries, also laid out what the donation was to be used for. The Chanda Foundation's donation provided the state share for the Federal Match. CMS deemed this a bona fide donation in 2012.

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. **Services Furnished in Residential Settings.** *Select one:*

- (●) **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- ( ) **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:
Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- (●) **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ( ) **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C -3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- (●) **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ( ) **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. **Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] **Nominal deductible**
- [ ] **Coinsurance**
- [ ] **Co-Payment**
- [ ] **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the

groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Hospital, Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	22853.02	32759.51	55612.53	41572.48	37156.89	78729.37	23116.84
2	14333.99	5620.54	19954.53	32391.92	6027.01	38418.93	18464.40
3	18304.32	5599.99	23904.31	33363.68	6058.42	39422.10	15517.79

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 7)

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

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care: Hospital	Level of Care: Nursing Facility
Year 1	67		67
Year 2	67	26	41
Year 3	67	26	41

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 7)

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

The Department estimated the average length of stay on the waiver by reviewing historical data pulled from the Medicaid Management Information System (MMIS). Over time this number has varied only slightly for the Elderly, Blind, and Disabled waiver, which is where a majority of Spinal Cord Injury Waiver clients utilized HCBS Service prior to SCI implementation. As a result, the Department took the average length of stay on the waiver for FY 2009-10 through FY 2011-12 to estimate the average length of stay on the waiver in the forecasted years. The average length of stay was calculated by dividing the total number of “enrolled days” of all waiver participants by the unduplicated number of participants. The Department defines “enrolled days” as the number of days between the client’s first date of service on the waiver and the client’s last date of service on the waiver during the fiscal year.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 7)

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:

To estimate waiver service costs, the Department analyzed data from clients currently utilizing HCBS waiver services with a spinal cord injury diagnosis. For each individual existing service the Department estimated the number of clients utilizing each service, the number of units per user, the average cost per unit and the total cost of the service. To estimate these factors the Department examined historical growth rates, the fraction of the total population that utilized each service and graphical trends. Once the historical data was analyzed, the Department selected trend factors to forecast the number clients utilizing each service, the number of units per user and the average cost per unit. These numbers were then multiplied together to calculate the total expenditure for each service and added to derive Factor D for existing waiver services.

To estimate utilization of new waiver services, chiropractic care, acupuncture and massage (alternative therapies), the Department worked closely with service providers to determine the average need for these services for clients with spinal cord injuries. Estimated utilization was then multiplied by the average cost for alternative therapies to derive Factor D for new services. These costs were then added to existing service costs to calculate the total factor D estimate.

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:

For each individual service the Department estimated the number clients utilizing each service, the number of units per user, the average cost per unit and the total cost of the service. To estimate these factors the Department examined historical growth rates, the fraction of the total population that utilized each service and graphical trends. Once the historical data was analyzed, the Department selected trend factors to forecast the number clients utilizing each service, the number of units per user and the average cost per unit. Although the data includes Medicaid pharmacy utilization for duals, it is only for the limited therapeutic classes of drugs covered by Medicaid, not Medicare Part D. These numbers were then multiplied together to calculate the total expenditure for each service and added to derive Factor D.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

To calculate nursing facility costs, the Department examined utilization and average per user nursing facility costs. The Department trended expenditure using trends from the Department's FY 2012-13 Budget Request, S-1, “Request for Medical Services Premiums”. The Department believes this methodology to be most consistent across various reports.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

When determining the state plan costs for nursing facility clients, the Department reviewed 5 years of historical data (for the EBD waiver) and chose .52% which was the growth in per capita costs from FY 2009-10 to FY 2010-11 on the EBD Waiver. 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 EBD waiver is used as a proxy for the SCI waiver, as most of the clients came from the EBD waiver prior to SCI. Although the data includes Medicaid pharmacy utilization for duals, it is only for the limited therapeutic classes of drugs covered by Medicaid, not Medicare Part D.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 7)

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	
Adult Day Health	
Homemaker	
Personal Care	
Respite	
Alternative Therapies	
Consumer Directed Attendant Support Services (CDASS)	
Home Modification	
In Home Support Services (IHSS)	
Non Medical Transportation	
Personal Emergency Response Systems (PERS)	
Supplies, Equipment, & Medication Management	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 7)

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
Adult Day Health Total:						**7323.81**
Adult Day Health	Half Day	1	267.00	27.43	**7323.81**	
Homemaker Total:						**65072.77**
Homemaker	15 Minutes	17	1043.00	3.67	**65072.77**	
Personal Care Total:						**266070.00**
Personal Care	15 Minutes	30	2450.00	3.62	**266070.00**	
Respite Total:						**1866.48**
Respite	Day	1	84.00	22.22	**1866.48**	
Alternative Therapies Total:						**187440.00**
Acupuncture	Visit	50	23.00	65.00	**74750.00**	
Chiropractic	Visit	17	8.00	65.00	**8840.00**	
				GRAND TOTAL:		**1531152.52**
				Total Estimated Unduplicated Participants:		**67**
				Factor D (Divide total by number of participants):		**22853.02**
				Average Length of Stay on the Waiver:		294

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Massage	Visit	67	31.00	50.00	103850.00	
Consumer Directed Attendant Support Services (CDASS) Total:						874946.40
Consumer Directed Attendant Support Services (CDASS)	Day	15	592.00	98.53	874946.40	
Home Modification Total:						24771.84
Home Modification	Project	4	2.00	3096.48	24771.84	
In Home Support Services (IHSS) Total:						73009.98
Health Maintenance	15 Minuets	2	4575.00	7.19	65788.50	
Homemaker	15 Minuets	1	1366.00	2.78	3797.48	
Personal Care	15 Minuets	1	1070.00	3.20	3424.00	
Non Medical Transportation Total:						13434.12
Non Medical Transportation	One Way Trip	7	108.00	17.77	13434.12	
Personal Emergency Response Systems (PERS) Total:						16159.52
PERS	Month	34	8.00	59.41	16159.52	
Supplies, Equipment, & Medication Management Total:						1057.60
Supplies, Equipment, & Medication Management	Month	2	8.00	66.10	1057.60	
				GRAND TOTAL:		1531152.52
				Total Estimated Unduplicated Participants:		67
				Factor D (Divide total by number of participants):		22853.02
				Average Length of Stay on the Waiver:		294

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 7)

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
Adult Day Health Total:						**5347.54**
Adult Day Health	Half Day	1	218.00	24.53	**5347.54**	
Homemaker Total:						**19897.92**
Homemaker	15 Minutes	18	294.00	3.76	**19897.92**	
Personal Care Total:						**45074.88**
Personal Care	15 Minutes	18	666.00	3.76	**45074.88**	
Respite Total:						**1874.00**
Respite	Day	1	40.00	46.85	**1874.00**	
Alternative Therapies Total:						**125774.84**
Acupuncture	15 Minuets	41	68.00	17.57	**48985.16**	
Chiropractic	15 Minuets	33	68.00	17.41	**39068.04**	
Massage	15 Minuets	41	68.00	13.53	**37721.64**	
Consumer Directed Attendant Support Services (CDASS) Total:						**709682.68**
Consumer Directed Attendant Support Services (CDASS)	Day	38	119.00	156.94	**709682.68**	
Home Modification Total:						**3545.18**
Home Modification	Lifetime Maximum	2	1.00	1772.59	**3545.18**	
In Home Support Services (IHSS) Total:						**32157.86**
Health Maintenance	15 Minuets	1	3466.00	7.09	**24573.94**	
Homemaker	15 Minuets	1	335.00	3.76	**1259.60**	
Personal Care	15 Minuets	1	1682.00	3.76	**6324.32**	
Non Medical Transportation Total:						**4390.20**
Non Medical Transportation	One Way Trip	9	30.00	16.26	**4390.20**	
Personal Emergency Response Systems (PERS) Total:						**11939.40**
PERS					**11939.40**	

GRAND TOTAL:	**960377.30**
Total Estimated Unduplicated Participants:	**67**
Factor D (Divide total by number of participants):	**14333.99**
Average Length of Stay on the Waiver:	286

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Month	30	9.00	44.22		
Supplies, Equipment, & Medication Management Total:						**692.80**
Supplies, Equipment, & Medication Management	Month	2	8.00	43.30	**692.80**	
				GRAND TOTAL:		**960377.30**
				Total Estimated Unduplicated Participants:		**67**
				Factor D (Divide total by number of participants):		**14333.99**
				Average Length of Stay on the Waiver:		286

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 7)

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
Adult Day Health Total:						**5504.40**
Adult Day Health	Half Day	1	220.00	25.02	**5504.40**	
Homemaker Total:						**27832.32**
Homemaker	15 Minutes	24	302.00	3.84	**27832.32**	
Personal Care Total:						**61655.04**
Personal Care	15 Minutes	24	669.00	3.84	**61655.04**	
Respite Total:						**3823.20**
Respite	Day	2	40.00	47.79	**3823.20**	
Alternative Therapies Total:						**208381.92**
Acupuncture	15 Minutes	54	68.00	17.92	**65802.24**	
Chiropractic	15 Minutes	66	68.00	17.76	**79706.88**	
Massage	15 Minutes	67	68.00	13.80	**62872.80**	
				GRAND TOTAL:		**1226389.21**
				Total Estimated Unduplicated Participants:		**67**
				Factor D (Divide total by number of participants):		**18304.32**
				Average Length of Stay on the Waiver:		286

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Consumer Directed Attendant Support Services (CDASS) Total:						**826973.28**
Consumer Directed Attendant Support Services (CDASS)	Day	42	123.00	160.08	**826973.28**	
Home Modification Total:						**7120.84**
Home Modification	Lifetime Maximum	4	1.00	1780.21	**7120.84**	
In Home Support Services (IHSS) Total:						**65608.92**
Health Maintenance	15 Minuets	2	3466.00	7.23	**50118.36**	
Homemaker	15 Minuets	2	335.00	3.84	**2572.80**	
Personal Care	15 Minuets	2	1682.00	3.84	**12917.76**	
Non Medical Transportation Total:						**4628.61**
Non Medical Transportation	One Way Trip	9	31.00	16.59	**4628.61**	
Personal Emergency Response Systems (PERS) Total:						**13800.60**
PERS	Month	34	9.00	45.10	**13800.60**	
Supplies, Equipment, & Medication Management Total:						**1060.08**
Supplies, Equipment, & Medication Management	Month	3	8.00	44.17	**1060.08**	
				GRAND TOTAL:		**1226389.21**
				Total Estimated Unduplicated Participants:		**67**
				Factor D (Divide total by number of participants):		**18304.32**
				Average Length of Stay on the Waiver:		286