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 section 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:
Complementary and Integrative Health (HCBS-CIH)

C. Waiver Number:CO.0961

D. Amendment Number:CO.0961.R03.04

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

07/01/26

Approved Effective Date: 07/01/26
Approved Effective Date of Waiver being Amended: 07/01/25

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

The purpose of the amendment is to:
- End certain waiver services that are transitioning from the 1915(c) Home and Community Based Services (HCBS) to Community First Choice (CFC). The following services will be discontinued: Homemaker, Personal Care, Consumer Directed Attendant Support Services (CDASS), Home Delivered Meals, In Home Support Services (IHSS), Medication Reminder, Personal Emergency Response Systems (PERS), Remote Support, and Transition Setup.
- Add clarifying language to update the grievance process to align with the Ensuring Access to Medicaid Services final rule requirements.
- Update WEB provider language from 'contracted entity' to 'provider'.
- Further define the role of the Administrative Services Organization (ASO).
- Update the Professional Medical Information Page (PMIP) process to support alignment with House Bill (HB)-1162.
- Update language regarding In-Person Level of Care (LOC) Screen exceptions
- Update Conflict Free Case Management language from Case Management Agency 'waiver' to Case Management Agency 'authorization' to align with current terminology and implementation of Conflict-Free Case Management.
- Update the cost neutrality demonstration in Appendix J with the new data from State Fiscal Year (SFY) 2023-24.

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**	1G, 2, 6I, B Additional Info
☑ **Appendix A - Waiver Administration and Operation**	3, 6, QI
☑ **Appendix B - Participant Access and Eligibility**	2c, 6d, 6f, QI
☑ **Appendix C - Participant Services**	1a, 1c, 1d, 2d, 2e, 5, QI
☑ **Appendix D - Participant Centered Service Planning and Delivery**	QI
☑ **Appendix E - Participant Direction of Services**	0
☑ **Appendix F - Participant Rights**	3b, 3c
☑ **Appendix G - Participant Safeguards**	QI
☑ **Appendix H**	1.a-i
☑ **Appendix I - Financial Accountability**	1, 2a, 2d, 3g, QI
☑ **Appendix J - Cost-Neutrality Demonstration**	

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

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

Specify:

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

1. Request Information (1 of 3)

A. The **State** of **Colorado** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of section 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*):

Complementary and Integrative Health (HCBS-CIH)

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.R03.04
Draft ID: CO.019.03.03

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/25
Approved Effective Date of Waiver being Amended: 07/01/25

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: July 31, 2027). The time required to complete this information collection is estimated to average 163 hours per response for a new waiver application and 78 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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 the hospital level of care.

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

☑ **Nursing Facility**

Select applicable level of care

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

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

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 section 1915(a)(1)(a) of the Act and described in Appendix I**

☑ **Waiver(s) authorized under section 1915(b) of the Act.**

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

The Colorado HCBS Wellness Education Benefit and Colorado Home and Community-Based Case Management 1915(b)(4) approved waivers operate concurrently with this 1915(c) waiver.

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

☐ **section 1915(b)(1) (mandated enrollment to managed care)**

☐ **section 1915(b)(2) (central broker)**

☐ **section 1915(b)(3) (employ cost savings to furnish additional services)**

☑ **section 1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under section 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 section 1915(i) of the Act.**

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

☐ **A program authorized under section 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 Complementary and Integrative Health (HCBS-CIH) assists individuals living with a primary condition of a spinal cord injury, multiple sclerosis, a brain injury, spina bifida, muscular dystrophy, or cerebral palsy resulting in the inability for independent ambulation that requires long term supports and services to remain in a community setting.

Eligibility is limited to individuals aged 18 and older who are living with a qualifying primary condition of a spinal cord injury, multiple sclerosis, a brain injury, spina bifida, muscular dystrophy, or cerebral palsy as defined by broad diagnoses related to each condition within the most current version of the International Classification of Diseases (ICD) at the time of assessment. Individuals must have been determined to have an inability for independent ambulation resulting from the primary condition identified by the case manager through the assessment process.

Inability for independent ambulation means:

1. The Member does not walk and requires the use of a wheelchair or scooter in all settings, whether or not they can operate the wheelchair or scooter safely, on their own, OR;
2. The Member does walk but requires the use of a walker or cane in all settings, whether or not they can use the walker or cane safely, on their own, or;
3. The Member does walk but requires "touch" or "stand-by" assistance to ambulate safely in all settings.

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

Adult Day Health
Respite
Home Modification
Life Skills Training
Non-Medical Transportation
Peer Mentorship
Wellness Education Benefit (WEB)

The Department has also included Complementary and Integrative Health Services (chiropractic, acupuncture, and massage) in the HCBS-CIH Waiver to treat conditions or symptoms related to the individual's qualifying primary diagnosis and the inability for independent ambulation. The Department does not require the use of Complementary and Integrative Health Services by participants of this waiver program.

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

The Department contracts with local, non-state entities called Case Management Agencies (CMAs) to enable people with long-term care needs to access appropriate support services. These agencies form a network that provides case management and care coordination for HCBS-CIH waiver members. Case management functions include intake/screening/referral, member needs assessment, functional eligibility determination, service plan development, ongoing case management, and monitoring to ensure participant protections and quality assurance. The Department currently contracts with CMAs across 20 defined service areas for the case management and utilization review of long-term care waivers unrelated to developmental disabilities.

Through a member's person-centered service planning process, waiver members assist the CMA case manager in identifying services and community supports needed to prevent placement in a nursing facility. The waiver provides members with a choice of service delivery options for the following services: personal care/assistance, homemaker, and health maintenance activities. Health Maintenance Activities are routine and repetitive activities of daily living that require skilled assistance for health and normal bodily functioning and would be carried out by an individual with a disability if he or she were physically/cognhttps://wms-mmdl.cms.gov/WMS/faces/protected/35/geninfo.jsp#itively able.

IHSS and CDASS provide HCBS-CIH 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 through CDASS or choose to have comparable services delivered by a traditional Medicaid provider agency through IHSS.

A member and/or authorized representative may choose to direct these services or choose to have the same services delivered by a traditional Medicaid agency provider. Members who choose to self-direct personal care/assistance and/or homemaker services will receive support for these services through a Financial Management Services (FMS) organization. The FMS will be

responsible for providing appropriate and timely fiscal management services to individuals and or authorized representatives who choose to self-direct these services.

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 section 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 section 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 section 1902(a)(1) of the Act *(select one)*:

- ● **No**
- ○ **Yes**

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

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

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

5. Assurances

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

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

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

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

3. Assurance that all facilities subject to section 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 section 1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR Part 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. 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 Part 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 public comment period ran from 2/12/2026 through 3/13/2026:

The process is summarized as follows: The Department sent, via electronic mail, a summary of all proposed changes to all Office of Community Living (OCL) stakeholders. Stakeholders include members, contractors, families, providers, advocates, and other interested parties. Non-Web-Based Notice: The Department posted a notice in the newspaper of the widest circulation in each city with a population of 50,000 or more on 2/12/2026 and 2/26/2026. The Department employed each separate form of notice as described. The Department understands that, by engaging in both separate forms of notice, it will have met the regulatory requirements, CMS Technical Guidance, as well as the guidance given by the CMS Regional Office. The Department posted on its website the full waiver and a summary of any proposed changes to that waiver at https://hcpf.colorado.gov/hcbs-public-comment. The Department made available paper copies of the summary of proposed changes and paper copies of the full waiver. These paper copies were available at the request of individuals. The Department allowed at least 30 days for public comment to be submitted via email, mail, or phone. The Department complied with the requirements of Section 1902(a)(73) of the Social Security Act by following the Tribal Consultation Requirements outlined in Section 1.4 of its State Plan on 2/12/2026. In addition to the specific action steps described above, the Department ensured that all waiver amendment documentation included instructions for obtaining a paper copy. All documentation states: "You may obtain a paper copy of the waiver and the proposed changes by calling (303) 866-3684 or visiting the Department at 303 E 17th Street, Denver, Colorado 80203."

Newspaper notices about the waiver amendment also included instructions on obtaining an electronic or paper copy. At stakeholder meetings that announced the proposed waiver amendment, attendees were offered a paper copy, which was provided at the meeting or offered to be mailed to them after the meeting. Attendees, both in person and on the telephone, were also instructed to call or visit the Department for a paper copy. All relevant items confirming noticing will be provided upon request.

Summaries of all the comments and the Department's responses are documented in a listening log posted to the Department's website and submitted to CMS.

The Department followed all items identified in the letter addressed to the Regional Centers for Medicare and Medicaid Services Director from the Department's legal counsel dated 6/15/15. A summary of this protocol is available upon request.

The Department allowed at least 30 days for public comment to be submitted via email, mail, or phone. At the end of the 30-day public comment period the Department received (2) comments.

Comment (1 total): Supports the proposed HCBS waiver amendments.

Department Response: Thank you for providing feedback for the 2026 Spring Waiver Amendments and for being part of this important community.

Comment (1 total): Requests that the Department publish further implementation guidance for the proposed changes which would assist Case Managers, members, and providers in understanding the proposed changes. Further asks that all documents be accessible and member-friendly. Also suggests that the Department monitor for changes in utilization, service gaps, institutional placement, and geographic disparities as implementation occurs.

Department Response: We appreciate your suggestion regarding an FAQ to support understanding of the updated criteria and will take that into consideration as implementation planning and guidance development move forward. We also appreciate the recommendation to monitor processing timelines and denial patterns following implementation. The Department routinely monitors access, eligibility determinations, and program performance to ensure waiver assurances are met and to identify potential barriers to access.

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: Eggers

First Name: Lana

Title: Waiver Innovation & Compliance Section Manager

Agency: Colorado Department of Health Care Policy & Financing

Address: 303 E 17th Ave

Address 2:

City: Denver

State: **Colorado**

Zip: 80203

Phone: (303) 910-4974 **Ext:** ☐ **TTY**

Fax: (303) 866-2786

E-mail: lana.eggers@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 section 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: Julie Masters

State Medicaid Director or Designee

Submission Date: Jun 12, 2026

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

Last Name: Flores-Brennan

First Name: Adela

Title: Medicaid Director

Agency: Colorado Department of Health Care Policy & Financing

Address: 303 E 17th Ave

Address 2:

City: Denver

State: **Colorado**

Zip:

80203

Phone:

(303) 866-3060 **Ext:** ☐ **TTY**

Fax:

(303) 866-2786

E-mail:

Adela.Flores-Brennan@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:

The state is eliminating certain waiver services that are transitioning from the 1915(c) Home and Community Based Services (HCBS) to 1915(k) Community First Choice (CFC). The following services will be eliminated: Homemaker, Personal Care, Consumer Directed Attendant Support Services (CDASS), Home Delivered Meals, In Home Support Services (IHSS), Medication Reminder, Personal Emergency Response Systems (PERS), Remote Support, and Transition Setup.

For current and future members, the impact will be minimal. Between July 1, 2025 through June 30, 2026, members that were previously accessing these services through 1915(c) have been transitioning to 1915(k). Come July 1, 2026, all members will be accessing services through 1915(k). Members will continue to work with their case manager to set up the PAR, work through assessments, and receive services that meet the person-centered needs of the member.

Members receiving services through CFC can continue receiving remaining needed services through their waiver, as long as they remain eligible and continue to utilize at least one waiver service per month. It is not expected that any members will lose waiver eligibility and has not happened during the transition year.

Services covered in 1915(c) are very similar to the services covered in 1915(k) and there are not any key differences. With the services moving to the 1915(k) authority, access was expanded and more members are able to utilize the services.

The state issued a memorandum to participants on April 30, 2025 with Informational Memo 25-026; May 20, 2025 with Informational Memo 25-030; August 14, 2025 with Informational Memo 25-057. Additionally, the state held monthly CFC Council meetings beginning in April of 2022 and these meetings are still ongoing.

The services are moving from the HCBS waivers and into 1915(k); these services are not being eliminated. There is a grievance and appeals process members can follow if there are any health and welfare concerns in moving these services from waiver to CFC. The State monitored enrollment, access, and health and welfare outcomes throughout the transition period, and will continue to do so in compliance with requirements.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

During the state fiscal year spanning July 1, 2025, through June 30, 2026, members receiving services through the 1915(c) waiver transitioned the following services to the 1915(k) Community First Choice (CFC) State Plan benefit: Personal Care, Homemaker, Health Maintenance Activities (HMA), Consumer Directed Attendant Support Services (CDASS), In-Home Support Services (IHSS), Personal Emergency Response System, Supplies, Equipment, and Medication Reminders, Transition Setup, Home Delivered Meals, and Remote Supports.
Effective July 1, 2026, all members will access these services through 1915(k). Accordingly, these services will no longer be available through the 1915(c) waiver and are being removed from this waiver application effective July 1, 2026.
To implement these changes, the state made the following updates to the waiver application:
Reviewed and revised applicable waiver sections to remove services transitioning to 1915(k);
Added "Ended 6/30/2026" to the title of each affected service;
Updated applicable sections of Appendix C, including C-2-d and C-2-e, to remove references to transitioning services; and
Zeroed out projected utilization and expenditures for these services in Appendix J beginning in state fiscal year 2026-2027.

Information about Appendix A-3 Use of Contracted Entities:

The Department contracts with the Department of Local Affairs-Division of Housing (DOH) to perform waiver operational and administrative functions on its behalf. The relationship between the Department and the DOH is regulated by an Interagency Agreement, which requires the Department and the DOH to meet at least quarterly to discuss ongoing program improvement. The Department of Health's (DOH) responsibilities include inspecting all Host Home locations on a two-year cycle, submitting regular reports to the Department on inspection results, and immediately notifying the Department of any failed inspections.

The Department contracts with an Administrative Services Organization (ASO) to credential providers for the Non-Medical Transportation (NMT) benefit. The ASO reviews required credentialing documentation submitted by all newly enrolling or revalidating provider agencies to ensure vehicles and drivers meet the Department's regulatory and safety requirements. Providers that meet all credentialing requirements will receive a Certificate of Compliance issued by the ASO.

Internal staff reviewers will primarily conduct post-payment reviews of Medicaid-paid services of individuals receiving benefits under the HCBS Waiver program. However, the Department's existing Recovery Audit Contractor (RAC) will also be utilized to conduct post-payment claims reviews. All audits will continue to focus on claims submitted by providers for any service rendered, billed, and paid as a benefit under a Home and Community-Based Services (HCBS) Waiver. The Department will also issue notices of adverse action to providers to recover any identified overpayments.

For out-of-state providers, the Department maintains an Interagency Agreement with the host state's Medicaid agency or licensing agency to perform quality assurance and quality improvement activities. The Department may contract with out-of-state providers for the in-person monitoring requirements for case management.

Additional information for E-2-a-ii:

The Department will provide and oversee the hiring of attendants through the exception process. Oversight measures for granted exceptions will include in-person monitoring by the case manager, including the assessment that the attendant is meeting the member's needs; monitoring of critical incidents by the department, FMS, Training and Operations vendor, and case manager; and reminding members and/or authorized representatives about the state's processes for reporting critical incidents, including mistreatment, abuse, neglect, and exploitation.

The CDASS attendant exception process will contain thorough oversight safeguards:

1. All newly enrolled CDASS members must submit an outline of general attendant safety measures. The case manager and Training and Operations Vendor will review and approve the outline before the member or authorized representative completes enrollment and services are rendered.
2. All current CDASS members seeking an exception to hire an ineligible individual must create a formal safety plan. The plan will be sent to the Department for review by the member or authorized representative.
3. The member's safety plan must demonstrate that the member or authorized representative has considered and planned several defined safety elements related to the individual they are choosing to hire. If the plan does not have thorough responses to each component, the exception will be denied, and the individual will remain ineligible for hire as an attendant. The plan may be resubmitted.
4. The Department will notify the member or authorized representative upon approval of the exception and share the safety plan with the member's case manager, FMS, and the Training and Operations Vendor once the exception is processed.

5. Quarterly safety plan review and service assessment by the case manager.
6. Additional fraud, mistreatment, abuse, neglect, and exploitation (MANE) reporting tools developed by the Department and to be implemented on January 2023.
7. Robust educational and training resources for CDASS members/authorized representatives developed by the Training and Operations vendor and increased promotion of its current peer support services.
8. Continual stakeholder engagement will occur to facilitate ongoing policy and operational improvements as necessary.

G-1-d Responsibility for Review of and Response to Critical Events or Incidents:
Administrative Review documentation, records, and notes gathered by the CMA will be maintained in the Department's IT case management system to ensure the availability of records. Members may request that information from their case records be sent to them by the CMA. The CMA shall inform the member within two business days when the Department has completed an administrative review.

The Department will maintain information gathered through the State Level Administrative Review process to ensure cross-state agency information sharing is consistent with confidentiality requirements as applicable.

Investigations completed by Adult Protective Services are subject to confidentiality requirements and are shared only with appropriate parties to ensure the member's health, safety, and welfare. Providers and other family members are not provided information if it conflicts with the confidentiality of the member. The results of investigations completed by CDPHE are provided to the complainant via letter once the investigation is completed. Complaint investigations are posted on the CDPHE website once completed and are available for public viewing. State Level Administrative Review results are subject to the Department's privacy policy.

I-1 Financial Integrity and Accountability:

PICO Audits continued -
Regarding the audits performed by the PICO Section, which are not randomly selected, below details how data samples and records are chosen, communications to providers are made, how CAPs are issued, and how inappropriate claims are handled: Providers are selected based on their status as outliers in variables of interest. Members are then randomly selected from among those providers, and all lines from those selected members are chosen.

The provider is contacted via email before the audit starts and asked to verify their contact information. The Records Request is sent via certified mail and encrypted email. The audit results are communicated to the provider via a Notice of Adverse Action Letter, Case Summary, or No Findings Letter. All audit results are sent electronically via encrypted email to the verified email address. If the provider requests a Review of Findings meeting, as outlined in the Records Request Letter, we will meet with them over the phone or via video to review the findings before issuing the Notice of Adverse Action.

The State does not require corrective action plans; however, the PICO Section utilizes corrective action plans (CAPs) when deficiencies or breaches are identified within the RAC contract or any post-payment claims review contract. When the PICO Section identifies the need for a CAP, the State notifies the vendor in writing of the area of non-compliance. It requests the vendor to create a CAP outlining the vendor's efforts to investigate the issue, the root cause of the problem, the outcome of the vendor's investigation, and the proposed remediation actions the vendor would like to implement. The State will review the CAP and make any necessary changes to address and correct the areas of non-compliance, then authorize the CAP. The State then monitors the CAP, including the milestones and steps outlined in the CAP, and determines when the vendor is back in compliance with the contract. If the vendor fails the CAP, the State can move to terminate the contract.

When the State receives payment from a provider for an inappropriately billed claim identified during a post-payment claims review, it attaches the claim information to the fee for processing by the accounting department. The information includes FFP calculations and the recovery amount that accounting staff should record on the CMS-64 report and return to the federal government.

The following waiver services require EVV:
Life Skills Training (LST)
Respite

The Department also mandates EVV for the following State Plan Services:
Home Health

Occupational Therapy
Pediatric Behavioral Therapies
Pediatric Personal Care
Physical Therapy
Private Duty Nursing
Speech Therapy
Consumer Directed Attendant Support Services (CDASS)
Homemaker
In-Home Support Services (IHSS)
Personal Care

For services subject to EVV, the state leverages a prepayment claim review process, see I-2-d for details. With the exception of Consumer Directed Attendant Support Services, which is monitored using post-payment review. Post-payment reviews ensure accuracy of provider billing and compliance with state and federal regulations and Department billing policies. Post-payment reviews include audits of systems and application data, medical records and documentation submitted by providers, and state and federal rules and regulation to identify vulnerabilities and improvement areas.

I-2-a, Rate Determination Methods:

Adult Day Health, Non-Medical Transportation, Alternative Therapies, Medication Reminder, Respite Care, and Complementary and Integrative Health Services were established in 2017 using the Department's approved rate methodology. Life Skills Training, Peer Mentorship, and Transition Services were established in 2018 using the Department's approved rate methodology as part of transitioning services from the Colorado Choice Transitions program to the Adult LTSS waivers in SFY 2018. These service rates and methodologies were reviewed upon the transition to the CIH waiver.

The rate methodology has not been changed; however, rates were rebased in 2020 as part of the waiver renewal using updated wages, direct and indirect care time for each position, the price per square footage information, and updated administrative and capital equipment costs. The methodology is now documented, and calculations were performed primarily by the Department rather than an independent contractor, Navigant.

[Note: Service rates do not vary by provider.]

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:

   Office of Community Living, Benefits and Services Management 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 maintains an Interagency Agreement (IA) with the Colorado Department of Public Health and Environment (CDPHE). This agreement allows CDPHE to survey and investigate complaints against the following HCBS providers: Personal Care, Homemaker, Adult Day Service, Complementary and Integrative Health Services, Life Skills Training, Transition Setup, Peer Mentorship, and Home-Delivered Meals. Once the CDPHE survey is completed, the provider is referred to the Department to obtain Medicaid Certification.

The Department contracts annually with Case Management Agencies (CMAs) serving 20 defined service areas throughout Colorado. CMAs consist of local/regional non-state public, private, and non-profit agencies. These governmental subdivisions comprise County Departments of Human and Social Services, Public Health, and County Area Agencies on Aging or County and District Nursing Services.

CMAs are contracted with the Department to provide case management services for HCBS participants, including disability and delay determination, level of care screening, needs assessment, and critical incident reporting. CMAs also provide Targeted Case Management, including case management, service planning, referral care coordination, utilization review, the prior authorization of waiver services, and service monitoring, reporting, and follow-up services through a Medicaid Provider Participation Agreement. All CMAs are selected through a competitive bid process.

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

The Dept. contracts with a Long-Term Care Utilization Review/Utilization Management (LTC UR/UM) to consolidate long-term care utilization management functions for waiver programs and Medicaid members. For the Service Accommodation request process, the LTC UT/UM reviews for duplication, medical orders, limits prescribed in rule and waiver, assessments outlining needs, and service plans to ensure all items are appropriate for the member. The LTC UR/UM also manages appeals that arise from a Service Accommodation request review denial.

The LTC UR/UM manages the Critical Incident Reports (CIR) for the BI waiver. The LTC UR/UM is responsible for assessing the appropriateness of provider and CMA response to critical incidents, gathering, aggregating, and analyzing CIR data, and ensuring appropriate follow-up for each incident is completed.

The LTC UR/UM supports the Department in analyzing CIR data, understanding the root cause of identified issues, and providing recommendations for changes in CIR and other waiver management protocols to reduce or prevent the occurrence of future critical incidents.

Additional information is located in Main B. Optional.

○ **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 non-state public agencies to act as Case Management Agencies (CMAs) throughout the state of Colorado to perform HCBS waiver operational and administrative services, case management, utilization review, and prior authorization of waiver services for CIH waiver recipients.

☑ **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 non-governmental, non-state, private, and non-profit agencies to act as Case Management Agencies (CMAs) throughout Colorado. These agencies are selected through a competitive bid process to provide HCBS waiver operational and administrative services, case management, utilization review, and prior authorization of waiver services for CIH waiver recipients.

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 & Financing

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 ongoing oversight of the Interagency Agreement (IA) with the Colorado Department of Public Health and Environment (CDPHE) through regular meetings and reports. Issues that impact the agreement, problems discovered at specific agencies, or widespread issues and solutions are discussed. In addition, the Department is provided with monthly and annual reports detailing the number of agencies that have been surveyed, the number of agencies that have deficiencies, the number of complaints received and investigated, and complaints that have been substantiated. The IA contract between the Department and CDPHE requires that all complaints be investigated and reported to the Department. 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 members to other provider agencies. By gathering this information, the Department can develop strategies to resolve issues that have been identified. Appendix G of the waiver application provides further information about the relationship between CDPHE and the Department.

The Department oversees the Case Management Agency (CMA) system. As part of its overall administrative and programmatic evaluation, it annually monitors each CMA. The Department also reviews compliance with regulations at 10 C.C.R. 2505-10 Sections 8.390 and 8.485.

The administrative evaluation monitors compliance with agency operations and functions outlined in the waiver and Department contract requirements. The Department will evaluate CMAs through the ongoing tracking of administrative contract deliverables on a monthly, quarterly, semi-annually, and yearly frequency basis, depending on the contract deliverable. These documents include an operations guide, personnel descriptions (to ensure the appropriateness of qualifications), complaint logs and procedures, case management training, appeal tracking, and critical incident trend analysis. The review also evaluates agency community advisory activity, provider, and other community service coordination. The agency must take corrective action if the Department finds that a CMA does not comply with policy or regulations. Technical assistance is provided to CMAs via phone, e-mail, and meetings. The Department conducts follow-up monitoring to ensure corrective action implementation and ongoing compliance. In addition, the contract with CMAs allows the Dept. to withhold funding and terminate a contract due to noncompliance. If a compliance issue extends to multiple CMAs, the Department provides clarification through formal Policy Memos, formal training, or both. Technical assistance is provided to CMAs via phone and e-mail.

The programmatic evaluation consists of a desk audit in conjunction with the state's case management IT system to audit member files and ensure that all components of the CMA contract have been performed according to necessary waiver requirements. The state's case management IT system is an electronic record each CMA uses to maintain member-specific data. Data includes member referrals, screening, Level of Care (LOC) assessments, individualized service plans, case notes, reassessment documentation, and all other case management activities. Additionally, the state's case management IT system tracks and evaluates timelines for assessments, reassessments, and notices of action requirements to ensure that processes are completed according to Department-prescribed schedules. The Department reviews a sample of member files to measure documentation accuracy and track the appropriateness of services based on the LOC determination.
Additionally, the sample is used to evaluate compliance with the aforementioned case management functions. The contracted case management agency submits deliverables to the Department on an annual and quarterly basis for review and determination of approval. Case management agencies are evaluated through quality improvement strategy reviews annually, completed by a quality improvement organization.

The Department oversees the Fiscal Agent, LTC UR/UM, and Transportation ASO contractor through different contractual requirements. Deliverable due dates include monthly, quarterly, and annual reports to ensure the vendor completes their delegated duties. The Department's Operations Division ensures that deliverables are given to the Department on time and in the correct format. Subject-matter experts who work with the vendors review deliverables for accuracy.

The department oversees the IA with DOH through regular meetings and reports. The Department requires DOH to provide detailed monthly and annual reports on issues arising in the benefit's operation, how funding is utilized under the benefit, and member and provider grievances. DOH will also report to the Department on provider recruitment and enrollment, home modification inspections, local building code standards issues, and integration with the Single-Family Owner-Occupied (SFOO) program administered by DOH. The Department and DOH have created standards specific to the home modification benefit and standardized forms for use during the home modification process. The Department has established a Home Modification Stakeholder Workgroup that meets periodically to provide input on creating these standards. DOH will inspect home modifications for adherence to local building codes, adherence to the standards created

for the home modification benefit, compliance with communication requirements between the provider and member, and quality of work performed by providers. DOH regularly reports to the Department with the results of these inspections. The Department retains oversight and authority over providers who are found to be out of compliance with the home modification benefit standards.

For any post-payment claims review work completed by the Department's Recovery Audit Contractor (RAC), all deliverables and work product will be reviewed and approved by the Department as outlined in the Contract. The Department requires the RAC to develop and implement an internal quality control process to ensure that all deliverables and work product-including audit work and issuance of findings to providers-are complete, accurate, easy to understand, and of high quality. The Department reviews and approves this process before the RAC implements its internal quality control process.

As part of the payment structure within the Contract, the Department calculates administrative payments to the RAC based on its audit work and the quality of its audit findings. These payments are in addition to the RAC's base payment for conducting its claim audits. Under the Contract, administrative payments are granted when at least eighty-five percent (85%) of post-payment reviews, recommendations, and findings are sustained during the informal reconsideration and formal appeal stages.

Under the Contract, the Department can also conduct performance reviews or evaluations of the RAC at its discretion, including if the quality of the work product has declined or administrative payments are not being approved. The RAC is required to provide all information necessary for the Department to complete all performance reviews or evaluations. The Department may conduct these reviews or evaluations at any point during the contract term or after its termination for any reason.

If the Contract is breached or the RAC is not performing the scope of work, the Department can also issue corrective action plans to correct any violations and return to compliance promptly.

The Department reviews and approves the RAC's internal quality control process at the onset of the Contract and monitors the Contract work product during its term. The Department can request changes to this process to improve work performance, which the RAC must incorporate into its process.

The Department evaluates, calculates, and approves administrative payments when the RAC invoices the Department work claims reviews completed. The Department reviews each claim associated with the invoice and determines if the Contractor met the administrative payment criteria for each claim. The Department only approves administrative payments for claims that meet the administrative payment criteria.

Reporting of assessment results follows the Program Integrity Contract Oversight Section clearance process, depending on the nature of the results and to what audience the results are being released. All assessments are reviewed by the RAC Manager, the Audit Contract Management and Oversight Unit Supervisor, and the Program Integrity and Contract Oversight Section Manager. Clearance for specific reporting, including legislative requests for information, can also include the Compliance Division Director, the Medicaid Operations Office Director, and other areas of the Department.

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.* Note: Medicaid eligibility determinations can only be performed by the State Medicaid Agency (SMA) or a government agency delegated by the SMA in accordance with 42 CFR § 431.10. Thus, eligibility determinations for the group described in 42 CFR § 435.217 (which includes a level-of-care evaluation, because meeting a 1915(c) level of care is a factor of determining Medicaid eligibility for the group) must comply with 42 CFR § 431.10. Non-governmental entities can support administrative functions of the eligibility determination process that do not require discretion

including, for example, data entry functions, IT support, and implementation of a standardized level-of-care evaluation tool. States should ensure that any use of an evaluation tool by a non-governmental entity to evaluate/determine an individual's required level-of-care involves no discretion by the non-governmental entity and that the development of the requirements, rules, and policies operationalized by the tool are overseen by the state agency.

Function	Medicaid Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	☑	☑	☑
Waiver enrollment managed against approved limits	☑	☐	☐
Waiver expenditures managed against approved levels	☑	☑	☑
Level of care waiver eligibility 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:
A.6 Number and Percent of Fiscal Intermediary service level agreements submitted to the Dept demonstrating financial monitoring of the CIH waiver N: # of Fiscal Intermediary service level agreements submitted to the Dept demonstrating financial monitoring of the CIH waiver D: Total # of service level agreements required from the fiscal intermediary as specified in their contract.

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: Fiscal Intermediary	☑ **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**

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

Performance Measure:
A.20 Number and percent of deliverables submitted by the CMAs reviewed by the Dept. demonstrating performance of contractual requirements. N: Number of deliverables submitted by the CMAs reviewed by the Dept. demonstrating performance of contractual requirements D: Total number of CMA deliverables mandated by the contract

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
A.3 Number and percent of deliverables submitted to the Department by the Long-Term Care Utilization Review/Utilization Management (LTC UR/UM) demonstrating performance of delegated functions N: # of deliverables submitted to the Department by the LTC UR/UM demonstrating performance of delegated functions per the contract D: Total # of LTC UR/UM deliverables mandated by the contract

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: LTC UR/UM	☑ **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:
A.16 Number and percent of quality inspections performed by DOLA-DOH during the performance review period N: Number of quality inspections completed for Home Modifications during the performance period D: Total number of inspections for Home Modification required to be completed during the performance period

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: DOLA-DOH	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
A.14 # and % of deliverables submitted by the Recovery Audit Contractor (RAC) vendor that are reviewed by the Department demonstrating performance of delegated functions N: # of deliverables submitted by the RAC vendor that are reviewed by the Department demonstrating performance of delegated functions D: Total # of deliverables for RAC reviews mandated by the contract

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

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: RAC Vendor	☐ **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:
A.18 # and % of data reports submitted by the Transportation ASO that are reviewed by the Dept demonstrating services meet Dept regulation requirements N: # of data reports submitted by the Transportation ASO that are reviewed by the Dept demonstrating services meet Dept regulation requirements D: # of data reports required to be submitted by the Transportation ASO as specified in the contract

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: Transportation ASO Contractor	☑ **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:
A.15 # and % of data reports submitted by DOLA-DOH as specified in the Interagency Agreement (IA) that ensure Home Mods meet Dept. reg. requirements N: # of data reports submitted by DOLA-DOH that are reviewed by the Department as specified in the IA ensuring Home Mods meet Dept. reg. requirements D: # of data reports required to be submitted by DOLA-DOH as 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: DOLA-DOH	☑ **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**

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

Performance Measure:
A.2 # and % of reports submitted by CDPHE as required in the Interagency Agreement (IA) that the Department reviews showing cert surveys are conducted ensuring providers meet Dept standards N: # of reports submitted by CDPHE per IA that are reviewed by Dept showing cert surveys are conducted ensuring providers meet Dept standards D: Total # of reports required to be submitted by CDPHE

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: CDPHE	☐ **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:
A.27 # and % of deliverables submitted by the Wellness Education Benefit (WEB) contractor reviewed by the Department, demonstrating performance of delegated functions N: Number of deliverables submitted by the WEB contractor that are reviewed by the Department, demonstrating performance of delegated functions D: Total number of deliverables for WEB contractor mandated by the contract

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: WEB Contractor	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The Department maintains oversight of waiver contracts and interagency agreements by tracking contract deliverables on a monthly, quarterly, semi-annual, and yearly basis, depending on the requirements of the contract deliverable. The Dept. reviews all required reports, documentation, and communications to ensure compliance with all contractual, regulatory, and statutory requirements.

A.2
The CDPHE IA manages aspects of provider qualifications, surveys, complaints, and critical incidents. The IA requires monthly and annual reports detailing the number and types of agencies surveyed, the number of agencies with deficiencies, the types of deficiencies cited, the date deficiencies were corrected, and the number of complaints received, investigated, and substantiated. Oversight is through monthly meetings and reports. Issues that impact the agreement, problems discovered at specific agencies, or widespread issues and solutions are discussed.

A.3
LTC UR/UM contractor oversight is through contractual requirements and deliverables. The Department reviews monthly, quarterly, and annual reports to ensure the LTC UR/UM performs delegated duties. The Department's Operations and Administration (OAD) Division ensures that deliverables are provided promptly and in accordance with the contract specifications. Subject Matter Experts review deliverables for accuracy.

A.6
The fiscal agent must submit weekly reports regarding performance standards established in the contract. The reports include summary data on timely and accurate coding, claims submission, claims reimbursement, time frames for completion of data entry, and processing claims PARs. The Department monitors the fiscal agent's compliance with Service Level Agreements through reports submitted by the fiscal agent on customer service activities, including provider enrollment, provider publication, and provider training. The Dept. requests ad hoc reports to monitor additional issues or concerns.

A.14
The RAC vendor is contractually required to develop a quality control plan and process to ensure that retrospective reviews are conducted accurately and in accordance with the scope of work. The Department may also conduct performance reviews or evaluations of the vendor. Performance standards within the contract are directly tied to the contractor's pay, based on the quality of the contractor's performance.

A.15, A.16
The Department maintains oversight of the DOH IA through regular meetings and reports specified in the IA. The Department reviews the required detailed monthly and annual reports submitted by the DOH, which address issues arising from the operation of the benefit, the utilization of funding under the benefit, and member and provider grievances.

A.16
The Department reviews DOH reports regarding the results of home modification inspections, which ensure adherence to local building codes and standards created for the benefit of home modifications, compliance with communication requirements between providers and members, and the quality of work performed by providers.

A.18
The Department contracts with an ASO to act as the Transportation Broker. The ASO is responsible for coordinating with the RTD, verifying eligibility, processing the RTD special discount card, disseminating transit fares, and producing reports demonstrating that services meet Department regulations.

A.20
CMAs are monitored by tracking administrative contract deliverables. Regular reporting is required to ensure compliance with the Department's policies, procedures, and contractual obligations. The Department audits CMA's administrative functions, including the qualifications of individuals performing assessments and service planning, processes related to the evaluation of need, service planning, participant monitoring, case reviews, complaint procedures, provision of participant choice, and waiver expenditures.

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 and the state's method for analyzing

information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

A.2, A.3, A.6, A.14, A.15, A.16, A.18, A.20
The Department's Office of Community Living (OCL) actively monitors the responsibilities delegated to contracted agencies and vendors. When deficiencies are identified-either through routine annual evaluations or in response to specific incidents-the Department collaborates with sister agencies and contractors to provide technical assistance and pursue appropriate resolutions based on the circumstances.

If timely or appropriate remediation is not achieved, the Department issues a formal "Notice to Cure," which requires the contracted agency to correct the deficiency within a designated timeframe to return to compliance.

A.14
When a deficiency is found, the Department issues a request for a Corrective Action Plan (CAP). The RAC vendor then must develop and submit a plan explaining how the deficiency will be fixed and how contractual compliance will be regained.

A.20
If issues arise during a case management agency (CMA) audit, the Department communicates the findings directly to the CMA Administrator. These findings are recorded in the CMA's annual audit report. When needed, the Department mandates corrective actions and performs follow-up monitoring to ensure proper implementation and ongoing compliance.

The Department's contract with CMAs allows withholding funds or ending agreements if they do not comply. When compliance issues involve multiple CMAs, the Department clarifies policies through official memos, training, or both. Technical help is also offered by phone and email.

The Department works collaboratively with responsible personnel-including case managers, supervisors, and CMA administrators-to ensure that all identified issues are appropriately remediated and compliance is maintained.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: In addition to the CMA annual review, continuous reviews are conducted with CDPHE and the fiscal agent, enabling the Department to gather data whenever a complaint or issue requires attention.

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-

operational.

- (●) **No**
- ( ) **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target Sub Group	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**			☐
☐ **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 aged 18 and older who are living with a qualifying condition of a spinal cord injury, multiple sclerosis, a brain injury, spina bifida, muscular dystrophy, or cerebral palsy as defined by broad diagnoses related to each condition within the most current version of the International Classification of Diseases (ICD) at the time of assessment. Individuals must have been determined to have an inability for independent ambulation resulting from the qualifying condition identified by the case manager through the assessment process.

Inability for independent ambulation means:
1. The Member does not walk, and requires the use of a wheelchair or scooter in all settings, whether or not they can operate the wheelchair or scooter safely, on their own, OR;
2. The Member does walk, but requires the use of a walker or cane in all settings, whether or not they can use the walker or cane safely, on their own, OR;
3. The Member does walk but requires "touch" or "stand-by" assistance to ambulate safely in all settings.

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, multiple sclerosis, a brain injury, spina bifida, muscular dystrophy, or cerebral palsy 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 member to develop a Person-Centered Support Plan (PCSP). If the case manager identifies that a member's needs are more extensive than the services offered in the waiver can support, the case manager informs the member that their health and safety cannot be assured in the community and provides the member with appeal rights. Please see Appendix F-1 for more information on the member'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 member's condition, the case manager evaluates the member to determine if the member's health and welfare can be assured in the community. If the case manager determines the member'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. The Department defines the home health daily limit as posted on the state's Provider Rates and Fee Schedules at https://hcpf.colorado.gov/provider-rates-fee-schedule.

Should the combined costs for waiver services and/or Long-Term Home Health exceed the cost threshold set by the Department, the case manager submits the Service Accommodation Request to the Long Term Care Utilization Review/Utilization Management (LTC UR/UM) contracted with the Department. The Service Accommodation Request review process is intended to prevent the duplication of HCBS Waiver and State Plan services for adults, which includes adult Long-Term Home Health (LTHH) services, ensure the appropriate level of care and services are authorized and ensure that the cost of care is less than the cost of providing the same services in an institutional setting. There are no maximum limits if a member needs to request services in excess of the home health daily limit. Staff responsible for performing Service Accommodation Request PAR reviews are required to be licensed progression such as an LPN, RN, PA, NA, or MD in the state of Colorado. Additionally, they are required to have at least two (2) years of professional experience in at least one of the following:

- Conducting utilization reviews.
- Providing services in a home and community-based setting.
- Providing services for elderly and/or disabled members in a facility-based setting, skilled nursing facility, or hospital.

The Contractor reviews PAR review requests for the Complementary and Integrative Health (CIH) waiver program to ensure that the costs requested are justified. The LTC UR/UM utilizes all submitted and electronic information available including, but not limited to, the following to conduct the reviews:

- Copy or screenshot of the PAR, signed by the case management supervisor, or other proof of supervisor approval.
- Physician orders and any other supporting documentation,
- Long-term care assessments,
- Medical records,
- Previous service plans,
- Current provider agency care plan. Including previous provider agency care plan, and
- Comparative data on similar individuals if available.

While the LTC UR/UM is reviewing the request, the member's existing services remain intact until the request for additional services is approved or denied. The LTC UR/UM notifies the submitting agency and requests the agency submit a revised PAR for review when it determines there is a duplication of services, the medical orders do not support the costs, and/or when the individual's needs and services plan do not support the costs.

In the event that the request is denied, the member is provided with appeal rights, as well as the case manager coordinating with the member non-Medicaid waiver resources and 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	544
Year 2	672
Year 3	831
Year 4	831
Year 5	831

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	
Year 4	
Year 5	

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:

This waiver provides for the entrance of all eligible persons. Individuals are enrolled based upon the date of the case manager's verification of financial eligibility, Medicaid eligibility, and certification that the individual meets the level of care and targeting criteria specified in this application.

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)*:

- (●) **Section 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)

☐ **Parents and Other Caretaker Relatives (42 CFR § 435.110)**

☐ **Pregnant Women (42 CFR § 435.116)**

☐ **Infants and Children under Age 19 (42 CFR § 435.118)**

☑ **SSI recipients**

☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR § 435.121**

☑ **Optional state supplement recipients**

☐ **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

○ **100% of the Federal poverty level (FPL)**

○ **% of FPL, which is lower than 100% of FPL.**

Specify percentage:

☑ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in section 1902(a)(10)(A)(ii)(XIII)) of the Act)**

☑ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in section 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 section 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 section 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 spend down 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 period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law), 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 section 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 section 1924 of the Act.**

Complete Items B-5-e (if the selection for B-4-a-i is SSI State or section 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 period after September 30, 2027 (or other date as required by law).

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law) (select one).

- (●) **Spousal impoverishment rules under section 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 section 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 (Section 1634 State/SSI Criteria 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 section 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 period after September 30, 2027 (or other date as required by law).

b. Regular Post-Eligibility Treatment of Income: Section 1634 State and SSI Criteria State after September 30, 2027 (or other date as required by law).

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 section 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 period after September 30, 2027 (or other date as required by law).

c. Regular Post-Eligibility Treatment of Income: 209(b) State or after September 30, 2027 (or other date as required by law).

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 period after September 30, 2027 (or other date as required by law).

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules after September 30, 2027 (or other date as required by law)

The state uses the post-eligibility rules of section 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 section 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 or 42 CFR § 435.735:

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 period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

e. Regular Post-Eligibility Treatment of Income: Section 1634 State or SSI Criteria State - January 1, 2014 through September 30, 2027 (or other date as required by law).

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

f. Regular Post-Eligibility Treatment of Income: 209(b) State - January 1, 2014 through September 30, 2027 (or other date as required by law).

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 (7 of 7)

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - January 1, 2014 through September 30, 2027 (or other date as required by law).

The state uses the post-eligibility rules of section 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 the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

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

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

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

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

Specify the entity:

Case Management Agencies (CMAs) are responsible for performing LOC Screens and re-screens. The Dept. contracts annually with Case Management Agencies (CMAs) serving 20 defined service areas throughout Colorado.

- ( ) **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:

Minimum qualifications for the HCBS case managers who perform the initial evaluation are:
• Bachelor's degree in a human behavioral science or related field of study
• An individual who does not meet the minimum educational requirement may qualify as a case manager under the following conditions:
o Experience working with the LTSS population, in a private or public agency may substitute for the required education on a year-for-year basis.
o When using a combination of experience and education to qualify, the education must have a strong emphasis on a human behavioral science field.
o The agency shall request a waiver/memo from the department in the event that the employee does not meet minimum educational requirements. A copy of this waiver/ memo stating Department approval will be kept in the employee's personnel file that justifies the hiring of an employee who does not meet the minimum educational requirements.

Agency supervisor educational experience:
The agency's supervisor(s) shall meet minimum standards for education and/or experience and shall be able to demonstrate competency in pertinent case management knowledge and skills.

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 the LOC Screen to determine an individual's need for an institutional level of care. The LOC Screen measures six defined Activities of Daily Living (ADL) and the need for supervision for behavioral or cognitive dysfunction. ADLs include bathing, dressing, toileting, mobility, transferring, and eating. For initial evaluations, Medical Documentation must be signed by a Treating Licensed Medical Professional who verifies the individual's need for institutional level of care.

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

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

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

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

Members are referred to the CMA for an LTSS eligibility determination. The CMA completes an intake screening of the referrals to determine if a LOC Screen is appropriate.
Should the CMA determine that a LOC Screen is not appropriate, the CMA provides information and referral to other agencies as needed. The member is informed of the right to request a LOC Screen if the member disagrees with the CMA's determination. If the member disagrees with the determination, the CMA will complete the LOC Screen, upon request.

Should the CMA determine that a LOC Screen is appropriate, the CMA:

- Verifies the applicant's current financial eligibility status,
- Refers the applicant to the county department of social services of the member's county of residence for application, or
- Provides the applicant with the 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 documents follow-up on the 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.

The eligibility site shall process an application for Medical Assistance Program benefits within the following deadlines:

- 90 days for persons who apply for the Medical Assistance Program and a disability determination is required.
- 45 days for all other Medical Assistance Program applicants.
- The above deadlines cover the period from the date of receipt of a complete application to the date the eligibility site mails a notice of its decision to the applicant.

In unusual circumstances, the eligibility site may delay its decision on the application beyond the applicable deadline at its discretion. Examples of such unusual circumstances are a delay or failure by the applicant or an examining physician to take a required action such as submitting required documentation, or administrative or other emergencies beyond the agency's control.

The eligibility site shall not use the above timeframes as a waiting period before determining eligibility or as a reason for denying eligibility.

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 member's LOC Screen is completed within ten (10) working days.;
- For a member who is being transferred from a nursing facility to an HCBS program, the LOC Screen is completed within five (5) working days.; or
- For a member who is being transferred from a hospital to an HCBS program, the LOC Screen is completed within two (2) working days.

The CMA is required to complete a reevaluation of members within 12 months of the initial or previous assessment. A reevaluation may be completed sooner if there is a significant change in the member's condition or if required by program criteria. At both evaluation and re-evaluation, a CM performs the following activities:

1. Assess the member's functional status at a time and location convenient to the individual.
2. Review Person-Centered Support Plan (PCSP), service agreements, and provider contracts or agreements;
3. Evaluate service effectiveness, quality of care, and appropriateness of services;
4. Verify continuing Medicaid eligibility, other financial and program eligibility;
5. Annually, or more often if indicated, complete new PCSP and service agreements;
6. Maintain appropriate documentation, including the type and frequency of long-term care services the member is receiving for certification of continued program eligibility if required by the program for a continued stay review.
7. Refer the member to community resources as needed and develop resources for the member if the resource is not available within the member's community; and
8. Submit appropriate documentation for authorization of services, in accordance with program requirements.

9. Case managers may use phone or telehealth to complete the LOC Screen in accordance with the approved targeted Case Management state plan service under Section 1915(g)(1) of the Act and the case management Medicaid administrative activity under the approved cost allocation plan.

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 State's case management IT system. The State's case management IT system is utilized by every CMA and contains electronic member records and the timeframes for evaluation and reevaluation. The annual program evaluation includes a review of a random sample to ensure LOC Screens and re-screens are being completed correctly and timely.

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

Case Management Agencies (CMAs) are required to keep documentation retrievable electronically by utilizing the State's case management IT system. The database is housed at the Department and the documentation is accessible electronically to monitoring staff and program administrators indefinitely. Additionally, CMAs are contractually required to maintain documents in a central location for a period of six (6) years of the last to occur: the contract expiration or termination, the final payment is made under a contract, the resolution of pending contract matters, or the resolution of a pending audit. 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:
B.a.1 Number and percent of new waiver enrollees who received a level of care eligibility determination screen (LOC Screen) indicating a need for appropriate institutional LOC prior to the receipt of services N: # of new waiver enrollees who received LOC Screen indicating a need for appropriate institutional LOC prior to the receipt of services D: Total # of new waiver enrollees reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
State's case management IT system

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% confidence level with +/- 5% margin of error
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the

method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

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

Performance Measures

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

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

Performance Measure:
B.c.2 Number and percent of new waiver participants whose eligibility was determined using the approved processes and instruments as described in the approved waiver Numerator: Number of new waiver participants whose eligibility was determined using the approved processes and instruments as described in the approved waiver Denominator: Total number of new waiver participants reviewed

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% confidence level 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:
B.c.3 Number and percent of new waiver participants for whom Medical Documentation was collected. N: Number of new waiver participants for whom Medical Documentation was collected. D: Total number of new waiver participants reviewed

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

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

Data Aggregation and Analysis:

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

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.

B.a.1, B.c.2, B.c.3
The Department utilizes the Super Aggregate Report as the primary data source for monitoring the Level of Care (LOC) assurance and performance measures. The Super Aggregate Report is a custom report comprising two parts: data extracted directly from the state's case management system, the state's case management IT system, the Bridge, and data obtained from the annual program evaluations document, the QI Review Tool. (Some performance measures use the state's case management IT system only data, some use QI Review Tool only data, and some use a combination of the state's case management IT system and/or Bridge and QI Review Tool data). The Super Aggregate Report provides initial compliance outcomes for performance measures in the LOC sub-assurances and performance measures.

The case manager completes the LOC Screen to determine whether an individual needs institutional care. The LOC Screen measures six defined Activities of Daily Living (ADLs) and whether behavioral or cognitive dysfunction supervision is required. ADLs include bathing, dressing, toileting, mobility, transferring, and eating. For initial evaluations, Medical Documentation must be signed by a Treating Licensed Medical Professional to verify the individual's need for institutional care.

B.a.1
The LOC Screen must be conducted before the start date of Long-Term Care (LTC) services; receipt of these services cannot occur before that date. The LOC Screen must indicate a need for an institutional level of care.
Discovery data for this performance measure is pulled directly from the state's case management IT system.

B.c.2
The LOC assessment must comply with Department regulations and requirements. All level-of-care eligibility questions must be completed to determine the level of care. The Department uses the results of the QI Review Tool and the participant's state's case management IT system record to discover deficiencies in this performance measure.

B.c.3
Compliance with this performance measure requires confirmation that each initial LOC Screen includes the required Medical Documentation, signed by a Treating Licensed Medical Professional, according to Department regulations, before and within six months of the LTC start date. The Department uses the QI Review Tool results and the participant's state's case management IT system record to discover deficiencies in this performance measure.

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 and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

B.a.1, B.c.2, B.c.3

The Department provides remediation training to CMAs annually to assist with improving compliance with the level of care performance measures and completing LOC Screens. The Department compiles and analyzes CMA CAPs to determine the statewide root cause of deficiencies. Based on the analysis, the Department identifies the need to provide policy clarifications and/or technical assistance, design specific training, and modify current processes to address statewide systemic issues.

The Department continually monitors the level of care CAP outcomes to determine whether individual CMA technical assistance is required, what changes need to be made to training plans, or what additional training needs to be developed. The Department will analyze future QIS results to determine the effectiveness of the training delivered. Based on those results, further training, technical assistance, or systems changes will be implemented.

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 warranted 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 LOC Screen and Person-Centered Support Planning (PCSP) process with their Case Manager (CM), 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 continued stay reviews.

The LOC Screen and the Person-Centered Support Planning process assist the case manager in identifying the member's needs and supports. Based on this assessment and discussion, a long-term PCSP is developed. All forms completed through the Person-Centered Support Planning Process are available for signature through digital or wet signatures based on the member's preference. During this process, case managers also provide a choice of providers, notify members of the right to select qualified providers, and change providers at any time.

This information is documented and maintained by the Case Management Agency (CMA) and in the State's case management IT system.

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 Case Management Agency (CMA) and in the State's case management IT system, housed at the Department indefinitely. Additionally, CMAs are contractually required to maintain documents in a central location for a period of six (6) years of the last to occur: the contract expiration or termination; the final payment is made under a contract; the resolution of pending contract matters; or the resolution of a pending audit.

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 reflect cultural considerations of members by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who have limited English proficiency. Documents include a written statement in Spanish instructing members on how to obtain assistance with translation. Documents are orally translated for members who speak other languages by a language translator.

CMAs may employ case management staff to provide translation to members. 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 (Ended 6/30/2026)**		
Statutory Service	**Personal Care (Ended 6/30/2026)**		
Statutory Service	**Respite**		

Service Type	Service		
Other Service	Complementary and Integrative Health Services - Acupuncture		
Other Service	Complementary and Integrative Health Services - Chiropractic		
Other Service	Complementary and Integrative Health Services - Massage Therapy		
Other Service	Consumer Directed Attendant Support Services (CDASS) (Ended 6/30/26)		
Other Service	Home Delivered Meals (Ended on 6/30/26)		
Other Service	Home Modification		
Other Service	In Home Support Services (IHSS) (Ended 6/30/26)		
Other Service	Life Skills Training		
Other Service	Medication Reminder (Ended 6/30/26)		
Other Service	Non Medical Transportation		
Other Service	Peer Mentorship		
Other Service	Personal Emergency Response Systems (PERS) (Ended 6/30/26)		
Other Service	Remote Support (Ended 6/30/2026)		
Other Service	Transition Setup (Ended 6/30/2026)		
Other Service	Wellness Education Benefit		

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:

04 Day Services

Sub-Category 1:

04050 adult day health

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

Adult Day Health service has 3 tiers

Tier 1:
- Up to 3 hours/day
- Can be delivered virtually or in-person

Tier 1 can be provided via telehealth or in-person for up to 3 hours a day for one or more days a week for members who may be vulnerable or at higher risk for contracting illness and do not want to be in a group setting or a facility site. This tier encompasses both health and social services to assure the optimal functioning of the individual. Outpatient settings include parks, churches, and office buildings. The requirement to provide lunch, meet other food safety requirements, and provide a place to shower are waived if services are not provided in person or over the lunch hour. Providers may utilize this tier to offer virtual classes, activities, and groups using telehealth to connect members to staff and other day program members.

Tier 2:
- Between 3-5 hours/day
- Must be delivered in person

Tier 2 can be provided for 3-5 hours a 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 ensure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a full nutritional regimen (3 meals per day). Physical, occupational, and speech therapies indicated in the individual's plan of care would be furnished as component parts of this service if such services are not being provided in the participant's home.

Tier 3:
- More than 5 hours of service
- Must be delivered in-person

Tier 3 can be provided for 5 hours or more on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a full nutritional regimen (3 meals per day). Physical, occupational and speech therapies indicated in the individual's plan of care would be furnished as component parts of this services if such services are not being provided in the participant's home.

A member shall have the choice in how they would like to receive Adult Day Services.

Specialized Adult Day Services (SADS) is provided by a community-based entity for participants with a primary diagnosis of dementia-related diseases, Multiple Sclerosis, Brain Injury, chronic mental illness, Intellectual and Developmental Disabilities, Huntington's Disease, Parkinson's, or post-stroke participants, who require extensive rehabilitative therapies. To be designated as specialized, two-thirds of an ADS Center's population must have a diagnosis which is one of any of the above diagnoses. Each diagnosis must be verified by a Licensed Medical Professional, either directly or through Case Management Agency documentation, in accordance with Section 8.7505.D.

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 member's assessed need for services, physician's orders, and prior authorization by case managers.

Transportation to and from the Adult Day Center is not reimbursed under the Adult Day Service

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☑ **Remote/via Telehealth**

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 Services 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 Services Center

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certification as a Medicaid provider of Adult Day Services C.R.S: 10 C.C.R. 2505-10, Section 8.7505.E.1(a).

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Colorado Department of Public Health and Environment (CDPHE), Health Facilities and Emergency Section Division

Frequency of Verification:

Providers are surveyed at a minimum every 36.9 months. Risk-based surveys may occur more often if a credible complaint is received by CDPHE. Credible complaints are ones that are validated; when investigated they have not been found to be fabricated allegations misinterpreted impressions of something that did not occur. During the investigation of a complaint by CDPHE, findings are severe - i.e. a systemic failure, patient harm, etc. it may cause an investigation to be converted to a full survey at the time the investigation is underway. The findings of the investigation may be grounds for CDPHE to initiate a full recertification 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:

Homemaker

Alternate Service Title (if any):

Homemaker (Ended 6/30/2026)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08050 homemaker

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

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

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

Service Definition *(Scope):*

Homemaker Services
Homemaker Services are those that consist of the performance of general household tasks and are provided by a qualified homemaker when the individual regularly responsible for these activities is temporarily absent, unable to manage the home and care for him/herself or others in the home. Homemaker service may include the following household tasks: routine light housecleaning, such as dusting, vacuuming, mopping, and cleaning bathroom and kitchen areas; meal preparation; dishwashing; bedmaking; laundry; and shopping.

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 member's assessed need for services and prior authorization by case managers up to the cost containment parameters. Members that choose to have homemaker services delivered by an agency shall have no duplication of these services by an In-Home Support Services (IHSS) agency or Consumer-Directed Attendant Support Services (CDASS). There shall be no duplication of housekeeping chores that are incidental to and reimbursed as personal care.

Homemaker services shall not duplicate any activity of daily living (ADL) or instrumental activity of daily living (IADL) need that has been identified in the person-centered support planning process that the member prefers and can be met with the Remote Supports service.

Homemaker services shall not be provided or billed at the same time as Remote Supports.

The Department's regulations provide guidance to Case Managers on developing effective person-centered support plans that meet members' unique needs without duplication of services for ADLs and IADLs.

Homemaker services shall not be delivered virtually or by telehealth. If it is the member's preference to have an ADL or IADL need through live virtual support, they shall use Remote Supports services provided by a Remote Supports provider.

Homemaker services are limited to additional services not otherwise covered under the state plan, but consistent with the waiver objectives of avoiding institutionalization.

There is a 16 hour per day limit for caregivers across Personal Care, Homemaker, Health Maintenance Activities (HMA) for all service delivery options. This also includes Long Term Home Health (LTHH) - Registered Nurse (RN) and LTHH - Certified Nursing Assistant (CNA). There is an exception for emergency situations.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker (Ended 6/30/2026)

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, Sections 8.7400 and 8.7527.E.1.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Colorado Department of Public Health and Environment (CDPHE), Health Facilities and Emergency Section Division

Frequency of Verification:

Providers are surveyed at a minimum every 36.9 months. Risk-based surveys may occur more often if a credible complaint is received by CDPHE. Credible complaints are ones that are validated; when investigated they have not been found to be fabricated allegations misinterpreted impressions of something that did not occur. During the investigation of a complaint by CDPHE, findings are severe - i.e. a systemic failure, patient harm, etc. it may cause an investigation to be converted to a full survey at the time the investigation is underway. The findings of the investigation may be grounds for CDPHE to initiate a full recertification 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 (Ended 6/30/2026)

Provider Category:

Agency

Provider Type:

Personal Care / Homemaker Agency

Provider Qualifications

License *(specify):*

Homecare 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 8.7403, 8.7538.E, and 8.7527.E.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Colorado Department of Public Health and Environment (CDPHE), Health Facilities and Emergency Section Division

Frequency of Verification:

Providers are surveyed at a minimum every 36.9 months. Risk-based surveys may occur more often if a credible complaint is received by CDPHE. Credible complaints are ones that are validated; when investigated they have not been found to be fabricated allegations misinterpreted impressions of something that did not occur. During the investigation of a complaint by CDPHE, findings are severe - i.e. a systemic failure, patient harm, etc. it may cause an investigation to be converted to a full survey at the time the investigation is underway. The findings of the investigation may be grounds for CDPHE to initiate a full recertification 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):

Personal Care (Ended 6/30/2026)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08030 personal care
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 light housekeeping chores like meal preparation, bed making, dusting, and vacuuming that are incidental to the care furnished.

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

Services similar in nature including assistance with ADLs in the Life Skills Training service are not allowed to be provided at the same time and are managed through MMIS system safeguards.

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

Relatives of 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 certification period.

There is a 16 hour per day limit for caregivers across Personal Care, Homemaker, Health Maintenance Activities (HMA) for all service delivery options. This also includes Long Term Home Health (LTHH) - Registered Nurse (RN) and LTHH - Certified Nursing Assistant (CNA). There is an exception for emergency situations.

Personal care services are limited based on the member's assessed need for services and prior authorization by case managers up to the cost containment parameters.

Individuals who are age 20 and under would access medically necessary Personal Care services via the State Plan under EPSDT. Examples of tasks that may be outside the scope of the EPSDT Personal Care include exercise, accompanying, and protective oversight.

Members that choose to have personal care services delivered by an agency shall have no duplication of these services by an In-Home Support Services (IHSS) agency or by Consumer Directed Attendant Support Services (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. This service can only be participant-directed if the member chooses to participate in CDASS.

Personal Care services shall not duplicate any activity of daily living (ADL) or instrumental activity of daily living (IADL) need that has been identified in the person-centered support planning process and the member prefers and can be met with the Remote Supports service.

Personal Care services shall not be provided or billed during the same time as Remote Supports.

The state's regulations provide guidance to Case Managers on developing effective person-centered support plans that meet the member's unique needs without duplication of services for ADLs and IADLs.

Personal Care services shall not be delivered virtually or by telehealth. If it is the member's preference to have an ADL or IADL need met through live virtual support, they shall use Remote Supports services provided by a Remote Supports provider.

Personal Care services are limited to additional services not otherwise covered under the state plan, but consistent with the waiver objectives of avoiding institutionalization.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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 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 (Ended 6/30/2026)

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 8.7403, 8.7538.E, and 8.7527.E.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Colorado Department of Public Health and Environment (CDPHE), 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 9-36 month risk based survey cycle. Providers that have deficiencies in areas of staff training/ supervision, or member 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 member 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 (Ended 6/30/2026)

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 Home and Community-Based Services C.R.S; 10 C.C.R. 2505-10, Section 8.7538.E.1.a

and 8.7403.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Colorado Department of Public Health and Environment (CDPHE), Health Facilities and Emergency Section Division

Frequency of Verification:

Providers are surveyed at a minimum every 36.9 months. Risk-based surveys may occur more often if a credible complaint is received by CDPHE. Credible complaints are ones that are validated; when investigated they have not been found to be fabricated allegations misinterpreted impressions of something that did not occur. During the investigation of a complaint by CDPHE, findings are severe - i.e. a systemic failure, patient harm, etc. it may cause an investigation to be converted to a full survey at the time the investigation is underway. The findings of the investigation may be grounds for CDPHE to initiate a full recertification 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:
09 Caregiver Support	09011 respite, out-of-home
Category 2:	**Sub-Category 2:**
09 Caregiver Support	09012 respite, in-home
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.

Respite may be received in the Member's home, a Nursing Facility (NF), an Alternative Care Facility (ACF) or in a

community setting.

Federal financial participation is not to be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence. An individual would be responsible for any prorated room and board costs for the time spent in an NF.

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

Member shall be authorized for no more than 30 days of respite care in each certification period.

The Department may approve a higher amount based on a documented increase in medical or behavioral needs as reflected in the behavior plan for behavioral needs or in the medical records for medical needs.

Respite cannot be provided concurrently with Personal Care Services and Consumer Directed Attendant Support Services (CDASS).

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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 Care / Homemaker Agency
Agency	Home Health Agency
Agency	Nursing Facility
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:

Personal Care / Homemaker Agency

Provider Qualifications

License *(specify):*

Home Care Agency licensed by CDPHE as either Class A or Class 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 8.7403, 8.7538.E, and 8.7527.E.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Colorado Department of Public Health and Environment (CDPHE), 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 9-36 month risk based survey cycle. Providers that have deficiencies in areas of staff training/ supervision, or member 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 member 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:

Home Health Agency

Provider Qualifications

License *(specify):*

Home Care Agency licensed by CDPHE as either Class A or Class 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 8.7403 and 8.7538.E.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Colorado Department of Public Health and Environment (CDPHE), 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 9-36 month risk based survey cycle. Providers that have deficiencies in areas of staff training/ supervision, or member 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 member 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:

Nursing Facility

Provider Qualifications

License *(specify):*

Nursing 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:

Colorado Department of Public Health and Environment (CDPHE), Health Facilities and Emergency Section Division

Frequency of Verification:

Every nursing facility is surveyed by DPHE every 9-15 months.

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 8.7506.F.1.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Colorado Department of Public Health and Environment (CDPHE), Health Facilities and Emergency Section Division

Frequency of Verification:

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, 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 CDPHE 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.

In accordance with the State Operations Manual, survey of Life Safety Code issues has been designated through an interagency agreement to the Colorado Division of Fire Protection.

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:

Complementary and Integrative Health Services - Acupuncture

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11130 other therapies
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Acupuncture means the insertion of needles and/or manual, mechanical, thermal, electrical, and electromagnetic treatment to stimulate specific anatomical tissues for promotion, maintenance and restoration of health and prevention of disease both physiologic and /or psychological. During an acupuncture treatment, dietary advice and therapeutic exercises may be recommended in support of the treatment.

Complementary and Integrative Health Services are limited to acupuncture, chiropractic care, and massage therapy as defined in this waiver. Services are to be delivered under the direction of a care plan recommended by a Complementary and Integrative Health Service Provider.

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

The utilization of Complementary and Integrative Health Services may fluctuate according to need over the course of a year. Authorization and payment for the Complementary and Integrative Health Services are limited as follows:

Services are capped per certification period of no more than 408 total units of any combination of Complimentary and Integrative Health Services.

Services are limited based on the member's assessed need for services, the care plan created by the Complementary and Integrative Health Service Provider, and prior authorization by case managers.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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	Complementary and Integrative Health Services Center
Individual	Acupuncturist

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Complementary and Integrative Health Services - Acupuncture

Provider Category:

Agency

Provider Type:

Complementary and Integrative Health Services Center

Provider Qualifications

License *(specify):*

Services must be provided by licensed, certified, and/or registered individuals operating within the applicable scope of practice and within the services outlined in the care plan created by that Complementary and Integrative Health Services Center.

Acupuncturists must be licensed by the Department of Regulatory Agencies, Division of Professions and Occupations as required by the Acupuncturists Practice Act (C.R.S. 12-200-106).

Chiropractors must be licensed by the State Board of Chiropractic Examiners as required by the Chiropractors Practice Act (C.R.S. 12-215-101).

Massage Therapists must be licensed by the Department of Regulatory Agencies, Division of Professions and Occupations as required by the Massage Therapists Practice Act (C.R.S. 12-235-107).

Certificate *(specify):*

Certification as an approved Medicaid provider of Complementary and Integrative Health Services

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy & Financing

Frequency of Verification:

HCPF: At enrollment, and then every 5 years at revalidation

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Complementary and Integrative Health Services - Acupuncture

Provider Category:

Individual

Provider Type:

Acupuncturist

Provider Qualifications

License *(specify):*

Acupuncturists must be licensed by the Department of Regulatory Agencies, Division of Professions and Occupations as required by the Acupuncturists Practice Act (C.R.S. 12-200-106).

Certificate *(specify):*

Certification as an approved Medicaid provider of Complementary and Integrative Health Services

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy & Financing

Frequency of Verification:

HCPF: At enrollment, and then every 5 years at revalidation.

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:

Complementary and Integrative Health Services - Chiropractic

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11130 other therapies
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

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

Service Definition *(Scope):*

Chiropractic means the use of manual adjustments (manipulation or mobilization) of the spine or other parts of the body with the goal of correcting and/or improving alignment, neurological function, and other musculoskeletal problems. During a chiropractic treatment, nutrition, exercise, and rehabilitative therapies may be recommended in support of the adjustment.

Complementary and Integrative Health Services are limited to acupuncture, chiropractic care, and massage therapy as defined in this waiver. Services are to be delivered under the direction of a care plan approved by a Complementary and Integrative Health Service Provider.

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

The utilization of Complementary and Integrative Health Services may fluctuate according to need over the course of a year. Authorization and payment for the Complementary and Integrative Health Services are limited as follows:

Services are capped per certification period of no more than 408 total units of any combination of Complementary and Integrative Health services.

Services are limited based on the member's assessed need for services, the care plan created by the Complementary and Integrative Health Service Provider, and prior authorization by case managers.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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	Chiropractor
Agency	Complementary and Integrative Health Services Center

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Complementary and Integrative Health Services - Chiropractic

Provider Category:

Individual

Provider Type:

Chiropractor

Provider Qualifications

License *(specify):*

Chiropractors must be licensed by the State Board of Chiropractic Examiners as required by the Chiropractors Practice Act (C.R.S. 12-215-101).

Certificate *(specify):*

Certification as an approved Medicaid provider of Complementary and Integrative Health Services

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy and Financing

Frequency of Verification:

HCPF: At enrollment and then every 5 years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Complementary and Integrative Health Services - Chiropractic

Provider Category:

Agency

Provider Type:

Complementary and Integrative Health Services Center

Provider Qualifications

License *(specify):*

Services must be provided by licensed, certified, and/or registered individuals operating within the applicable scope of practice and within the services outlined in the care plan created by that Complementary and Integrative Health Services Center.

Acupuncturists must be licensed by the Department of Regulatory Agencies, Division of Professions and Occupations as required by the Acupuncturists Practice Act (C.R.S. 12-200-106).

Chiropractors must be licensed by the State Board of Chiropractic Examiners as required by the Chiropractors Practice Act (C.R.S. 12-215-101).

Massage Therapists must be licensed by the Department of Regulatory Agencies, Division of Professions and Occupations as required by the Massage Therapists Practice Act (C.R.S. 12-235-107).

Certificate *(specify):*

Certification as an approved Medicaid provider of Complementary and Integrative Health Services

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy & Financing

Frequency of Verification:

HCPF: At enrollment, and then every 5 years at revalidation

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:

Complementary and Integrative Health Services - Massage Therapy

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11130 other therapies
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

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.

Complementary and Integrative Health Services are limited to acupuncture, chiropractic care, and massage therapy as defined in this waiver. Services are to be delivered under the direction of a care plan recommended by a Complementary and Integrative Health Service Provider.

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

The utilization of Complementary and Integrative Health Services may fluctuate according to need over the course of a year. Authorization and payment for the Complementary and Integrative Health Services are limited as follows:

Services are capped per certification period of no more than 408 total units of any combination of Complementary and Integrative Health services.

Services are limited based on the member's assessed need for services, the care plan created by the Complementary and Integrative Health Service Provider, and prior authorization by case managers.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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	Complementary and Integrative Health Services Center
Individual	Massage Therapist

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Complementary and Integrative Health Services - Massage Therapy

Provider Category:

Agency

Provider Type:

Complementary and Integrative Health Services Center

Provider Qualifications

License *(specify):*

Services must be provided by licensed, certified, and/or registered individuals operating within the applicable scope of practice and within the services outlined in the care plan created by that Complementary and Integrative Health Services Center.

Acupuncturists must be licensed by the Department of Regulatory Agencies, Division of Professions and Occupations as required by the Acupuncturists Practice Act (C.R.S. 12-200-106).

Chiropractors must be licensed by the State Board of Chiropractic Examiners as required by the Chiropractors Practice Act (C.R.S. 12-215-101).

Massage Therapists must be licensed by the Department of Regulatory Agencies, Division of Professions and Occupations as required by the Massage Therapists Practice Act (C.R.S. 12-235-107).

Certificate *(specify):*

Certification as an approved Medicaid provider of Complementary and Integrative Health Services

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Health Care Policy & Financing

Frequency of Verification:

At enrollment, and then every 5 years at revalidation.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Complementary and Integrative Health Services - Massage Therapy

Provider Category:

Individual

Provider Type:

Massage Therapist

Provider Qualifications

License *(specify):*

Massage Therapists must be licensed by the Department of Regulatory Agencies, Division of Professions and Occupations as required by the Massage Therapist Practice Act (C.R.S. 12-235-107)

Certificate *(specify):*

Certification as an approved Medicaid provider of Complementary and Integrative Health Services

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health Care Policy and Financing

Frequency of Verification:

HCPF: At enrollment and then every 5 years at revalidation

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) (Ended 6/30/26)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
12 Services Supporting Self-Direction	12010 financial management services in support of self-dir
Category 2:	**Sub-Category 2:**
12 Services Supporting Self-Direction	12020 information and assistance in support of self-directio
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Services that assist an individual to accomplish Activities of Daily Living (ADLs) include health maintenance, personal care, and homemaker activities.

Health maintenance activities include routine and repetitive health-related tasks furnished to an eligible member in the community or in the member's home which are necessary for health and normal bodily functioning that a person with a disability is physically unable to carry out.

Personal Care services are furnished to an eligible member in the community or in the member's home to meet the member's physical, maintenance, and supportive needs.

Homemaker services are general household activities provided by an attendant in a member's home to maintain a healthy and safe environment for the member. Homemaker services shall be provided only in the primary living space of the member; multiple attendants may not be reimbursed for duplicating homemaker tasks. Tasks may include the provision of homemaker activities or teaching the member homemaker activities.

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

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

CDASS offered in this waiver is limited based on the member's assessed need for services and prior authorization by case managers.

In addition, spouses, guardians, and family members are limited to providing CDASS under the guidelines described in Appendix C-2, d, and e.

Coverage is distinct under CDASS due to the method of service delivery being materially different due to it being a participant-directed option unavailable under the State Plan.

Members are also unable to receive personal care services in conjunction with CDASS services. Furthermore, individual attendants must be at least 16 years of age.

CDASS services shall not duplicate any activity of daily living (ADL) or instrumental activity of daily living (IADL) need that has been identified in the person-centered support planning process that the member prefers and can be met with the Remote Supports service.

CDASS services shall not be provided or billed during the same time as Remote Supports.

The state's regulations provide guidance to Case Managers on developing effective person-centered support plans that meet the member's unique needs without duplication of services for ADLs and IADLs.

CDASS services shall not be delivered virtually or by telehealth. If it is the member's preference to have an ADL or IADL need met through live virtual support, they shall use Remote Supports services provided by a Remote Supports provider.

CDASS services are limited to additional services not otherwise covered under the state plan, but consistent with the waiver objectives of avoiding institutionalization.
Service Delivery Method (check each that applies

There is a 16 hour per day limit for caregivers across Personal Care, Homemaker, Health Maintenance Activities (HMA) for all service delivery options. This also includes Long Term Home Health (LTHH) - Registered Nurse (RN) and LTHH - Certified Nursing Assistant (CNA). There is an exception for emergency situations.

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

☐ **Participant-directed as specified in Appendix E**

☑ **Provider managed**

☐ **Remote/via Telehealth**

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	The program participant or representative is the common law employer of workers hired, trained and managed by the participant or representative.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consumer Directed Attendant Support Services (CDASS) (Ended 6/30/26)

Provider Category:

Individual

Provider Type:

The program participant or representative is the common law employer of workers hired, trained and managed by the participant or representative.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The Department contracts with Financial Management Service (FMS) Vendors to review the hiring agreements between the member and their selected CDASS attendant to ensure all forms are complete and follow employment qualifications established by the federal and state government.

At a minimum, attendants must be at least 16 years of age, trained to perform appropriate tasks to meet the member's needs, and demonstrate the ability to provide support to the member and/or the authorized representative as defined in the member'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 a person may not represent him or herself to the public as a licensed nurse, certified nurse aide, licensed practical or professional nurse, registered nurse, or 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 & Financing, Office of Community Living

Frequency of Verification:

The FMS vendor shall ensure all employment paperwork required by the federal and state government is complete and filed prior to the attendant being hired and eligible to perform services.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

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 Delivered Meals (Ended on 6/30/26)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
06 Home Delivered Meals	06010 home delivered meals
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Home Delivered Meals services offer nutritional counseling and meal planning, preparation, and delivery to support a member.

Services do not include the provision of items outside of the nutritional meals identified in the meal planning, such as additional food items or cooking appliances.

To access Home Delivered Meals, a member must participate in a needs assessment through which they demonstrate a need for the service based on the following:

- The member demonstrates a need for nutritional counseling, meal planning, and preparation;
- The member shows documented special dietary restrictions or specific nutritional needs;
- The member cannot prepare meals with the type of nutrition vital to meeting their special dietary restrictions or special nutritional needs;
- The member has limited or no outside assistance, services, or resources through which they can access meals with the type of nutrition vital to meeting their special dietary restrictions or special nutritional needs;
- The member's need demonstrates a risk to health, safety, or institutionalization; and
- The member demonstrates that, within 365 days, they have the ability to acquire skills, other services, or other resources to access meals.

To access Home Delivered Meals for individuals who are discharged from the hospital, a member must meet the following requirements:

- Has been admitted to the hospital or Emergency Department for at least 24 hours;
- Screened by a physician, registered dietician or nutrition professional, or clinical social worker to receive meals through the program.
- Demonstrates a risk to health, safety, institutionalization, or readmission to the hospital;
- Demonstrates a need for nutritional counseling, meal planning, and preparation;
- Has a documented special dietary restrictions or specific nutritional needs;
- Cannot prepare meals with the type of nutrition vital to meeting their special dietary restrictions or special nutritional needs;
- Does not reside in a provider-owned or controlled setting; and
- Has limited or no outside assistance, services, or resources through which they can access meals with the type of

nutrition vital to meeting their special dietary restrictions or special nutritional needs.

The assessed need is documented in the Service Plan as part of the member's acquisition process, which includes gradually becoming capable of preparing his/her own meals or establishing the resources to obtain needed meals.

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

Home Delivered Meal services are available over a period of 365 days following the first day the service is provided.

The unit designation for Home Delivered Meal services is per meal. Meals are limited to two meals per day or 14 meals delivered one day per week. Home Delivered Meals is not available when the person resides in a provider-owned or controlled setting.

Home Delivered Meals services post hospital discharge are available for 30 calendar days following discharge from a qualifying hospital stay up to two (2) times per service plan certification year. Meals are limited to two meals per day or 14 meals delivered one day per week.

Exceptions will be granted based on extraordinary circumstances.

Home Delivered Meal services are limited to additional services not otherwise covered under the state plan, but consistent with the waiver objectives of avoiding institutionalization.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Delivered Meals Provider
Agency	Home Delivered Meals Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meals (Ended on 6/30/26)

Provider Category:

Agency

Provider Type:

Home Delivered Meals Provider

Provider Qualifications

License *(specify):*

The provider must be a legally constituted entity or foreign entity (outside of Colorado) registered with the Colorado Secretary of State Colorado with a Certificate of Good Standing to do business in Colorado.

The provider shall have all licensures required by the State of Colorado Department of Public Health and Environment (CDPHE) for the performance of the service or support being provided, including necessary Retail Food License and Food Handling License for Staff; or be approved by Medicaid as a home delivered meals provider in their home state.

Certificate *(specify):*

The provider must meet the certification standards in §8.7526.F (10 CCR 2505-10).

The provider must have an on-staff or contracted certified Registered Dietitian (RD) or Registered Dietitian Nutritionist (RDN).

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health Care Policy & Financing

Frequency of Verification:

Initially and at submission of renewed license upon expiration of each required license. In addition, if CDPHE receives a complaint involving member care, the findings of the investigation may be grounds for CDPHE to initiate a full survey of the provider agency regardless of the date of their last survey.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meals (Ended on 6/30/26)

Provider Category:

Agency

Provider Type:

Home Delivered Meals Provider

Provider Qualifications

License *(specify):*

The provider must be a legally constituted entity or foreign entity (outside of Colorado) registered with the Colorado Secretary of State Colorado with a Certificate of Good Standing to do business in Colorado.

The provider shall have all licensures required by the State of Colorado Department of Public Health and Environment (CDPHE) for the performance of the service or support being provided, including necessary Retail Food License and Food Handling License for Staff; or be approved by Medicaid as a home delivered meals provider in their home state.

Certificate *(specify):*

The provider must meet the certification standards in §8.7526.F (10 CCR 2505-10).

The provider must have an on-staff or contracted certified Registered Dietitian (RD) or Registered Dietitian Nutritionist (RDN).

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health Care Policy & Financing

Frequency of Verification:

Initially and at submission of renewed license upon expiration of each required license. In addition, if CDPHE receives a complaint involving member care, the findings of the investigation may be grounds for CDPHE to initiate a full survey of the provider agency regardless of the date of their last survey.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home Modification

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
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 individual'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.

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, or are covered under the Durable Medical Equipment benefit within the State Plan. Adaptations that add to the total square footage of the home are excluded from this benefit. Work completed prior to approval is not eligible for reimbursement through the benefit. All services shall be provided in accordance with applicable State and local building codes.

It may be necessary to make home modifications to an individual's place of residence before they transition from an institution to the community. Utilizing funding through Money Follows the Person, such modifications may be made while the person is institutionalized, if the individual is in the process of transitioning. Home modifications, included in the individual's plan of care, may be furnished up to 180 consecutive days prior to the individual's discharge from an institution. However, such modifications will not be considered complete until the date the individual leaves the institution and is enrolled in the waiver. Home modifications made under this circumstance may not be billed to HCBS waiver authority until the date the individual leaves the institution and enters the HCBS waiver.

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

Home modifications are limited based on the member's assessed need for services. The total cost of home modification shall not exceed $14,000 over the life of the waiver except that, on a case-by-case basis, a higher amount may be approved, if there is an immediate risk of the member being institutionalized or a significant change in the member's needs since a previous home modification.

Criteria for consideration above the $14,000 to ensure member health and welfare include: 1) a change in the member's

condition and needs since the previous home modification, if applicable; 2) length of time since previous home modification, if applicable; and 3) amount requested over the cap. On occasion, the health, safety, and welfare of the member may still not be ensured by exceeding the lifetime cap. In these limited situations, the Department would evaluate the member for eligibility for other programs, supports, and services that would ensure the member's health and welfare. This could include removing the member from the waiver. The Home Modification service under this waiver is limited to additional services not otherwise covered under the State Plan, but consistent with waiver objectives of avoiding institutionalization.

Home modifications shall not be made to provider-owned housing. All medically necessary Home Modifications that are covered under the Durable Medical Equipment benefit within the State Plan shall be accessed first.

It may be necessary to make home modifications to an individual's place of residence before they transition from an institution to the community. Utilizing funding through Money Follows the Person, such modifications may be made while the person is institutionalized if the individual is in the process of transitioning. Home modifications, included in the individual's plan of care, may be furnished up to 180 consecutive days prior to the individual's discharge from an institution. However, such modifications will not be considered complete until the date the individual leaves the institution and is enrolled in the waiver. Home modifications made under this circumstance may not be billed to the HCBS waiver authority until the date the individual leaves the institution and enters the HCBS waiver.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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	Contractor Agency
Individual	Licensed Building Contractor

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. Meets Uniform Building Codes as outlined by Department 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 every five years through provider revalidation.

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. Meets Uniform Building Codes as outlined by Department 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 every five years through provider revalidation.

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) (Ended 6/30/26)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
16 Community Transition Services	16010 community transition services
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 member, or an authorized representative who is designated by the member.

Currently, IHSS agencies are required by statute and rule to provide additional assistance to IHSS members. The statutory requirements for IHSS agencies include providing information and referral services, systems advocacy, independent living skills training, cross-disability peer counseling, and 24-hour back-up staffing. IHSS regulations further stipulate that IHSS agencies must offer intake and orientation services, assistance with selecting attendants, verification of attendant skills and competency, attendant training and oversight and monitoring by a licensed health professional. As a result of these requirements, IHSS agencies are already providing that level of support to members who want to direct their own services.

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

IHSS offered in this waiver are limited based on the member's assessed need for services and prior authorization by case managers. All IHSS attendants must be employed by an agency certified by the Department to provide this service.

Family members may be reimbursed up to the limitations established in Appendix C-2-d and e of the waiver application.

There is an annual limit of 19,000 units for Health Maintenance Activities (HMA), 10,000 for Personal Care, and 4,500 for Homemaker services. The Department has a process in place that allows for case managers to request additional units of service for a member in this service if their needs exceed the unit maximum.

There is a 16 hour per day limit for caregivers across Personal Care, Homemaker, Health Maintenance Activities (HMA) for all service delivery options. This also includes Long Term Home Health (LTHH) - Registered Nurse (RN) and LTHH - Certified Nursing Assistant (CNA). There is an exception for emergency situations.

A Legally Responsible Person may not provide more than 5 hours of homemaker services to a single member, per week.

Members 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.

There is no duplication between IHSS services and case management.

Life Skills Training is not to be delivered simultaneously during the direct provision of Personal Care Services to prevent duplicate billing. This must be documented in the provider Service Plan.

IHSS services shall not duplicate any activity of daily living (ADL) or instrumental activity of daily living (IADL) need that has been identified in the person-centered support planning process that the member prefers and can be met with the Remote Supports service.

IHSS services shall not be provided or billed during the same time as Remote Supports.

The state's regulations provide guidance to Case Managers on developing effective person-centered support plans that meet the member's unique needs without duplication of services for ADLs and IADLs.

IHSS services shall not be delivered virtually or by telehealth. If it is the member preference to have an ADL or IADL need met through live virtual support, they shall use Remote Supports services provided by a Remote Supports provider.

IHSS is limited to additional services not otherwise covered under the state plan, but consistent with the waiver objectives of avoiding institutionalization.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency - Certified to provide In Home Support Services
Agency	In Home Support Services Agency
Agency	Personal Care Agency - Certified to provide In Home Support Services

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: In Home Support Services (IHSS) (Ended 6/30/26)

Provider Category:

Agency

Provider Type:

Home Health Agency - Certified to provide In Home Support Services

Provider Qualifications

License *(specify):*

Class A or B

Certificate *(specify):*

Certification as a Medicaid provider of In Home Support Services. 10 C.C.R. 2505-10, Sections 8.7403 and 8.7528.G.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Environment (CDPHE), Health Facilities and Emergency Section Division

Frequency of Verification:

Providers are surveyed at a minimum every 36.9 months. Risk-based surveys may occur more often if a credible complaint

is received by CDPHE. Credible complaints are ones that are validated; when investigated they have not been found to be fabricated allegations misinterpreted impressions of something that did not occur. During the investigation of a complaint by CDPHE, findings are severe - i.e. a systemic failure, patient harm, etc. it may cause an investigation to be converted to a full survey at the time the investigation is underway. The findings of the investigation may be grounds for CDPHE to initiate a full recertification 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) (Ended 6/30/26)

Provider Category:

Agency

Provider Type:

In Home Support Services Agency

Provider Qualifications

License *(specify):*

Class A or B

Certificate *(specify):*

Certification as a Medicaid provider of In Home Support Services. 10 C.C.R. 2505-10, Section 8.7403 and 8.7528.G.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Environment (CDPHE), Health Facilities and Emergency Section Division

Frequency of Verification:

Providers are surveyed at a minimum every 36.9 months. Risk-based surveys may occur more often if a credible complaint is received by CDPHE. Credible complaints are ones that are validated; when investigated they have not been found to be fabricated allegations misinterpreted impressions of something that did not occur. During the investigation of a complaint by CDPHE, findings are severe - i.e. a systemic failure, patient harm, etc. it may cause an investigation to be converted to a full survey at the time the investigation is underway. The findings of the investigation may be grounds for CDPHE to initiate a full recertification 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) (Ended 6/30/26)

Provider Category:

Agency

Provider Type:

Personal Care Agency - Certified to provide In Home Support Services

Provider Qualifications

License *(specify):*

Class A or B

Certificate *(specify):*

Certification as a Medicaid provider of In Home Support Services. 10 C.C.R. 2505-10, Sections 8.7403 and 8.7528.G.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Environment, Health (CDPHE) Facilities and Emergency Section Division

Frequency of Verification:

Providers are surveyed at a minimum every 36.9 months. Risk-based surveys may occur more often if a credible complaint is received by CDPHE. Credible complaints are ones that are validated; when investigated they have not been found to be fabricated allegations misinterpreted impressions of something that did not occur. During the investigation of a complaint by CDPHE, findings are severe - i.e. a systemic failure, patient harm, etc. it may cause an investigation to be converted to a full survey at the time the investigation is underway. The findings of the investigation may be grounds for CDPHE to initiate a full recertification 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:

Life Skills Training

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08010 home-based habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Life Skills Training (LST) supports the member through skills training designed and directed with the member to develop and maintain their ability to sustain themselves physically, emotionally, socially and economically in the community. Skills training includes assessing, training, supervising, or assisting the member with self-care and the activities of daily living,

medication reminders and supervision, time management skill-building, safety awareness skill development and training, task completion, communication skill-building, interpersonal skill development, socialization training, community mobility training, identifying and accessing mental and behavioral health services, reduction or elimination of maladaptive behaviors, understanding and following plans for occupational or sensory skill development, problem-solving, benefits coordination, resource coordination, financial management, and household management.

LST also includes working with the member and the member's providers to achieve an integrated Service Plan that will reinforce skills training during and beyond the provision of LST. LST shall be delivered according to the Service Plan.

To access LST, a member must participate in a needs assessment through which they demonstrate a need for the service based on the following:

- The member demonstrates a need for training designed and directed with the member to develop and maintain their ability to sustain themselves physically, emotionally, socially and economically in the community;
- The need demonstrates the risk to health, safety, or institutionalization; and
- The member demonstrates that with the training they have the ability to acquire these skills or services necessary within 365 days.

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

Members may utilize LST up to 24 units (six hours) a day over a period of 365 days following the first day the service is provided. LST shall be delivered no more than 40 hours per week.

Exceptions will be granted based on extraordinary circumstances.

Life Skills Training is not to be delivered simultaneously during the direct provision of Personal Care Services to prevent duplicate billing. This must be documented in the provider Service Plan.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☑ **Remote/via Telehealth**

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	Life Skills Training Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Life Skills Training

Provider Category:

Agency

Provider Type:

Life Skills Training Provider

Provider Qualifications

License *(specify):*

A Provider Agency must maintain a Class A or B Home Care Agency License issued by the Colorado Department of Public

Health and Environment (CDPHE) if that Agency chooses to provide training on Personal Care as defined in 10 C.C.R. 2505-10, Section 8.7538.

Certificate *(specify):*

Certified as a Medicaid provider of Life Skills Training: 10 C.C.R. 2505-10, Section 8.7530.G.

Other Standard *(specify):*

Providers for the Telehealth service delivery option must demonstrate policies and procedures that include:

•HIPAA compliant platforms;

•Member support given when member needs include: accessibility, translation, or limited auditory or visual capacities are present;

•Have a contingency plan for provision of services if technology fails;

•Professionals do not practice outside of their respective scope; and

•Assessment of members and caregivers that identifies a member's ability to participate in and outlines any accommodations needed while utilizing Telehealth.

For the Telehealth service delivery option, Case Management Agencies (CMA)s will be required to:

•Provide prior authorization for all services to be rendered using Telehealth; and

Indicate member choice to use telehealth and indicate in service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health and Environment.

Frequency of Verification:

Initially and every three years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

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:

Medication Reminder (Ended 6/30/26)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14031 equipment and technology
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 member to take prescribed 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's illness, impairment, or disability as documented in the member's Person Centered Support 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 member. Medication Reminder shall be authorized only if they are in accordance with currently accepted standards of medical practice in the treatment of the member'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**
- ☐ **Remote/via Telehealth**

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: Medication Reminder (Ended 6/30/26)

Provider Category:

Agency

Provider Type:

Specialized Medical Equipment and Supplies Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certification as a Medicaid provider of Electronic Monitoring Services at 10 C.C.R. 2505-10, Section 8.7520.E.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health Care Policy & Financing

Frequency of Verification:

The Department currently reviews the provider qualifications at the time of initial application and every 5 years at revalidation.

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:
15 Non-Medical Transportation	15010 non-medical transportation
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 individual's service plan. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge will be utilized.

Members may utilize public conveyance, to include the purchase of single use, weekly and monthly transit passes, when equivalent to or more cost effective than the applicable mileage band rate.
Members may use Non-Medical Transportation service to access Adult Day Health.

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

Excluding transportation to Adult Day facilities, a member may not receive more than the equivalent of four one-way trip services per week or 104 round trips (two one-way trips) per certification period unless otherwise authorized by the

Department. Non-medical transportation services offered in this waiver are limited based on the member's assessed need for services, physician's orders, and prior authorization by case managers up to the cost containment parameters. Members may utilize a combination of NMT services up to the Department's prescribed limit.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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 8.7535.E: All drivers shall possess a valid Colorado driver's 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):*

The contracted Administrative Services Organization (ASO) must be engaged in a provider agreement with the Department and comply with all regulations in C.R.S 10 C.C.R. 2505-10, Sections 8.7535 and 8.7535.E.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health Care Policy & 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:

Peer Mentorship

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08010 home-based habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Peer Mentorship is provided by a peer who draws from common experience to support a member with acclimating to community living. The peer supports a member with advice, guidance, and encouragement on matters of community living including through describing real-world experiences, encouraging the member's self-advocacy and independent living goals, and modeling strategies, skills, and problem-solving.

Peer Mentorship does not include services or activities that are solely diversional or recreational in nature.

To access Peer Mentorship, a member must participate in a needs assessment through which they demonstrate a need for the service based on the following:

- The member demonstrates a need for a peer to mentor the member in acclimating to community living;
- The member's need demonstrates health, safety, or institutional risk;
- There are no other services or resources available to meet the need; and
- The member demonstrates that, within 365 days, they have the ability to acquire these skills or establish other services or resources necessary to their need.

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

Members may utilize Peer Mentorship services over a period of 365 days following the first day the service is provided.

Peer Mentorship is billed in 15-minute units. Members may utilize Peer Mentorship up to 24 units (six hours) a day, and up to 365 days upon initial service provision.

Exceptions will be granted based on extraordinary circumstances.

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

☐ **Participant-directed as specified in Appendix E**

☑ **Provider managed**

☑ **Remote/via Telehealth**

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	Peer Mentorship Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Peer Mentorship

Provider Category:

Agency

Provider Type:

Peer Mentorship Provider

Provider Qualifications

License *(specify):*

The provider agency must be licensed under a governing body that is legally responsible for overseeing the management and operation of all programs conducted by the licensee including ensuring that each aspect of the agency's programs operates in compliance with all applicable local, state, and federal requirements, laws, and regulations.

Certificate *(specify):*

The provider agency must be a legally constituted entity or foreign entity (outside of Colorado) registered with the Colorado Secretary of State Colorado with a Certificate of Good Standing to do business in Colorado.

The provider must meet the standards for a Certified Medicaid provider under 10 C.C.R. 2505-10 Section 8.7535.F.

Other Standard *(specify):*

The provider must ensure services are delivered by a peer mentor staff who:

•Has lived experience transferable to support a member in acclimating to community living through providing the member advice, guidance, and encouragement on matters of community living, including through describing real-world experiences, encouraging the member's self-advocacy and independent living goals, and modeling strategies, skills, and problem-solving;

• Is qualified in the customized needs of the member as described in the Service Plan.

• Has completed the provider agency's peer mentor training, which is to be consistent with core competencies as defined by the Department.

Providers for the Telehealth service delivery option must demonstrate policies and procedures that include:

• HIPAA compliant platform

• Member support given when member needs include: accessibility, translation, or limited auditory or visual capacities are present;

• Have a contingency plan for provision of services if technology fails;

•Professionals do not practice outside of their respective scope; and

• Assessment of members and caregivers that identifies a member's ability to participate in and outlines any

accommodations needed while utilizing Telehealth.

For the Telehealth service delivery option, Case Management Agencies (CMA)s will be required to:

- Provide prior authorization for all services to be rendered using Telehealth; and

Indicate member choice to use telehealth and indicate in service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Colorado Department of Health Care Policy & Financing

Frequency of Verification:

The Department currently reviews the Provider Agency qualifications at the time of initial application and every five years through provider re-validation.

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) (Ended 6/30/26)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)
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 member may also wear a portable help button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once the help button is activated. The 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 members 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.

PERS services are limited to additional services not otherwise covered under the state plan, but consistent with the waiver objectives of avoiding institutionalization.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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) (Ended 6/30/26)

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 8.7520.E.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health Care Policy & Financing

Frequency of Verification:

The Department currently reviews the provider qualifications at the time of initial application and every 5 years at revalidation.

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:

Remote Support (Ended 6/30/2026)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Remote Support includes live two-way support from a HIPAA compliant location different than the member's home that increases the HCBS member's independence and integration into the community. Remote Support is available to the member if needs are identified through the person-centered planning process that can be met through remote coaching, prompts, supervision, or consultation rather than with in-person assistance.

The goal of Remote Support is to increase autonomy by providing the member an opportunity to build life skills through independent learning via cueing, coaching, and on-call support. The member engages with their remote support in the setting they choose. This support not only allows the member to be more independent and have increased autonomy, but directly supports community integration, rather than institutionalization, since the member receives their needed supports in their chosen community and in a person-centered way.

This service includes purchasing and maintaining technology equipment and training the member on using the equipment. The member must be able to initiate the service when needed and turn off the equipment when no longer needed.

Remote Support does not replace informal or formal support but reduces the need for in-person assistance at the member's discretion. Only the member may initiate live two-way interactions unless otherwise documented in the member's person-centered support plan. Video may only be used during live two-way support communications when the member chooses.

Remote Supports does not include passive monitoring of HCBS members or supports. Video and audio recording is not permitted. Providers are only reimbursed for active monitoring and virtual support provided, whichever the member prefers and is indicated in their person-centered support plan. Sensors and Remote Technology can be used by the member to help with this virtual assistance and will be billed in a different line item within the Remote Supports benefit.

Member Consent and Privacy:

Members will acknowledge the risks of using technology in any setting. When remote support is added to a member's home where there is family living (and not providing informal support), every member of the household must consent to the use of the Remote Support Technology devices during the person-centered planning process. The member can choose an area within the home to video call or video chat their Remote Support provider for privacy.

The member's interaction with support staff may be scheduled, on-demand, or in response to an alert from a device in the technology integrated system. The type of technology and where it is placed will depend upon the needs and preferences of the member. When a member elects to receive remote support, the person-centered support plan will reflect how many hours/days per week a member will receive this support.

Video and audio devices may not be mounted in a bathroom or bedroom. The Department will not allow the use of video or audio monitoring technology without a documented need identified in the member's Person-Centered Support Plan prior to use and consented to by every member of the household during the person-centered planning process.

Additionally, Remote Support Providers will have written policies and procedures regarding the safeguarding of member privacy.

Remote Support Plan and Backup Support Person(s):

Department policy requires the Remote Support Provider to provide documentation in the form of a Remote Support Plan that details when and where the Remote Support provider will be expected to provide support, what the support is for (coaching for Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs), reminders, check ins, etc), what Remote Support Technology will be used, and a list of backup persons or agency to contact in the case of emergency or when in-person support is needed for a specific task.

Department policy will direct case managers to ensure a completed remote support plan with a list of backup support is in place in the member's person-centered support plan before authorizing services.

The Remote Supports Plan with the back up support list must be kept by the provider and be up to date.

Remote Support Technology

Remote Support Technology means any item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used for Remote Supports and maintained by an enrolled Remote Supports Provider to increase, maintain, or improve functional capabilities of members. Remote Support Technology does not include the cost of cell phones, internet access, landline telephone lines, cellular phone voice, and/or data plans necessary for the provision of services.

Remote Support Technology will enhance/increase the member's independence by providing real-time support with tasks that do not require hands-on assistance and that would otherwise require an in-home visit by a provider.

Remote Support Technology will help members increase opportunities to fully integrate into the community and participate in community activities by allowing members to connect with Remote Support providers and their community at times when inclement weather or a health condition would confine them to their homes.

The provision of all necessary equipment to deliver Remote Supports is the responsibility of the Remote Supports provider and the cost for this equipment is built into a separate line-item dollar for dollar rate within the Remote Supports service. The Remote Supports provider will be responsible for the installation, maintenance, and removal of all Remote Support Technology. Need for Remote Support technology is based on the person-centered planning process.

The Remote Support methodology is accepted by the state's HIPAA Compliance Officer.

The Remote Support Provider will have a backup power system (such as battery power and/or generator) in place at the monitoring base in the event of electrical power outages.

Case managers will also be responsible for ensuring equipment is functioning and that the member has the training and ability to use the equipment during regular monitoring visits.

Assurances:

The well-developed person-centered support plan will document the member's specific health and welfare needs and how each support selected by the member contributes to meeting their needs and ensures no duplication of services or supports.

Policy requires providers to work collaboratively with the member, and case manager at a minimum, for selecting Remote Supports and identifying goals and desired outcomes in the member's Person-Centered Support Plan. The Department's

regulations provide guidance to Case Managers on developing effective person-centered support plans that meet members' unique needs without duplication of services for ADLs and IADLs.

Remote Supports shall not duplicate or be reimbursed for any service authorized for delivery via telehealth at 10 C.C.R. 2505-10 Section 8.7562.

Each provider of Remote Supports must demonstrate policies and procedures that include the use of a HIPAA compliant platform. Each provider will sign an attestation that they are using a HIPAA compliant platform for the technology/devices used. The provider requirements and assurances regarding HIPAA have been approved by the state's HIPAA Compliance Officer.

The privacy rights of a member will be assured by the Remote Supports provider and Case Manager. The member has full control of any device. The Remote Supports provider will ensure that the member can turn off devices and technology being used and end services any time they choose. All individuals in the household of the member receiving Remote Supports shall give their consent for Remote Supports during the person-centered support planning process.

Policy requires providers to maintain emergency contact protocols in the event the member requests in-person assistance.

Policy requires the provider to maintain contact with the member until the responsible backup person arrives or in the event of an emergency until emergency services personnel arrive.

Members must have an informed choice between Remote Supports and other in-person services.

Remote Support service must be used in conjunction with Remote Support Technology for an integrated support approach.

The member's Home and Community-Based Services may not be delivered remotely 100% of the time. There will always be an option for in-person services available.

The use of the remote supports option will not block, prohibit or discourage the use of in-person services or access to the community.

If it is determined that hands-on assistance is required, remote support may not be provided. This process will be outlined in each provider's policies and procedures.

Remote support technology will not be used for the provider's convenience. The option must be used to support a member to reach identified outcomes in the member's Person-Centered Support Plan.

Members will be fully trained initially and ongoing, if needed, by the Remote Support Provider on the use of equipment and remote support service, including how to turn it on/off.

Members will maintain the right to revoke consent and discontinue the use of Remote Supports at any time.

The case manager is required to work with the member and their family/guardian to ensure member choice and appropriateness in selecting any home and community-based service, including Remote Support. These discussions and decisions will be documented by the case manager in the Person-Centered Support Plan.

Case managers will be responsible for ensuring the health and safety of members utilizing remote support during regular monitoring visits.

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

Remote Support is limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Remote Support must replace an identified need for in-person support and not be duplicative of any other waiver service, including Personal Care, Homemaker, IHSS, or CDASS.

Life Skills Training is not to be delivered simultaneously during the direct provision of Personal Care Services to prevent duplicate billing. This must be documented in the provider Service Plan.

Remote Supports services shall not be provided or billed at the same time as any other HCBS or State Plan service,

including services authorized for delivery via telehealth at 10 C.C.R Section 8.7562.

Remote Supports must never be used to restrict a person from their home, community, or body autonomy.

Remote Support Technology must be provided in conjunction with Remote Support service.

Remote Support is provider managed and must be provided by a Remote Support enrolled Medicaid Provider.

Remote Supports service may NOT be provided by:
• Legally Responsible Person
• Relative
• Legal Guardian

Remote Support services are limited to additional services not otherwise covered under the state plan, but consistent with the waiver objectives of avoiding institutionalization.

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

☐ **Participant-directed as specified in Appendix E**
☑ **Provider managed**
☑ **Remote/via Telehealth**

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	Remote Supports Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Remote Support (Ended 6/30/2026)

Provider Category:
Agency
Provider Type:
Remote Supports Provider
Provider Qualifications
License *(specify):*

Certificate *(specify):*
The provider must meet the standards for a Certified Remote Supports Medicaid provider under 10 C.C.R. 2505-10 Section 8.7544.E and must receive the Department Remote Support Provider Training Completion Certificate.
Other Standard *(specify):*
• Must be at least 18 years of age

• Have the ability to communicate effectively, complete required forms and reports, and follow verbal and written instructions

• Have the ability to provide services in accordance with a Service Plan

• Have competed minimum training based on State training guidelines

• Have necessary ability to perform the required job tasks

• Have the interpersonal skills needed to effectively interact with members receiving waiver services

Verification of Provider Qualifications

Entity Responsible for Verification:

Colorado Department of Health Care Policy & Financing

Frequency of Verification:

The Department currently reviews the provider qualifications at the time of initial application and every 5 years at recertification.

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:

Transition Setup (Ended 6/30/2026)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
16 Community Transition Services	16010 community transition services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Transition Setup includes coordination and purchase of one-time, non-recurring expenses necessary for a member to establish a basic household upon transitioning from an institutional setting to a community living arrangement.

Allowable setup expenses include:

1. Security deposits that are required to obtain a lease on an apartment or home.
2. Setup fees or deposits to access basic utilities or services (telephone, electricity, heat, and water).
3. Services necessary for the individual's health and safety such as pest eradication or one-time cleaning prior to occupancy.
4. Essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, or bed or bath linens.
5. Expenses incurred directly from the moving, transport, provision, or assembly of household furnishings to the residence.
6. Fees associated with obtaining legal and/or identification documents necessary for a housing application such as a birth certificate, state-issued ID, or criminal background check.

Setup expenses do not include rental or mortgage expenses, ongoing food costs, regular utility charges, or items that are intended for purely diversional, recreational, or entertainment purposes. Setup expenses do not include the furnishing of living arrangements that are owned or leased by a waiver provider where the provision of these items and services are inherent to the service they are already providing. Setup expenses do not include payment for room and board.

To access Transition Setup, a member must be transitioning from an institutional to a community living arrangement and participate in a needs assessment through which they demonstrate a need for the service based on the following:

- The member demonstrates a need for the coordination and purchase of one-time, non-recurring expenses necessary for a member to establish a basic household in the community;
- The need demonstrates health, safety, or institutional risk; and
- Other services/resources to meet the need are not available.

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

Transition Setup coordination is billed in 15-minute unit increments. The coordination must not exceed 40 units per eligible member. Transition Setup is not available when the person resides in a provider-owned or controlled setting.

Transition Setup expenses must not exceed a total of $2,000 per eligible member unless otherwise authorized by the Department. The Department may authorize additional funds above the $2,000 unit limit, not to exceed a total value of $2,500, when it is demonstrated as a necessary expense to ensure the health, safety, and welfare of the member.

Transition Setup services are limited to additional services not otherwise covered under the state plan, but consistent with the waiver objectives of avoiding institutionalization.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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	Transition Setup Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transition Setup (Ended 6/30/2026)

Provider Category:

Agency

Provider Type:

Transition Setup Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

The provider must be a legally constituted entity or foreign entity (outside of Colorado) registered with the Colorado Secretary of State with a Certificate of Good Standing to do business in Colorado.

The provider must meet the standards for a Certified Medicaid provider under 10 C.C.R. 2505-10 Section 8.7552.F.

Other Standard *(specify):*

The product or service to be delivered shall meet all applicable manufacturer specifications, state and local building codes, and Uniform Federal Accessibility Standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

Colorado Department of Health Care Policy & Financing

Frequency of Verification:

The Department currently reviews the Provider Agency qualifications at the time of initial application and every five years through provider re-validation.

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:

Wellness Education Benefit

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

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

Service Definition *(Scope):*

Wellness Education Benefit (WEB) is individualized educational materials designed to reduce the need for a higher level of care by offering educational materials that provide Members and their families with actionable tools that can be used to prevent the progression of a disability, increase community engagement, combat isolation, and improve awareness of Medicaid services. The Wellness Education Benefit helps Members and their unpaid caregivers to obtain, process, and understand information that assists with managing health-related issues, promoting community living, and achieving goals identified in their Person-Centered Support Plan. For example, the Wellness Education Benefit can provide the information needed to:

- Navigate the Medicaid/medical system to achieve better health outcomes.
- Successfully manage chronic conditions in order to decrease risk of nursing facility placement.
- Effectively communicating health and wellness goals.
- Effectively communicate with medical and social service professionals.
- Provide unpaid caregivers with relevant information regarding best practices around support and care of the Member.
- Achieve community living goals identified in the Person-Centered Support Plan by providing simple, actionable suggestions to help support the health and welfare of waiver Members; including local community resources.
- Prevent and avoid health risks such as pneumonia, influenza, infections, and other illnesses or conditions that can lead to nursing facility placement for medically unstable individuals and older adults;
- Develop support networks that can promote engagement and combat isolation that can lead to increased health and safety risks that can result in institutional placement.

Materials are furnished in the format and/or language preferred by the participant and may be delivered through monthly printed mailings via United States Postal Service. The WEB will be delivered in multiple languages and formats at the request of the beneficiary and their support team, to ensure all Members can access these materials. For Members who cannot read standard print and would benefit from an alternative format, educational materials will be sent to Members in the requested accessible format, which may include larger print or braille. Wellness Education Benefit services include varied topics such as engaging in community activities, nutrition, adaptive exercise, balance training and fall prevention, money management, and developing social networks.

The Wellness Education Benefit (WEB) ensures a continuum of care for Members by expanding upon information from Providers and Case Managers, along with the inclusion of additional information that a Provider and/or Case Manager may not have provided during a visit. The WEB does not duplicate services found in EPSDT. The WEB provides actionable, day-to-day tools that differ by the individual's Person-Centered Support Plan to prevent the need for additional medical care. Additionally, the WEB will provide educational information that supports Members and their families in identifying local community resources that will promote community engagement, develop networks of support, and combat isolation.

The Wellness Education Benefit Provider Agency will conduct Member outreach to gather information on how the service has helped Members thrive in the community and meet the health and wellness goals that are identified in their Person-Centered Support Plan. The Case Manager will work with the Member to update their Person-Centered Support Plan with goals that will be utilized to target specific Wellness Education Benefit materials. The Case Manager will work with the Provider Agency to ensure the educational materials are being targeted to meet any new needs the Member may have. The Provider Agency will also utilize monthly data on the Member's Person-Centered Support Plan and updated health conditions to guide the subject matter of the educational materials. Finally, the WEB materials will include Department contact information for Members to ask questions or provide feedback.

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

The Wellness Education Benefit will be delivered once every month equaling 12 units that will initially be included on the PAR. The Case Manager may authorize up to 12 additional units per service plan year for the following:

- A member has requested reasonable accommodation for an alternative format, such as braille.
- A member requests that their representative receives a copy of the benefit to help them better utilize information provided in the benefit. Department approval required.

The Annual total units that may be authorized shall not exceed 24 units per plan year.

The services under the HCBS waivers are limited to additional services not otherwise covered under the state plan, including

EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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	Wellness Education Benefit Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Wellness Education Benefit

Provider Category:

Agency

Provider Type:

Wellness Education Benefit Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Medicaid provider of benefit - 10 CCR 25.5 § 8.7400 et seq

Other Standard *(specify):*

The Provider Agency, WEB provider, furnishing services to waiver members shall abide by all general certification standards, conditions, and processes established for the member's respective waiver: Complementary and Integrative Health Services (CIH)

The Provider Agency is selected by the Department in accordance with Colorado Procurement rules and regulations, is a registered provider with the state of Colorado to deliver these benefits, including the Departments HIPAA Business Agreement (BA), and meets all other provider qualifications found in the section. Complies with requirements outlined in 10 CCR 25.5 § 8.7400 et seq.

The WEB provider must also have the ability and resources to:
- Receive and manage member data in compliance with all applicable HIPAA regulations and ensure member confidentiality and privacy.
- Translate materials, as directed by the Department.
- Ability to target materials into the member's Person-Centered Support Plan.

The Department contracts with a single Provider Agency under the service approved through the concurrent 1915(b)(4) Colorado HCBS Wellness Education Benefit.

Verification of Provider Qualifications

Entity Responsible for Verification:

Colorado Department of Health Care Policy & Financing

Frequency of Verification:

The Department currently reviews the Provider Agency qualifications at the time of initial application and every five years through provider re-validation.

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 section 1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☑ **As a Medicaid state plan service under section 1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☑ **As an administrative activity.** *Complete item C-1-c.*
- ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 1945 and/or section 1945A of the Act (Health Homes Comprehensive Care Management).** *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 and the requirements for their training on the HCBS settings regulation and person-centered planning requirements:

The Department contracts through competitive procurement with Case Management Agencies serving 20 defined service areas throughout Colorado to perform Home and Community-Based Services waiver operational and administrative services, case management, utilization review, and prior authorization of waiver services.

TCM includes the following case management functions: service planning meetings, dissemination of service plan, LTHH PAR review, person-centered support planning, internal case consultation, case administration, PAR development, monitoring of long-term service delivery, coordination of care, intake screening, and referral.

Administrative contractual activities include Level of Care Screen, Needs Assessments, Human Rights Committee, Critical Incidents, appeals, developmental disability and delay determinations, and specific contract deliverables.

The Department provides Case Management Agencies training on the Home & Community Based Services Settings Final Rule and Person-Centered Support Planning processes. The mandatory curriculum for case managers on the Colorado Learns Learning Management System (LMS) includes two modules on the HCBS Settings Final Rule. The training covers the rule, the rights protected by the rule, the rights modification process, and the case manager's role in this process.

d. Remote/Telehealth Delivery of Waiver Services. Specify whether each waiver service that is specified in Appendix C-1/C-3 can be delivered remotely/via telehealth.

Service
Adult Day Health
Life Skills Training
Peer Mentorship
Remote Support (Ended 6/30/2026)

1. Will any in-person visits be required?

- (●) **Yes.**
- ( ) **No.**

2. *By checking each box below, the state assures that it will address the following when delivering the service remotely/via telehealth.*

☑ **The remote service will be delivered in a way that respects privacy of the individual especially in instances of toileting, dressing, etc. *Explain:***

Telehealth use is by the choice of the member and policy requires assessment for use through the support planning process by the CMA. Policy requires the provider to maintain member consent and assessment for telehealth use. The telehealth delivery option must meet the following requirements:

• Each provider of the telehealth service delivery option must demonstrate policies and procedures that include having a HIPAA-compliant platform. HIPAA compliance will be reviewed regularly through the Colorado Department of Public Health and Environment (CDPHE) monitoring process or by the state's HIPAA Compliance Officer.
• Each provider will sign an attestation that they are using a HIPAA-compliant platform for the Telehealth service component.
• The privacy rights of individuals will be assured. Each member will utilize their own equipment or equipment provided by the provider during the provision of telehealth services. The member has full control of the device. The member can turn off the device and end services at any time they wish.
• Members must have an informed choice between in-person and telehealth services.
• Video cameras/monitors are not permitted in bathrooms. Video cameras/monitors may be permitted in bedrooms for members who are bedridden or if they are determined to be necessary on an individual basis and justified in the person-centered service plan.
• Providers must create a published schedule of virtual services members can select from.

☑ **How the telehealth service delivery will facilitate community integration. *Explain:***

The purpose of the telehealth option in services is to maintain and/or improve a member's ability to support relationships while also encouraging and promoting their ability to participate in the community. The member's services may not be delivered virtually 100% of the time. The service providers must maintain a physical location where in-person services are offered. There will always be an option for in-person services available.

The use of the telehealth option will not block, prohibit or discourage the use of in-person services or access to the community. Telehealth is available as an option for members who may not be inclined to participate in person but may still want to participate in services and engage with their community and their friends, when they choose or when they would otherwise be unable to do so due to illness, transportation issues, pandemics, or other personal reasons.

☑ **How the telehealth will ensure the successful delivery of services for individuals who need hands on assistance/physical assistance, including whether the service can be rendered without someone who is physically present or is separated from the individual. *Explain:***

Members who require hands-on assistance during the provision of the service must receive services in person. In order to ensure the health and safety of members, case managers and providers must assess the appropriateness of virtual services with members. If it is determined that hands-on assistance is required, virtual services may not be provided. This process will be outlined in each provider's policies and procedures.

Telehealth will not be used for the provider's convenience. The option must be used to support a member to reach identified outcomes in the member's Person-Centered Plan.

☑ **How the state will support individuals who need assistance with using the technology required for telehealth delivery of the service.** ***Explain:***

Members who need assistance utilizing remote delivery of the service will be provided training initially by the providers and ongoing if needed on how to use the equipment, including how to turn it on/off.

Reimbursement for telehealth services is limited to enrolled Colorado Medicaid providers and excludes the purchasing or installation of telehealth equipment or technologies unless otherwise specifically authorized in the service definition for services such as Workplace Assistance.

Providers for the telehealth service delivery option must demonstrate policies and procedures that include:

• Member support given when member needs include: accessibility, translation, or limited auditory or visual capacities are present
• Have a contingency plan for provision of services if technology fails

☑ **How the telehealth will ensure the health and safety of an individual.** ***Explain:***

The state remains responsible for the assurance of the health and welfare of the waiver member. Oversight is performed directly by the case management agency via telehealth options and by the host state in which services are received.

Providers for the telehealth service delivery option must demonstrate policies and procedures that include:
• HIPAA compliant platforms;
• Member support given when member needs include: accessibility, translation, or limited auditory or visual capacities are present;
• Have a contingency plan for provision of services if technology fails;
• Professionals do not practice outside of their respective scope; and
• Assessment of members and caregivers that identifies a member's ability to participate in and outlines any accommodations needed while using Telehealth.

For the telehealth service delivery option, Case Management Agencies (CMA) will be required to:
• Provide prior authorization for all services to be rendered using telehealth; and
• Indicate member choice to use telehealth and indicate in the person-centered service plan (PCSP).

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 Colorado Department of Public Health and Environment (CDPHE). 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 the 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-CIH members 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 (CNA) also require CBI criminal history checks upon admission to the education program.

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 60 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 Professions, and Occupations. The license requires acupuncturists to report to the Professions and Occupations Director any of the following events 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; and 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 licensed by the Department of Regulatory Agencies, Division of Professions and Occupations. The license requires a CBI criminal history record check and that massage therapists report to the Division of Professions and Occupations 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; and 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.

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-CIH waiver service providers, though many providers complete the checks on staff voluntarily.

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; (c) the process for ensuring that mandatory screenings have been conducted; and (d) the process for ensuring continuity of care for a waiver participant whose service provider was added to the abuse registry. 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):

Statute 26-3.1-111(6)(a)(I) and State regulation, 12 CCR 2518-1 30.960 states that employees providing direct care to at-risk adults must submit to a Colorado Adult Protective Services (CAPS) check. The Colorado Department of Human Services is the operating agency ensuring screening takes place and processing the CAPS checks. Employers are required to complete a Colorado Adult Protective Services (CAPS) check prior to hiring a new employee who will provide direct care to an at-risk adult. Employers must register prior to requesting a CAPS check to allow for verification of the employer's legal authority to request the check. The Employer then obtains written authorization and any required identifying information from the new employee prior to requesting the CAPS check and submits the request using an online or hard copy to the Department of Human Services (DHS). DHS completes the CAPS check and will respond to the request as soon as possible, but no later than five business days from the receipt of the request. The CAPS check will include: Whether or not there is a substantiated finding for the new employee, the purpose for which the information in CAPS may be made available, consequences for improper release of information in CAPS. For CAPS checks in which there is a substantiated finding, the CAPS check results will include the date(s) of the report, county department(s) that completed the investigation(s), and the type(s) of severity level(s) of the mistreatment. If a members' direct care provider is added to the abuse registry, the member would work with the provider agency to find a new direct care provider to ensure continuity of care.

Out-of-state providers must meet comparable requirements for abuse registry screening in their state.

Appendix C: Participant Services

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

Note: Required information from this page is contained in response to C-5.

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 or regulations to care for another person (e.g., the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child). At the option of the state and under extraordinary circumstances specified by the state, payment may be made to a legally responsible individual for the provision of personal care or similar services. *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 types of legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) the method for determining that the amount of personal care or similar services provided by a legally responsible individual is ***"extraordinary care"***, exceeding the ordinary care that would be provided to a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization; (c) the state policies to determine that the provision of services by a legally responsible individual is in the best interest of the participant; (d) the state processes to ensure that legally responsible individuals who have decision-making authority over the selection of waiver service providers use substituted judgement on behalf of the individual; (e) any limitations on the circumstances under which payment will be authorized or the amount of personal care or similar services for which payment may be made; (f) any additional safeguards the state implements when legally responsible individuals provide personal care or similar services; and, (g) the procedures that are used to implement required state oversight, such as ensuring that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

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

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

Specify the types of relatives/legal guardians to whom payment may be made, the services for which payment may be made, the specific circumstances under which payment is made, and the method of determining that such circumstances apply. Also specify any limitations on the amount of services that may be furnished by a relative or legal guardian, and any additional safeguards the state implements when relatives/legal guardians provide waiver services. Specify the state policies to determine that that the provision of services by a relative/legal guardian is in the best interests of the individual. When the relative/legal guardian has decision-making authority over the selection of providers of waiver services, specify the state's process for ensuring that the relative/legal guardian uses substituted judgement on behalf of the individual. Specify the procedures that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

Payment may be made to relatives who are not legal guardians when the relative is qualified to provide the following service: Respite services. For this section, a relative is defined as all persons related to the participant but does not have a legal obligation to care for the participant defined as a spouse by marriage or common law marriage.

In the authorization of services, the case manager works directly with the member to identify needs. If the Member has identified a relative to provide the necessary services, the Case Manager can provide a referral to provider agencies. The member is offered a choice of providers. Services are then referred to the Member's agency of choice, at which point the agency works to interview, hire, and train the identified individuals. The agency and case manager conduct quarterly contacts to ensure member satisfaction with services and adherence to the care plan. Allowing a Member to receive services from a relative provides an opportunity for the Member to receive consistent services from a caregiver who is uniquely familiar with the Member's needs.

When using substituted judgment, the legally responsible individual must actively try to understand the individual's desires and preferences, even if they are not explicitly stated, to make decisions that align with their best interests and avoid making decisions based on their own personal biases or convenience.

The waiver services identified in the PCSP are submitted for approval using a Prior Authorization Request (PAR.) When the PAR is approved those services are uploaded into the Medicaid Management Information System (MMIS). Only those approved services may be reimbursed.

For all services, the Department contracts with a vendor to conduct a post-payment review of claims to ensure that all services delivered receive payment.

A Member shall be authorized for no more than 30 days of respite care in each certification period.
The Department may approve a higher amount based on a documented increase in medical or behavioral needs as reflected in the behavior plan for behavioral needs or in the medical records for medical needs.
Respite cannot be provided concurrently with Alternative Care Facility Services, Consumer Directed Attendant Support Services (CDASS), Personal Care Services, and In-Home Support Services.

The total amount of respite provided in one support plan year may not exceed an amount equal to thirty (30) day units and one thousand eight hundred eighty (1,880) individual units, where one unit is equal to 15 minutes. The Department may approve a higher amount when needed due to the Member's age, disability or unique Family circumstances.

- **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 members must first obtain certification from the Department. Certification is obtained by a provider after undergoing a survey by the Colorado Department of Public Health and Environment (CDPHE). CDPHE will recommend a provider for Medicaid certification after the provider has successfully completed a survey. The Department will review the recommendation by CDPHE and either certify the provider or ask that the provider improve conformance to rules and/or regulations before certifying the provider.

The Complementary and Integrative Health Services will require the enrollment of providers that are not likely to be enrolled to serve Medicaid members. The Department has worked in collaboration with Complementary and Integrative Health Services practitioners and professional associations in the development of this service and its regulation.

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.

CDPHE does not survey providers of the following services: Life Skills Training, Peer Mentorship, 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 members.

g. State Option to Provide HCBS in Acute Care Hospitals in accordance with Section 1902(h)(1) of the Act. Specify whether the state chooses the option to provide waiver HCBS in acute care hospitals. *Select one*:

- (●) **No, the state does not choose the option to provide HCBS in acute care hospitals.**
- ( ) **Yes, the state chooses the option to provide HCBS in acute care hospitals under the following conditions.** *By checking the boxes below, the state assures:*
  - ☐ **The HCBS are provided to meet the needs of the individual that are not met through the provision of acute care hospital services;**
  - ☐ **The HCBS are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide;**
  - ☐ **The HCBS must be identified in the individual's person-centered service plan; and**
  - ☐ **The HCBS will be used to ensure smooth transitions between acute care setting and community-based settings and to preserve the individual's functional abilities.**

*And specify:***(a) The 1915(c) HCBS in this waiver that can be provided by the 1915(c) HCBS provider that are not duplicative of services available in the acute care hospital setting;(b) How the 1915(c) HCBS will assist the individual in returning to the community; and(c) Whether there is any difference from the typically billed rate for these HCBS provided during a hospitalization. If yes, please specify the rate methodology in Appendix I-2-a.**

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:
C.a.2 # & % of waiver providers enrolled within the perfce period, by type, that have the reqd prof'l licensure or cert prior to serving waiver participants N: # of waiver providers enrolled within the perfce period, by type, that have the reqd prof'l licensure or certification prior to serving waiver participants D: Total # of waiver providers enrolled within the performance period, by type.

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

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

		Interval =
☑ **Other** Specify: CDPHE	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
C.a.1 # & % of licensed/certified waiver providers, by type, that met licensing stds or cert reqrmts at time of scheduled or periodic recert. survey Numerator: # of licensed/certified waiver providers, by type, that met licensing stds or cert reqrmts at time of scheduled or periodic recert. survey Denominator: Total licensed/certified waiver providers, by type, surveyed during perfce period

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: CDPHE	☐ **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:
C.a.6 Number and percent of non-surveyed licensed/certified waiver providers, by type, that continually meet waiver licensure/certification standards Numerator: Number of non-surveyed licensed/certified waiver providers, by type, that continually meet waiver licensure/certification standards Denominator: Total number of non-surveyed licensed/certified waiver providers, by type

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

Performance Measure:
C.b.1 Number and percent of non-surveyed non-licensed/non-certified providers that initially and continually meet waiver requirements Numerator: Number of non-

surveyed non-licensed/non-certified providers that initially and continually meet waiver requirements Denominator: Total number of non-surveyed non-licensed/non-certified waiver providers

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **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:
C.c.2 Number and percent of CIH waiver non-surveyed providers who meet department training requirements in accordance with state requirements and the approved waiver N: Number of CIH waiver non-surveyed providers who meet Department training requirements in accordance with state requirements and the approved waiver D: Total CIH waiver non-surveyed providers

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
C.c.1 Number and percent of surveyed CIH waiver providers who meet Department waiver training requirements in accordance with state requirements and the approved waiver Numerator: Number of surveyed CIH waiver providers who meet Department waiver training requirements in accordance with state requirements and the approved waiver Denominator: Total number of surveyed waiver providers

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

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

C.a.1
Providers interested in providing HCBS services required by Medical Assistance Program regulations must undergo a survey before certification to ensure compliance with licensing and qualification standards and requirements. Certified providers are re-surveyed according to the CDPHE schedule to ensure ongoing compliance.
The Department is provided with monthly and annual reports detailing the number and types of agencies surveyed, the number of agencies with deficiencies and the types of deficiencies cited, the date deficiencies were corrected, the number of complaints received, and the number of complaints investigated, substantiated, and resolved.
The Department uses CDPHE survey reports as the primary data source for this performance measure.

C.a.2
Licensed or certified providers must be in good standing with their specialty practice and comply with current state licensure regulations. Following Medicaid provider certification, all providers are referred to the Department's fiscal agent to obtain a provider number and a Medicaid provider agreement. The fiscal agent enrolls providers in accordance with Medical Assistance Program regulations and maintains provider enrollment information in the MMIS. The fi cal agent verifies all provider qualifications and required professional licenses upon initial enrollment and in a revalidation cycle at least every five years. The Department's provider enrollment staff maintains data reports that verify required professional licensure and certification.

C.a.6
The fiscal agent verifies all provider qualifications upon initial enrollment and in a revalidation cycle at least every five years. The Department's waiver provider enrollment staff maintains data reports to confirm that non-surveyed licensed and certified providers continually meet waiver requirements.

Department records are the primary data source for this performance measure.

C.b.1 The Department reviews the waiver provider qualifications. The fiscal agent enrolls providers in accordance with program regulations and maintains provider enrollment information in the MMIS. All provider qualifications are verified by the fiscal agent upon initial enrollment and in a revalidation cycle at least every five years. Data reports verifying that non-surveyed providers continually meet waiver requirements are maintained by the Department's waiver provider enrollment staff.

Department records are the primary data source for this performance measure.

C.c.1
CDPHE reviews personnel records as part of their provider surveying activities and includes training deficiencies identified during the surveys in the written statement of deficiencies.

C.c.2
Department regulations for provider general certification standards require provider agencies to maintain personnel records for each employee and supervisor, including qualification documentation and proof of required training completed.

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 and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

C.a.1
Providers that are not in compliance with CDPHE or other state standards receive deficiency citations. Based on the level of risk to client health and welfare, deficiencies require, at a minimum, submission of a plan of correction to CDPHE. Providers that fail to correct deficiencies within prescribed timelines are recommended for termination by CDPHE and terminated by the Department.
When required or appropriate, CDPHE refers survey findings to other agencies or licensing boards and immediately notifies the Department of any license denial, revocation, or imposition of conditions. Complaints received by CDPHE are assessed for immediate jeopardy or life-threatening risk and investigated in accordance with applicable federal requirements and timeframes.

The Department reviews all CDPHE surveys to ensure that deficiencies have been remediated and to identify patterns and/or problems on a statewide basis, by service area, and by program. The results of these reviews help the Department determine the need for technical assistance, training resources, and other necessary interventions.

C.a.2
The Department initiates termination of the provider agreement for any provider who is in violation of any applicable certification standard, licensure requirement, or provision of the provider agreement and fails to adequately respond to a corrective action plan within the prescribed timeframe.

C.a.6
If areas of non-compliance with standards exist, the Department issues a list of deficiencies to the provider. The provider is required to submit an acceptable Plan of Correction (POC) to the Department within a specified timeframe. If areas of non-compliance exist that put the health and welfare of participants receiving services at risk, the provider is required to correct the issue immediately and provide documentation of the corrections to the Department. The Department initiates termination of the provider agreement for any provider who violates any applicable certification standard, licensure requirement, or provision of the provider agreement and fails to respond to a POC within the prescribed time adequately.

C.b.1
If areas of non-compliance with standards exist, the Department issues a list of deficiencies to the provider. The provider is required to submit an acceptable Plan of Correction to the Department within a specified timeframe. If areas of non-compliance exist that put the health and welfare of participants receiving services at risk, the provider is required to correct the issue immediately and provide documentation of the corrections to the Department. Providers that do not remediate deficiencies per the POC are terminated from the program.

C.c.1
The Department reviews CDPHE provider surveys to ensure that plans of correction are followed up on and that waiver providers are trained in accordance with Department regulations.

C.c.2
The Department initiates termination of the provider agreement for any provider who violates any applicable certification standard, licensure requirement, training requirement, or provision of the provider agreement and fails to adequately respond to a corrective action plan within the prescribed period.

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 in which 1915(c) HCBS are recieved. *(Specify and describe the types of settings in which waiver services are received.)*

Services under this waiver are provided in the following setting types:

• Adult Day Health center/facility
Services offered at this setting type: Adult Day Health and Non-Medical Transportation (NMT).

• Alternative Care Facility (ACF)
Services offered at this setting type: Respite.

• Complementary and Integrative Health (CIH) Services Center
Services offered at this setting type: CIH (chiropractic, acupuncture, and massage) and NMT.

• Nursing facility (NF)
Services offered at this setting type: Respite.

• Participants' own/family homes
Services offered at this setting type: Adult Day Health (virtual), CIH (chiropractic, acupuncture, and massage), Home Modification, Life Skills Training, NMT, Peer Mentorship, and Respite.

• Various locations in the community where participants wish to go (e.g., grocery store, park, events)
Services offered at this setting type: Adult Day Health, Life Skills Training, NMT, Peer Mentorship, and Respite.

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 in the future as part of ongoing monitoring. *(Describe the process that the state will use to assess each setting including a detailed explanation of how the state will perform on-going monitoring across residential and non-residential settings in which waiver HCBS are received.)*

Ongoing monitoring for compliance with all HCBS Settings Final Rule requirements is conducted as follows:

~ Global notes applicable to various setting types below

• In connection with all Colorado Department of Public Health & Environment (CDPHE) surveys described in this Appendix, for any setting type in this Appendix surveyed by CDPHE other than surveys of settings exclusively offering Respite (which are excluded from the HCBS Settings Final Rule), note that: (i) the Department codified the settings criteria in rule (10 CCR 2505-10 section 8.7001.B), with Section 8.7001.B.2 of the rule detailing requirements for all HCBS settings and Section 8.7001.B.3 detailing additional requirements for certain setting types; (ii) CDPHE updated the tools and processes it uses to conduct routine provider enrollment and quality assurance surveys, with cross-training of survey staff on settings rule criteria such that the initial enrollment/certification process and recertification process ensure that settings meet all applicable HCBS Settings Final Rule requirements as codified in the foregoing citations; (iii) both HCPF and CDPHE updated their websites and materials sent to providers and prospective providers seeking to add/expand their HCBS offerings, to enhance awareness of settings rule expectations.

• For purposes of all case management monitoring contacts described in this Appendix, note that (i) case managers perform quarterly monitoring contacts with members to evaluate the members' health, safety, and welfare, including respect for individual rights; (ii) at least one such contact occurs in person, and the other three may occur in person, on the phone, or through other technological means based on member preference; and (iii) the Department developed processes for case managers to confirm with individuals that the settings at which they receive services are compliant. This includes the December 2024 release of an Ongoing Monitoring Guide, helping case managers make observations and ask questions relevant to a setting's HCBS Settings Final Rule compliance. Case managers are required to have general familiarity with the guide so they can identify possible compliance concerns as they arise during quarterly monitoring contacts with members. The guide explains how to escalate concerns for inquiry and enforcement actions as needed.

• Members are informed of their rights under the HCBS Settings Final Rule through videos and resource sheets. Across all waivers, case managers are instructed and have been trained to offer members a chance to view the videos and access the resource sheet as part of arranging for the discussion about whether to consent to a proposed rights modification. At any time, if they have a question or concern about potential noncompliance, they can escalate it as detailed in the dedicated Ask a Question/Report a Concern section of the Department's settings rule website.

~ Specific setting types

• Adult Day Health center/facility
o The Colorado Department of Health Care Policy & Financing (HCPF) verifies provider qualifications of the following provider types upon initial enrollment/certification and through revalidation every five years thereafter: Adult Day Health and Non-Medical Transportation (NMT). For NMT, HCPF reviews provider qualifications at the time of initial application and on an annual basis.
o Under an Interagency Agreement (IA), CDPHE is tasked with surveying the following provider types upon initial enrollment/certification and for purposes of recertification every 36.9 months thereafter: Adult Day Health.
o Case managers engage in quarterly monitoring contacts with members.
o At any time, members can escalate questions or concerns as detailed in the dedicated Ask a Question/Report a Concern section of the Department's settings rule website.

• Alternative Care Facility (ACF)
o HCPF verifies provider qualifications of the following provider types upon initial enrollment/certification and through revalidation every five years thereafter: Respite. However, insofar as Respite is provided in settings exclusively offering this service (which is excluded from the HCBS Settings Final Rule), such settings are excluded from the federal and state versions of the settings rule. See 10 CCR 2505-10 section 8.7001.A.2. Therefore, these provider validations do not encompass settings requirements.
o Under an IA, CDPHE is tasked with surveying the following provider types upon initial enrollment/certification and for purposes of recertification every three years thereafter: ACF.
o Case managers engage in quarterly monitoring contacts with members.
o At any time, members can escalate questions or concerns as detailed in the dedicated Ask a Question/Report a Concern section of the Department's settings rule website.

• Complementary and Integrative Health (CIH) Services Center
o HCPF verifies provider qualifications of the following provider types upon initial enrollment/certification and through revalidation every five years thereafter: CIH (chiropractic, acupuncture, and massage) and NMT. For NMT, HCPF reviews provider qualifications at the time of initial application and on an annual basis.
o Case managers engage in quarterly monitoring contacts with members.
o At any time, members can escalate questions or concerns as detailed in the dedicated Ask a Question/Report a Concern section of the Department's settings rule website.

• Nursing facility (NF)
o HCPF verifies provider qualifications of the following provider types upon initial enrollment/certification and through revalidation every five years thereafter: Respite. However, insofar as Respite is provided in settings exclusively offering this service (which is excluded from the HCBS Settings Final Rule), such settings are excluded from the federal and state versions of the settings rule. See 10 CCR 2505-10 section 8.7001.A.2. Therefore, these provider validations do not encompass settings requirements.
o CDPHE surveys nursing facilities. However, insofar as Respite is provided in settings exclusively offering this single HCBS waiver service, and otherwise offering only institutional (nursing facility) services, such settings are excluded from the federal and state versions of the settings rule. Therefore, these surveys do not encompass settings requirements.
o Case managers engage in quarterly monitoring contacts with members.
o At any time, members can escalate questions or concerns as detailed in the dedicated Ask a Question/Report a Concern section of the Department's settings rule website.

• Participants' own/family homes
o HCPF verifies provider qualifications of the following provider types upon initial enrollment/certification and through revalidation every five years thereafter: Adult Day Health, CIH (chiropractic, acupuncture, and massage), Home Modification, Life Skills Training, NMT, Peer Mentorship, Respite, and Wellness Education Benefit. For NMT, HCPF reviews provider qualifications at the time of initial application and on an annual basis.
o Under an IA, CDPHE is tasked with surveying the following provider types upon initial enrollment/certification and for purposes of recertification every three years thereafter, or every 36.9 months for provider types marked with an asterisk: Adult Day Health,* Home Health, and Respite. Again, insofar as Respite is provided in settings exclusively offering this service, such settings are excluded from the federal and state versions of the settings rule, and surveys of such settings would not encompass settings requirements.
o Case managers engage in quarterly monitoring contacts with members.
o At any time, members can escalate questions or concerns as detailed in the dedicated Ask a Question/Report a Concern section of the Department's settings rule website.

• Various locations in the community where participants wish to go (e.g., grocery store, park, events)
o HCPF verifies provider qualifications of the following provider types upon initial enrollment/certification and through revalidation every five years thereafter: Adult Day Health, Life Skills Training, NMT, Peer Mentorship, and Respite. For NMT, HCPF reviews provider qualifications at the time of initial application and on an annual basis.
o Under an IA, CDPHE is tasked with surveying the following provider types upon initial enrollment/certification and for purposes of recertification every three years thereafter, or every 36.9 months for provider types marked with an asterisk: Adult Day Health* and Respite. Again, insofar as Respite is provided in settings exclusively offering this service, such settings are excluded from the federal and state versions of the settings rule, and surveys of such settings would not encompass settings requirements.
o Case managers engage in quarterly monitoring contacts with members.
o At any time, members can escalate questions or concerns as detailed in the dedicated Ask a Question/Report a Concern section of the Department's settings rule website.

• Additional information for item 3 below:
Under the header "Provider-owned or controlled residential settings," HCPF is selecting the "No" radio button. This is because while some settings within this waiver may be provider-owned or -controlled, they are either nonresidential (Adult Day Health center/facility, CIH Services Center, various locations in the community where participants wish to go), or excluded from the HCBS Settings Final Rule (ACFs and nursing facilities where, under this waiver, only Respite is offered, not residential services). Nevertheless, it is worth noting that in its codification of the HCBS Settings Final Rule (10 CCR 2505-10 section 8.7001.B), HCPF did extend a number of the additional rights to settings that are nonresidential and/or not provider-owned or -controlled (Section 8.7001.B.3) and did provide that modifications of these rights are subject to the Rights Modification process (Section 8.7001.B.4).

3. *By checking each box below, the state assures that the process will ensure that each setting will meet each requirement:*

☑ **The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.**

☑ **The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.** ***(see Appendix D-1-d-ii)***

☑ **Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.**

☑ **Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.**

☑ **Facilitates individual choice regarding services and supports, and who provides them.**

☑ **Home and community-based settings do not include a nursing facility, an institution for mental diseases, an intermediate care facility for individuals with intellectual disabilities, a hospital; or any other locations that have qualities of an institutional setting.**

Provider-owned or controlled residential settings. (*Specify whether the waiver includes provider-owned or controlled settings*.)

◉ **No, the waiver does not include provider-owned or controlled settings.**

○ **Yes, the waiver includes provider-owned or controlled settings.** (By checking each box below, the state assures that each setting, *in addition to meeting the above requirements, will meet the following additional conditions*):

☐ **The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.**

☐ **Each individual has privacy in their sleeping or living unit:**

- ☐ **Units have entrance doors lockable by the individual.**
- ☐ **Only appropriate staff have keys to unit entrance doors.**
- ☐ **Individuals sharing units have a choice of roommates in that setting.**
- ☐ **Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.**

☐ **Individuals have the freedom and support to control their own schedules and activities.**

☐ **Individuals have access to food at any time.**

☐ **Individuals are able to have visitors of their choosing at any time.**

☐ **The setting is physically accessible to the individual.**

☐ **Any modification of these additional conditions for provider-owned or controlled settings, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan*(see Appendix D-1-d-ii of this waiver application).***

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Person-Centered Support Plan (PCSP)

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. Given the importance of the role of the person-centered service plan in HCBS provision, the qualifications should include the training or competency requirements for the HCBS settings criteria and person-centered service plan development. *(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 minimum qualifications for HCBS Case Managers who conduct the person-centered service plan are:
1. A bachelor's degree; or
2. Five (5) years of experience in the field of LTSS, which includes Developmental Disabilities; or
3. Some combination of education and relevant experience appropriate to the position's requirements.
4. Relevant experience is defined as:
a. Experience in one of the following areas: long-term care services and supports, gerontology, physical rehabilitation, disability services, children with special health care needs, behavioral science, special education, public health or non-profit administration, or health/medical services, including working directly with persons with physical, intellectual or developmental disabilities, mental illness, or other vulnerable populations as appropriate to the position being filled; and
b. Completed coursework and/or experience related to the type of administrative duties performed by case managers may qualify for up to two (2) years of required relevant experience.

Agency supervisor educational experience:
The agency's supervisor(s) shall meet minimum standards for education and/or experience and shall be able to demonstrate competency in pertinent case management knowledge and skills.

The Department provides Case Management Agencies training on the Home & Community Based Services Settings Final Rule and Person-Centered Support Planning processes.

The mandatory curriculum for case managers on the Colorado Learns Learning Management System (LMS) includes two modules on the HCBS Settings Final Rule. The training covers the rule, the rights protected by the rule, the rights modification process, and the case manager's role in this process.

☐ **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. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for service plan development except, at the

option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *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.** ***Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can develop the service plan:***

The State Medicaid Agency allows for entities to provide both case management and direct care waiver services only when no other willing and qualified providers are available to provide the direct care waiver services. When a Case Management Agency submits a request to the Department to permit them to develop the person-centered plan and provide direct waiver services, the Case Management Agency must provide the Department with the following information:

1. Specific service that is lacking in the Case Management Agency Defined Service Area.
2. Number of other providers available in the Case Management Agency Defined Service Area for this service.
3. Number of Medicaid members being served by the Case Management Agency for this service.
4. If the lack of service is in a particular area, indicate the area and the number of members being served in that area.
5. Efforts the Case Management Agency has made to develop the service that is lacking.
6. Procedure the Case Management Agency follows to ensure the member has been offered a choice of providers.
7. Procedure the CMA uses to avoid any possible bias of using only the CMA as the only willing and qualified provider when another service agency is unavailable in the area.
8. Written documentation indicating Direct Service Provider functions and Case Management Agency functions are being administered separately.
9. Any other information the Case Management Agency may feel is pertinent to obtain this request.

The Department reviews the above information to ensure that the Case Management Agency is in compliance with State laws, regulations, and policies regarding service provisions at 10 C.C.R. 2505-10, Section 8.393.1.M, prior to granting the request.

The state currently allows an individual's HCBS provider to develop the Person Centered Support Plan (PCSP) in Prowers, Baca, Kiowa, Logan, Morgan, Phillips, Sedgwick, Washington, and Yuma.

For those counties where the Department allows the Home and Community-Based Service provider to develop the PCSP due to a lack of other available willing and qualified providers, per the contract, the Case Management Agency is required to do the following in regards to mitigating conflict: Obtaining a request from the Department to provide direct services based on criteria in applicable Department regulations and submitting an annual report to update the status of their request. If the CMA is granted to provide services, the CMA shall provide written notification to the member and/or guardian of the potential influence the CMA has on the service planning process and ensure the member and/or guardian are informed of their choice.

The CMA shall provide the member and/or guardian with written information about how to file a provider agency and/or Case Management Agency complaint. Upon the member and/or legal guardian's request, the Case Management Agency shall provide an option for the member and/or legal guardian to request a different Case Management Agency to develop the PCSP. The Case Management Agency shall provide an option for the service plan to be monitored by a different CMA entity or individual.

When granted, the Case Management Agency must provide the following:
1. Case Management Agencies that are permitted to provide services must provide written notification to the member and/or guardian about the potential influence the Case Management Agency has on the support planning process (such as exercising free choice of providers, controlling the content of the PCSP, including assessment of risk, services, frequency, and duration, and informing the member of their rights).
2. The Case Management Agency must also provide the member and/or guardian with written information about how to file a provider agency complaint and how to make a complaint against the Case Management Agency.
3. Upon member and/or guardian request, the Case Management Agency must provide an option for the member and/or guardian to choose a different entity or individual to develop the PCSP. The Case Management Agency must also provide an option for the PCSP to be monitored by a different Case Management entity or individual.

The Department requires all Case Management Agencies to provide information about the full range of waiver services to eligible members and/or guardians. The Department does not establish rules about how this information is to be provided. The Department requires the use of universal PCSP by all Home and Community-Based Services case managers. The person-centered support plan includes all services available to the member provided in the waiver. In addition to the list of waiver services the PCSP provides, case management agencies may choose to provide information to members in a format that best meets their needs.

The Department issued Operational Memo 23-002, which explains how the state provides oversight and approval of the process to determine that the provider of HCBS is also the only willing and qualified provider to develop the PCSP.

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in service plan development. *By checking each box, the state attests to having a process in place to ensure:*

☑ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**

☑ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**

☑ **Direct oversight of the process or periodic evaluation by a state agency;**

☑ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**

☑ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

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 members about the potential services, supports, and resources that are available to long-term care members. CMAs are located throughout the State, and 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 members about all of the supports available to members.

In 2017, 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 members but also identify a "Best Practice" approach to provide members and/ or family members with meaningful information and supports to actively engage in and direct the process.

The Department website provides members with access to meaningful information and supports that are available to assist the participant (or others designated by the participant) to actively engage in and direct the PCSP process.

Information is continually updated and added in order to assist the member and/or family members to make informed decisions about waiver services, informal supports, and State Plan benefits.

Members, guardians, and/or legal representatives may choose among qualified providers and services. The case manager will advise the members and/or guardians or legal representative of the range of services and supports for which the members is eligible in advance of PCSP development. The choice of services and providers for the waiver benefit package is ensured by facilitating a Person-Centered Planning process and providing a list of all providers from which to choose.

When scheduling to meet with the members, the case manager makes reasonable attempts to schedule meeting times that are convenient for the member. In addition, a waiver member and/or guardian or legal representative are informed they have the authority to select and invite individuals of their choice to actively participate in the PCSP process. Case managers develop emergency backup plans with the member and/or child's legal guardian or representative during the service planning process and document the plan on the PCSP. The member must be seen at the time of the initial assessment and at the redetermination to ensure that the member is in the home.

The case manager shall perform quarterly monitoring contacts with the member, as defined by the member's certification period start and end dates. An in-person monitoring contact is required at least one (1) time during the Person-Centered Support Plan certification period. The case manager shall ensure the one (1) required in-person monitoring contact occurs, with the Member physically present, in the Member's place of residence or location of services.

Upon Department approval in advance, contact may be completed by the case manager at an alternate location, via the telephone, or using a virtual technology method, in accordance with the approved targeted Case Management state plan service under Section 1915(g)(1) of the Act and the case management Medicaid administrative activity under the approved cost allocation plan.

The case manager shall perform three additional monitoring contacts each certification period either in-person, on the phone, or through other technological modalities based on the member's preference of engagement.

To facilitate person-centered practices, CMAs may use phone or other technological contact to engage in the development and monitoring of the PCSP.

All forms completed through the Person-Centered Support Planning process are available for signature through digital or wet signatures based on the member's preference.

Appendix D: Participant-Centered Planning and Service Delivery

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

d. i. 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; (g) how and when the plan is updated, including when the participant's needs changed; (h) how the participant engages in and/or directs the planning process; and (i) how the state documents consent of the person-centered service plan from the waiver participant or their legal representative. 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 PCSP [10 C.C.R. 2505-10, Section 8.7202.J]. The case manager meets face-to-face with the member and/or legal guardian to complete a Level of Care Eligibility Determination Screen (LOC Screen), making reasonable attempts to schedule the meeting at a time and location convenient for all participants. To facilitate person-centered practices, CMAs may use phone or other technological contact to engage in the development and monitoring of the PCSP. For each certification period, the level of care determination or redetermination will be in person (unless one of the circumstances specified below applies).

The case manager shall perform quarterly monitoring contacts with the member, as defined by the member's certification period start and end dates. An in-person monitoring contact is required at least one (1) time during the Person-Centered Support Plan certification period. The case manager shall ensure the one (1) required in-person monitoring contact occurs, with the Member physically present, in the Member's place of residence or location of services.

Upon Department approval in advance, contact may be completed by the case manager at an alternate location, via the telephone, or using a virtual technology method. CMAs may use phone or telehealth in accordance with the approved Targeted Case Management state plan service under section 1915(g)(1) of the Act and the case management Medicaid administrative activity under the approved cost allocation plan.

The case manager shall perform three additional monitoring contacts each certification period either in-person, on the phone, or through other technological modalities based on the member's preference of engagement.

The member and/or legal guardian have the authority to select and invite individuals of their choice to actively participate in the assessment process. The member and the member's chosen group provide the case manager with information about the member's needs, preferences, and goals. In addition, the case manager obtains diagnostic and health status information from the member's medical provider and determines the member's level of care using the state-prescribed LOC Screen instrument.

The case manager also identifies if any natural supports 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 member and/or the group of representatives to identify any risk factors and addresses risk factors with appropriate parties.

Beginning December 2021 or sooner, the case manager will complete a needs assessment (Assessment), basic or comprehensive, as determined by the member. The Assessment collects information about the member's strengths and support needs in these areas: health; functioning; sensory & communication; safety & self-preservation; housing, employment, volunteering, and training; memory & cognition; and psychosocial. The Assessment also identifies the member's goals and needed referrals and will determine if specific waiver targeting criteria is met. Prior to the Assessment is completed, the case manager will explain the assessment process to the member and/or guardian and explain options for waivers and waiver services, as well as the option to choose between the basic or comprehensive assessment. The comprehensive option covers all of the areas of the basic option but collects more detailed information about the member. The Assessment identifies which HCBS waiver(s) the member is eligible for and be utilized to develop the PCSP.

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

Referrals are made to the appropriate providers of the member'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 PCSP defines the type of services, frequency, and duration of services needed. The PCSP also documents that the member 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 member may contact the case manager for ongoing case management such as assistance in coordinating services, conflict resolution, or crisis intervention. The PCSP must be finalized in accordance with CFR 441.301 c (2)(ix), " Be finalized and agreed to, with the informed consent of the individual in

writing, and signed by all individuals and providers responsible for its implementation."

All support plans created by the case management with the member/representative are signed by the member/representative and maintained in the case management record.

The case manager reviews the LOC Screen and PCSP with the member during the required monitoring contact. This review includes the evaluation and assessment of strategies for meeting the needs, preferences, and goals of the member. It also includes evaluating and obtaining information concerning the member's satisfaction with the services, the effectiveness of services being provided, an informal assessment of changes in the member's function, service appropriateness, and service cost-effectiveness.

If complaints are raised by the member about the Person-Centered Planning process, case manager, or other CMA functions, case managers are required to document the complaint on the CMA complaint log and assist the member to resolve the complaint. The case manager and/or case manager's supervisor are also required to assist in the resolution of the complaint.

This complaint log is reviewed by the Department on a quarterly basis. Department staff is 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 member 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 in the copy of the PCSP that is provided to the member. The member also has the option of lodging an anonymous complaint to the case manager, CMA, or the Department.

Members, 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 Department investigates the complaint and remediates the issue.

The case manager is required to complete a face-to-face reevaluation, at a time and location chosen by the member, within twelve months of the initial or previous evaluation. A reevaluation shall be completed sooner if the member's condition changes or as needed by program requirements. Upon Department approval, the annual evaluation and/or development of the PCSP may be completed by the case manager at an alternate location or via the telephone. CMAs may use phone or telehealth in accordance with the approved Targeted Case Management state plan service under section 1915(g)(1) of the Act and the case management Medicaid administrative activity under the approved cost allocation plan.

In cases of emergency or evacuation, the case manager may authorize needed services using a temporary interim service plan, not to exceed 60 days. This plan will be developed when additional services, essential to the member's health and safety, related to the emergency situation are identified. The case manager will authorize the services using the most effective means of written communication. Service providers may provide services authorized in this manner until the case manager is able to complete a service plan revision which will backdate to the date of the temporary interim service plan. This type of interim temporary plan will only be used for already enrolled waiver participants who have been determined eligible for the waiver pursuant to the eligibility process in the waiver.

State laws, regulations, and policies that affect the PCSP development process are available through the Department of Health Care Policy & Financing.

ii. HCBS Settings Requirements for the Service Plan. *By checking these boxes, the state assures that the following will be included in the service plan:*

☑ **The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.**

☑ **For provider owned or controlled settings, any modification of the additional conditions under 42 CFR § 441.301(c)(4)(vi)(A) through (D) must be supported by a specific assessed need and justified in the person-centered service plan and the following will be documented in the person-centered service plan:**

☑ **A specific and individualized assessed need for the modification.**

☑ **Positive interventions and supports used prior to any modifications to the person-centered service plan.**

☑ **Less intrusive methods of meeting the need that have been tried but did not work.**

☑ **A clear description of the condition that is directly proportionate to the specific assessed need.**

☑ **Regular collection and review of data to measure the ongoing effectiveness of the modification.**

☑ **Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.**

☑ **Informed consent of the individual.**

☑ **An assurance that interventions and supports will cause no harm to the individual.**

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 person-centered support planning and are documented in the member's electronic record. Case managers are required to provide members with all of the choices available to the member for Long Term Care. These choices include continuing to live in the member's home or choosing to live in a Nursing Facility.

The case manager discusses the possible risks associated with the member's choice of living arrangement with the member and/or guardian. The case manager and the member then develop strategies for reducing these risks. Strategies for reducing these risks include developing back-up plans. Back-up plans are designed to be member-centered and often include relying on the member's choice of family, friends, or neighbors to care for the member if a provider is unable to do so, or for life or limb emergencies, members 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.

Case Management Agencies (CMAs) are required to provide members with a free choice of all qualified providers in an accessible format based on the member's needs. Some services and/or providers that are available in one part of the State may not be available in other areas of the State. In order to ensure that members continue to exercise a free choice of providers, the Department has added a signature section to the PCSP that allows members to indicate whether they have been provided with free choice of providers. Additionally, CMAs are required to provide any information and support needed to fully ensure that the member directs the Person-Centered Support Planning process to the maximum extent possible. The Department has opted not to mandate that CMAs use a specific form or method to inform members about all the supports available to members. This approach by CMAs and assurance of non-coercion is culminated by having the member or guardian sign a document and attestation stating that they were not compelled to choose a particular provider against their will.

All CIH services are available throughout the state as indicated by the waiver agreement. The Department plans to increase efforts to seek willing partners to build capacity for Complementary and Integrative Health Services throughout the state. The Department also continues to work with current providers to expand their coverage area.

The Department has also developed an informational tool in coordination with the Colorado Department of Public Health and Environment (CDPHE) to assist members in selecting a service agency. The Department has provided all CMAs with this informational tool and it is available on the CDPHE website.

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 PCSP according to their contract with the Department and CMS waiver requirements. The Department monitors each CMA annually for compliance. A sample of individual PCSP documentation which is representative of the demographic makeup of the waiver population is reviewed for accuracy, appropriateness, and compliance with regulations at 10 C.C.R. 2505-10, Section 8.7000 and 42 CFR § 441.301(c)

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

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, when the individual's circumstances or needs change significantly, or at the request of the individual, to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

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

Specify the other schedule:

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

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

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan, participant health and welfare, and adherence to the HCBS settings requirements under 42 CFR §§ 441.301(c)(4)-(5); (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 PCSP development, implementation, and monitoring. Case managers are required to meet with members annually for support plan development. When scheduling to meet with the member and or the member's legal guardian or representative, the case manager makes reasonable attempts to schedule the meeting at a time and location convenient for all participants. Once the PCSP plan is implemented case managers are required to conduct monitoring with the member to ensure the PCSP continues to meet the member's goals, preferences, and needs. Case managers are also required to contact the member when significant changes occur in the member's physical or mental condition. To facilitate person-centered practices, CMAs may use phone or other technological contact to engage in the development and monitoring of PCSP.

The case manager shall perform quarterly monitoring contacts with the member, as defined by the member's certification period start and end dates. An in-person monitoring contact is required at least one (1) time during the Person-Centered Support Plan certification period. The case manager shall ensure the one (1) required in-person monitoring contact occurs, with the Member physically present, in the Member's place of residence or location of services.

Upon department approval in advance, the case manager may complete contact at an alternate location, via telephone, or via virtual technology. CMAs may use phone or telehealth in accordance with the approved Targeted Case Management state plan service under section 1915(g)(1) of the Act and the case management Medicaid administrative activity under the approved cost allocation plan.

The case manager shall perform three additional monitoring contacts each certification period either in-person, on the phone, or through other technological modality based on the member's preference of engagement.

Members create contingency plans as part of the PCSP development. Contingency plans are reviewed with the member during monitoring, and annual evaluations to identify changes needed to the plan. Contingency planning reviews what a member would do if their service provider did not show up, how they would deal with an emergency, etc. Case managers perform monitoring with members to review satisfaction with service delivery and assess changes to needs. A member who is experiencing a problem or concern with services or supports receives immediate assistance from their case manager to assess the concern and identify options such as changes to services or providers.

Participant's exercise of free choice of providers:

Each Case Management Agency (CMA) is required to provide members 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 members. In order to ensure that members continue to exercise a free choice of providers, the Department has added a signature section to the PCSP that allows members to indicate whether they have been provided with a free choice of providers. All forms completed through the assessment and care plan process are available for signature through digital or wet signatures based on the member's preference.

Participants have access to non-waiver services in the PCSP, including health services. Methods for prompt follow-up and remediation of identified problems:

Members are provided with this information during the initial and annual support planning process using the "Member Roles and Responsibilities" and the Case Manager's "Roles and Responsibilities" form. The form provides information to the member about the following, but not limited to, case management responsibilities:

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

The form also states that members are responsible for notifying their case manager of any changes in the member's care needs and/or problems with services. If a case manager is notified about an issue that requires prompt follow-up and/or remediation the case manager is required to assist the member. Case managers document the issue and the follow-up in the state's case management IT system.

In cases of emergency or evacuation, the case manager may authorize needed services using a temporary interim service plan, not to exceed 60 days. This plan will be developed when additional services, essential to the member's health and

safety, related to the emergency situation are identified. The case manager will authorize the services using the most effective means of written communication. Service providers may provide services authorized in this manner until the case manager is able to complete a service plan revision which will backdate to the date of the temporary interim service plan. This type of interim temporary plan will only be used for already enrolled waiver participants who have been determined eligible for the waiver pursuant to the eligibility process in the waiver.

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

The Department will conduct annual 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.

Evidentiary information supporting the CMA's 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 compares information submitted by the CMA to the state's case management IT system documentation and Prior Authorization Request (PAR) submissions, member signature pages including but not limited to intake, service planning, the release of information or HIPAA, and Medical Documentation that must be signed by a Treating Licensed Medical Professional. If the Department discovers errors 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 Person-Centered Support Planning regarding the evaluation of needs, member monitoring (contact), case reviews, complaint procedures, provision of member 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 Program Integrity section only reviews specific cases that are referred to PI from the Department, CDPHE, or member complaints. At this time, the Department has not sent any cases for Program Integrity to review, and therefore there is no annual sample size or resolution information available.

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

b. Monitoring Safeguard. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for monitoring the implementation of the service plan except, at the option of the state, when providers are given this responsibility because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may not provide other direct waiver services to the participant.**
- ● **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation.** *(Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can monitor service plan implementation).*

The State Medicaid Agency allows entities to provide both case management and direct care waiver services only when no other willing and qualified providers are available. The Department issued Operational Memo 23-002, which explains how the state provides oversight and approval of the process to determine that the provider of HCBS is also the only willing and qualified provider to develop the PCSP.

When a CMA submits a request to the Dept. the CMA must provide the Dept. with the following information:

1. Specific service that is lacking in the CMA Defined Service Area.
2. Number of other providers available in the CMA Defined Service Area for this service.
3. Number of Medicaid members the CMA serves for this service.
4. If the lack of service is in a particular area, indicate the area and the number of members served there.
5. Efforts the CMA has made to develop the service that is lacking.
6. Procedure the CMA follows to ensure the member has been offered a choice of providers.
7. Procedure the CMA uses to avoid any possible bias of using only the CMA as the only willing and qualified provider when another service agency is unavailable in the area.
8. Written documentation indicating Direct Service Provider functions and CMA functions are being administered separately.
9. Any other information the CMA may feel is pertinent to obtaining this request.

The Department reviews the above information to ensure that the CMA complies with State laws, regulations, and policies regarding service provision at 10 C.C.R. 2505-10, Section 8.7400, prior to granting a request.

The state currently allows an individual's HCBS provider to develop the Person-Centered Support Plan (PCSP) in Prowers, Baca, Kiowa, Logan, Morgan, Phillips, Sedgwick, Washington, and Yuma.
Per the contract, the CMA must do the following to mitigate conflict:

For those counties where the Dept allows the HCB service provider to develop the PCSP due to a lack of other available willing and qualified providers, per the contract, the CMA is required to do the following in regards to mitigating conflict: Obtain a request annually from the Department to provide direct services based on criteria in applicable Department regulations. If the CMA is granted to provide services, the CMA shall provide written notification to the member and/or guardian of the potential influence the CMA has on the Person-Centered Support Planning process. The CMA shall provide the member and/or guardian with written information about how to file a provider agency and/or CMA agency complaint. Upon the member and/or guardian's request, the CMA shall provide an option for the member and/or guardian to request a different CMA to develop the PCSP. The CMA shall provide an option for the PCSP to be monitored by a different CMA entity or individual.

1. CMAs that are granted to provide services must provide written notification to the member and/or guardian about the potential influence the CMA has on the Person-Centered Support Planning process (such as exercising free choice of providers, controlling the content of the Person-Centered Support Plan, including assessment of risk, services, frequency, and duration, and informing the member of their rights).
2. The CMA must also provide the member and/or guardian with written information about how to file a provider agency complaint and how to make a complaint against the CMA.
3. Upon member and/or guardian request, the CMA must provide an option for the member and/or guardian to choose a different entity or individual to develop the support plan. The CMA must also provide an option for the PCSP to be monitored by a different CMA entity or individual.

The Dept. requires that all CMAs provide information about the full range of waiver services to eligible members and/or guardians. The Department does not establish rules about how this information is to be provided. The Dept. requires a universal PCSP used by all HCBS case managers. The PCSP includes a list of all services available to the member provided in the waiver. In addition to the list of waiver services provided by the PCSP, CMAs may choose to provide the information to members in a format that best meets the member's needs. For example, many CMAs prepare a comprehensive list of qualified HCBS providers in their area that is provided to members during the Person-Centered Support Planning process.

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in monitoring of service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements. *By checking each box, the state attests to having a process in place to ensure:*

☑ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**

☑ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**

☑ **Direct oversight of the process or periodic evaluation by a state agency;**

☑ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**

☑ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

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:
D.a.2 Number and percent of waiver participants whose PCSPs address the waiver participant's personal goals N: Number of waiver participants whose PCSPs address the waiver participant's personal goals D: Total number of waiver participants reviewed

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
D.a.3 Number and percent of waiver participants whose PCSPs address identified health and safety risks through a contingency plan Numerator: Number of waiver participants whose PCSPs address identified health and safety risks through a contingency plan Denominator: Total number of waiver participants reviewed

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% confidence level 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:
D.a.1 Number and percent of waiver participants whose person-centered support plan (PCSP) addresses the needs identified in the Level of Care eligibility determination screen (LOC Screen) Numerator: Number of participants whose PCSPs address the needs identified in the LOC screen Denominator: Total number of waiver participants reviewed

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

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

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

Data Aggregation and Analysis:

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

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

b. ***Sub-assurance: Service plans are updated/revised at least annually, when the individual's circumstances or needs change significantly, or at the request of the individual.***

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:
D.c.1 Number and percent of waiver participants whose PCSPs were revised, as needed, to address changing needs Numerator: Number of waiver participants whose PCSPs were revised, as needed, to address changing needs Denominator: Total number of participants who required a revision to their PCSP to address changing needs that were reviewed

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

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

		95% confidence level with +/- 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:

D.c.2. Number and percent of waiver participants with a prior PCSP that was updated within one year Numerator: Number of waiver participants with a prior PCSP that was updated within one year Denominator: Total number of waiver participants with a prior PCSP in the sample

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% confidence level 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:
D.c.3 # and % of waiver participants and/or family members who indicate on the experience-of-care (EoC) survey they know who to contact to make changes to their PCSP N: # of waiver participants and/or family members who indicate on the EoC survey they know who to contact to make changes to their PCSP D: Total number waiver participants and/or family members responding to the EoC survey

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 =

☑ **Other** Specify: Experience-of-care survey team	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Every other year	

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: Every other year

c. ***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:
D.d.1 # and % of waiver participants and/or family members responding to the experience-of-care (EoC) survey who indicate they received services and supports outlined in their PCSP N: # of waiver participants and/or family members responding to the EoC survey who indicate they received services and supports outlined in their PCSP D: Total # of waiver participants responding to EoC Survey

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 =
☑ **Other** Specify: Experience-of-care survey team	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Every other year	

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: Every other year

Performance Measure:
D.d.2 Number and percent of waiver participants for whom the scope and type of services are delivered as specified in the PCSP N: # of waiver participants for whom scope and type of services are delivered as specified in the PCSP D: Total # of waiver participants in the sample

Data Source (Select one):
Other
If 'Other' is selected, specify:
Participant's record in the State's case management IT system/Bridge records

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% confidence level with a +/- 5% margin of error.

☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% confidence level 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:
D.d.4 Number and percent of waiver participants for whom the amount of services are delivered as specified in the PCSP Numerator: Number of waiver participants for whom the amount of services is delivered as specified in the PCSP Denominator: Total number of waiver participants in the sample

Data Source (Select one):
Other
If 'Other' is selected, specify:
Participant's record in the State's case management IT system/Bridge record

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

collection/generation *(check each that applies):*	*(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% confidence level with a +/- 5% margin of error.
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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

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

		Review
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% confidence level 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:
D.d.5 Number and percent of waiver participants for whom the frequency and duration of services are delivered as specified in the PCSP Numerator: # of waiver participants for whom the frequency and duration of services are delivered as specified in the PCSP Denominator: Total # of waiver participants in the sample

Data Source (Select one):
Other
If 'Other' is selected, specify:
Participant's record in the State's case management IT system/Bridge records

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

	☐ **Other** Specify:	

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% confidence level 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: Participants are afforded choice 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:
D.e.1 Number and percent of waiver participants whose PCSPs document a choice between/among HCBS waiver services and qualified waiver service providers
Numerator: Number of waiver participants whose PCSPs document a choice between/among HCBS waiver services and qualified waiver service providers.
Denominator: Total number of waiver participants in the sample

Data Source (Select one):
Other
If 'Other' is selected, specify:
State's case management IT 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% confidence level with a +/- 5% margin of error.
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
D.e.2 # and % percent of waiver participants and/or family members responding to the Experience-of-care (EoC) survey who indicated they had a choice of service providers N: # of waiver participants and/or family members responding to the EoC survey who indicated they had a choice of service providers D: Total # of waiver participants and/or family members responding to the EoC survey

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 =
☑ **Other** Specify: Experience-of-care survey team	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☑ **Other** Specify: Every other year	

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: Every other year

e. ***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.

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 utilizes the Super Aggregate Report as the primary data source for monitoring the PCSP assurance and performance measures. The Super Aggregate Report is a custom report comprising two parts: data extracted directly from the state's case management IT system, the Bridge, and data obtained from the annual program evaluations document, the QI Review Tool. (Some performance measures use the state's case management IT system-only data, some use QI Review Tool-only data, and some use a combination of the state's case management IT system, Bridge, and QI Review Tool data). The Super Aggregate Report provides initial compliance outcomes for the SP sub-assurances and performance measures.

D.a.1
All services listed in the PCSP must correspond with the needs listed in the ADLs, Supervision, and medical sections of the LOC Screen. If a participant scores two or more on the LOC Screen, the participant's need must be addressed through a waiver/state PCSP or by a third party (natural supports, another state program, private health insurance, or private pay). The reviewers utilize the state's case management IT system and/or Bridge to identify deficiencies for this performance measure and report them in the QI Review Tool.

D.a.2
PCSPs must address personal goals as identified in the Personal Goals section appropriately. Goals should be individualized and documented in the HCBS Goals sections of the participant's record. The reviewers use the state's case management IT system and/or Bridge to discover deficiencies for this performance measure and report them in the QI Review Tool.

D.a.3
A contingency plan must address health and safety risks in the participant's record. The narrative in the contingency plan must be individualized and include a plan to address situations in which a participant's health and welfare may be at risk if services are unavailable. The reviewers use the state's case management IT system to discover deficiencies in this performance measure and report them in the QI Review Tool.

D.c.1
If SP revision need is indicated, the revision must be included in the participant's record, supported by documentation in the applicable areas of the LOC Screen, Log notes, or CIRS, and address all service changes following Department policy, delivered to the participant or the participant's representative; and, signed by the participant or the legal guardian, as appropriate. All forms completed through the Person-Centered Support Planning process are available for signature, either digitally or with a wet signature, based on the member's preference. The reviewers utilize the state's case management IT system and/or Bridge to identify deficiencies for this performance measure and report them in the QI Review Tool.

D.c.2
The PCSP start date must be within one year of the prior PCSP start date for existing, non-new waiver participants in the sample. Discovery data for this performance measure is pulled directly from the state's case management IT system.

D.c.3, D.d.1, D.e.2
Colorado participates in Experience-of-Care (EoC) surveys that assess performance and outcome indicators for state developmental disabilities service systems. These surveys enable the Department to compare its performance with that of service systems in other states and within the state every year.
Performance and outcome indicators to be assessed covering the following domains:
- Consumer Outcomes
- System Performance
- Health, Welfare, & Rights
- Service Delivery System Strength & Stability

Additionally, Colorado has added waiver-specific questions to ensure that participants know who to contact if their PCSPs need updating, that PCSPs meet their expectations, and that they have a choice of providers.

D.d.2-5
The Department compares data collected from MMIS claims and the participant's PCSP to discover deficiencies in this performance measure. Case managers must follow up with participants and providers to ensure that the state's case management IT system accurately reflects the authorized services and the necessary amount to meet the participant's identified needs.

D.e.1
The PCSP Service and Provider Choice page must indicate that the participant has been given a choice between Home and Community-Based Services (HCBS) waiver services and qualified service providers. Discovery data for this performance measure is pulled directly from the state's case management IT system.

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 and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In

addition, provide information on the methods used by the state to document these items.

D.a.1, D.a.2, D.a.3, D.c.1, D.c.2, D.d.2, D.d.4, D.d.5, D.e.1
The Department provides comprehensive remediation training to CMAs annually to assist with improving compliance with service planning performance measures and in developing future individual PCSPs. The remediation process includes a standardized template for individual CMA corrective actions plans (CAPs) to ensure that all essential elements, including root-cause analysis, are addressed in the CAP. Time-limited CAPs are required for each performance measure when the threshold of compliance is at or below 85%. The CAPs must also include a detailed account of the actions to be taken, the staff responsible for implementing these actions, timeframes, and a completion date. The Department reviews the CAPs and either accepts or requires additional remedial action. The Department follows up with each CMA quarterly to monitor the progress of the action items outlined in their CAP.

The Department compiles and analyzes CMA CAPs to determine a statewide root cause for deficiencies. Based on the analysis, the Department identifies the need to provide policy clarifications and/or technical assistance, design specific training annually, and determine the need for modifications to current processes to address statewide systemic issues.

The Department monitors service planning CAP outcomes continually to determine if individual CMA technical assistance is required, what changes need to be made to training plans, or what additional training needs to be developed. The Department will analyze future QIS results to determine the effectiveness of the training delivered. Further training, technical assistance, or systems changes will be implemented based on those results.

D.c.3, D.d.1, D.e.2
The Department compares data on response rates to EoC questions and responses from one survey period to the next. The Department analyzes the survey's outcome and uses this information to assist with the development of the waiver training curriculum, as well as to inform the development of necessary policy changes.

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 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 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.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

Case Management Agency notifies the member and/or legal guardian when any of the adverse actions identified at 42 CFR Part 431, Subpart E. These adverse actions include not being given the choice of home and community-based services as an alternative to institutional care, are denied the choice of services or providers, or if services are denied, suspended, reduced, or terminated. Notice of member appeal rights is mailed using the Department approved Notice of Action form number 803 and/or the prior authorization request. The CMA is required to provide information regarding the right to request a fair hearing to the member 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 members 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 members 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 members in developing a written request for an appeal if they are unable to complete the request alone.

Appeal rights are also included in the Long Term Care Plan Information form. The case manager reviews this form with the applicant/member/and/or authorized representative at the time of initial assessment and reassessment. A copy of this form is provided to the member and/or authorized representative. During the monitoring of the CMA by the Department, reviewers monitor a random sample of member 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 member on fair hearing rights. The Department monitors also have access to the state's case management IT system which allows them to review 803 forms as reviewers receive individual complaints.

Member appeal rights are maintained on a Notice of Action (803) form in the state's case management IT system. Case managers are instructed to send a Notice of Action whenever there is a change or reduction in services or when a member has been denied HCBS services due to functional or financial ineligibility. The 803 forms completed are available for the case manager and case manager supervisor signature through digital or wet signatures.

If a member submits an appeal within the required time frame, the member 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 member may be financially liable for services rendered.

Members 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.

Every Medicaid action that is appealed to the OAC is reviewed by the Department. When a member 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**

- **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.

Do not complete this item.

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**

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

The Department of Health Care Policy & Financing (the State Medicaid Agency/Agency) is responsible for operating the grievance complaint system in compliance with the federal Ensuring Access to Medicaid Services final rule (CMS-2442-F). Case Management Agencies (CMAs) are responsible for operating an internal grievance system and the CMA grievance is overseen by the State Medicaid Agency. The State Medicaid Agency operates a formal escalation/grievance process. A Home Health Hotline is maintained by the Colorado Department of Public Health and Environment, Health Facilities and Emergency Services Division (CDPHE). A second critical incident hotline 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.

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

The Department currently has a formal escalation/grievance process that includes direct contact with members. Members, family members and/or advocates that have concerns or complaints may contact the state Medicaid Agency directly via web form, telephone, US mail or e-mail to complain or escalate issues with Case Management Agencies, provider agencies, the State Medicaid Agency or regarding financial eligibility issues, person centered planning, or HCBS settings rule requirements.
When the State Medicaid Agency receives a complaint, the Agency investigates the complaint and remediates the issue, often with the help and support of local Case Management Agencies. The State Medicaid Agency offers reasonable translation and support services in filing complaints at no cost to participants. The State Medicaid Agency maintains written procedures for the grievance process. These procedures specify that the Agency staff receiving complaints follow the below procedure:
1. Provide acknowledgement of receipt of complaint
2. Determine the level of involvement of state staff in resolving the complaint including, where indicated, direct complaint investigation by the State Medicaid Agency staff based on severity of complaint and topic of complaint
3. Ensure documentation of complaint in Agency complaint log with
a) Date of complaint,
b) Name of reporter,
c) Name of member associated with complaint,
d) Description of complaint,
e) Notes for Agency staff and CMA to fill in as action is taken, including mechanisms for resolution such as collaboration with local providers, searching for new providers, outreach to local CMA or individual case managers, collaboration with Colorado Department of Health and Environment for surveys of providers, reports to county Child Protective Services or Adult Protective Services, or collaboration with county financial offices,
f) Date of resolution,
g) Description of resolution including communication to complainant and member involved in complaint.

All complaints received via voice mail or e-mail are responded to within one business day with an acknowledgement of receipt to the complainant. . Primary involvement by the State Medicaid Agency staff in resolving the complaint is implemented when local efforts to resolve the complaint have failed, or if the complainant has a valid reason for not contacting the local agency (e.g., previous efforts to resolve similar complaints have failed, complaint involves a manager at the agency, fear of retaliation, etc.)

The State Medicaid Agency staff are responsible for documenting the complaint and its resolution in the Department's Complaint Log, and follow-up with the complainant including resolution of the complaint. The Department staff maintain conflict of interest standards and appropriate expertise for resolution of grievances.

Timelines for response and resolution for grievance tickets are triaged to four categories commensurate with the seriousness of the complaint; urgent, high, medium, and low. Specific response and resolution timelines can be found in 42 CFR 441.301(c)(7)(v)(B).

Case Management Agencies (CMAs) are required to maintain an internal log system for complaints and grievances, and may seek resolution themselves or refer to the appropriate oversight agency. A waiver member may file a grievance/complaint regarding any dissatisfaction with services and supports provided. All Case Management Agencies (CMA) and qualified provider agencies are required to have specific written procedures to address how grievances will be handled. The agencies' procedures shall identify who at the agency is to receive the grievance, who will support the participant in pursuing resolution of the grievance, how parties shall come together to resolve the grievance (including the use of mediation), the timeline for resolving the grievance, and that the agency director considers the matter if the grievance cannot be resolved at a lower level. An agency is required to maintain documentation of grievances/complaints received and the resolution thereof. An agency shall provide information on its grievance/complaint procedure at the time a participant is enrolled into the waiver and anytime the participant indicates dissatisfaction with any aspect of the services and supports provided. The Department reviews the complaint/grievance process through Case Management Agency contract deliverables, including CMA's methods of informing members how to file a grievance. 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 and follow up with any necessary corrective action.

Case managers perform quarterly monitoring contacts with the member to inquire about the quality of services members 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 members 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 in the copy of the service plan that is provided to the member and/or authorized representative. The member also has the option of logging an anonymous complaint to the case manager, CMA, or the Department.

If the member experiences a reduction, termination or denial of services, they will be provided a Notice of Action form with their appeal rights and instructions for filing an appeal for a Medicaid Fair Hearing with the Office of Administrative Courts. Participants 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 member with any notice of adverse action. The Notice of Action form does not direct the member to follow a complaint process prior to requesting a hearing.

The Home Health Hotline maintained by the Colorado Department of Public Health and Environment, Health Facilities and Emergency Services Division (CDPHE) is set up for complaints about care providers, fraud, abuse, and misuse of personal property. CDPHE evaluates the complaint and initiates an investigation. The hotline system is in addition to the 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. CDPHE evaluates the complaint and initiates an investigation. Most investigations will be initiated within three days of CDPHE receiving a complaint or for complaints considered to be a severe risk to the member'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 that are reported to the Department and require that a plan of correction be submitted to CDPHE within specified timelines. Immediate jeopardy situations require actions to correct the situation at the time of the survey.

A second critical incident line is used by agencies licensed and/or surveyed by CDPHE and CMAs to report issues such as unexpected death or disability, abuse, neglect, and misuse of personal property. These follow the same timelines and procedures as the above Home Health Hotline.

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

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

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

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

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

The Department of Health Care Policy and Financing (the Department) has made improvements to plain language of requirements of incident reporting from Provider Agencies, Case Management Agencies (CMA), and collaborating state agencies such as Colorado Department of Public Health and Environment (CDPHE) while ensuring Provider Agencies and CMAs adhere to legal responsibilities of mandated reporting laws. Initial incident reporting occurs at the provider level, at minimum, and with increased risk of health, safety, and welfare of the member, there is increased reporting, oversight, and follow-up required. Incident reporting may occur from the member or other reporting parties.

The Department works collaboratively with CDPHE as they have additional reporting, oversight, and follow-up requirements of licensed Community Group Homes and Provider Agencies that overlap with the Department's incident reporting requirements, respond to complaints regarding services provided by agencies licensed by their agency, and conduct compliance surveys of Provider Agencies.

Reporting to Law Enforcement and Adult Protection- All provider agencies and Case Management Agencies (CMAs) are required to report any incident in which a crime may have been committed to local law enforcement according to Title 18-8-115, C.R.S. (Colorado Criminal Code -Duty To Report A Crime). The Provider agency and CMA also shall report any suspected incidents of mistreatment, abuse, neglect, or self-neglect to law enforcement and county departments of social services adult protection units under Title 26-3.1-101, C.R.S. (At-Risk Adult Statute. Requirements for such reporting are included in Rules located at 10 CCR 2505-10 § 8.8.7201.M.3.

Provider Reporting: The Department requires all provider agencies to complete all reporting necessary for compliance with CDPHE and the Department as outlined in Section 8.7411. Any Incident that meets or is suspected to meet Critical Incident criteria is required to be reported to the CMA immediately upon detection via telephone, e-mail, or facsimile but no more than 24 hours after the incident occurrence. These incidents include allegations of mistreatment, abuse, neglect and exploitation, medical crises requiring emergency treatment, death, victimization as a result of a serious crime, alleged perpetration of a serious crime, and missing persons. Requirements for such reporting are located at 10 CCR 2505-10 Section 8.7411.B After initial reporting, the agency must submit a written incident report to the CMA within 24 hours of the discovery of the incident.

Licensed Community Group Home Reporting- All provider agencies operating group homes licensed by the Colorado Department of Public Health and Environment (CDPHE) are required to report a specific class of incidents through the CDPHE Occurrence Reporting Program no later than the end of the next business day after discovery. A list and definition of critical incidents that must be reported to DPHE through the Occurrence Reporting Program are included in the Occurrence Reporting Manual and include the following types of incidents: Physical abuse, sexual abuse, verbal abuse, neglect, brain injuries, burns, death, diverted drugs, life-threatening complications due to anesthesia, transfusions, malfunction or misuse of medical equipment, misappropriation of resident property, missing persons and spinal cord injuries.

The Colorado State Long-Term Care Ombudsman Program is an independent program that advocates for residents of Alternative Care Facilities (ACF). The authority of the long-term care ombudsman program comes from Title VII, Chapter 2, of the Older Americans Act, as well as Title 26, Article 11.5, of the Older Coloradans Act. The primary purpose of the Long-Term Care Ombudsman Program is to promote and protect the residents' rights guaranteed to residents under federal and state law. Certified Long-Term Care Ombudsmen are trained to receive complaints and resolve problems in situations involving quality of care, use of restraints, transfer and discharge, abuse, and other aspects of resident dignity and rights. Ombudsman services are free, confidential, and resident directed.

Out-of-state providers must comply with comparable requirements in that state's waiver for reporting to law enforcement and Adult Protective Services.

CDPHE occurrences are a licensing mechanism that CDPHE implemented separately and apart from our oversight and quality measures. CDPHE evaluates the complaint and initiates an investigation if appropriate. The investigation begins within twenty-four hours or up to three days depending upon the nature of the complaint and risk to the member's health and welfare."

CDPHE submits monthly complaint reports to the Department. The reports provide the Department with information about the facility type, type of complaint, the source of the complaint when the complaint will be investigated, and the investigation findings.

Additionally, the Department receives a weekly list of any Occurrences filed that week for licensed group homes with CDPHE involving licensed Group Residential Services and Supports facilities (group homes). HCPF uses that weekly report to cross-check for required critical incident reporting.

Critical Incidents are those incidents that create the risk of serious harm to the health or welfare of an individual receiving services and it may endanger or negatively impact the mental and/or physical well-being of an individual.
Critical Incident reporting is required when the following occurs
a. Injury/Illness;
b. Missing Person;
c. Criminal Activity;
d. Unsafe Housing/Displacement;
e. Death;
f. Medication Management Issues;
g. Other High-Risk Issues;
h. Allegations of Abuse, Mistreatment, Neglect, or Exploitation;
i. Damage to the member's Property/Theft

Abuse means:
The non-accidental infliction of physical pain or injury, as demonstrated by, but not limited to, substantial or multiple skin bruising, bleeding, malnutrition, dehydration, burns, bone fractures, poisoning, subdural hematoma, soft tissue swelling, or suffocation;
Confinement or restraint that is unreasonable under generally accepted caretaking standards; or
Subjection to sexual conduct or contact classified as a crime under the "Colorado Criminal Code", Title 18, C.R.S.

Caretaker Neglect means:
Neglect occurs when adequate food, clothing, shelter, psychological care, physical care, medical care, habilitation, supervision, or other treatment necessary for the health, safety, or welfare of a person is not secured for or is not provided by a caretaker promptly and with the degree of care that a reasonable person in the same situation would exercise, or a caretaker knowingly uses harassment, undue influence, or intimidation to create a hostile or fearful environment for waiver participant.

Exploitation means:
An act or omission committed by a person who:
Uses deception, harassment, intimidation, or undue influence to permanently or temporarily deprive a person of the use, benefit, or possession of anything of value;
Employs the services of a third party for the profit or advantage of the person or another person to the detriment of the person receiving services;
Forces, compels, coerces, or entices a person to perform services for the profit or advantage of the person or another person against the will of the person receiving services; or
Misuses the property of a person receiving services in a manner that adversely affects the person to receive health care or health care benefits or to pay bills for basic needs or obligations.

Harmful Act means -
An act committed against the participant by a person with a relationship to the participant when such act is not defined as abuse, caretaker neglect, or exploitation but causes harm to the health, safety, or welfare of the participant.

Injury/Illness to Member means:
An injury or illness that requires treatment beyond first aid which includes lacerations requiring stitches or staples, fractures, dislocations, loss of limb, serious burns, skin wounds, etc.
An injury or illness requiring immediate emergency medical treatment to preserve life or limb.
An emergency medical treatment that results in admission to the hospital.
A psychiatric crisis resulting in unplanned hospitalization

Damage to Consumer's Property/Theft means:
Deliberate damage, destruction, theft, or use of a waiver recipient's belongings or money.
If the incident is mistreatment by a caretaker that results in damage to the consumer's property or theft the incident shall be listed as mistreatment

Medication Management Issues means:
Issues with medication dosage, scheduling, timing, set-up, compliance, and administration or monitoring which result in harm or an adverse effect that necessitates medical care.

Missing Person means:
Person is not immediately found, their safety is at serious risk, or there is a risk to public safety.

Criminal Activity means:
A criminal offense that is committed by a person.
A violation of parole or probation that potentially will result in the revocation of parole/probation.

Unsafe Housing/Displacement means:
Individual is residing in unsafe living conditions due to a natural event (such as a fire or flood) or environmental hazard (such as infestation) and is at risk of eviction or homelessness

CMA Reporting- The Department requires all CMAs to report all Critical Incidents to the Department within 24 hours (1 business day). Critical Incidents are reported to the Department via the web-based Critical Incident Reporting System (CIRS) operated by the Department through a secure portal. The Department and the contract LTC UR/UM review and track critical incident reports to ensure that a resolution is reached and the member's health and safety have been maintained.

In the event an individual must evacuate their current setting, the Department has developed processes that will ensure the health, safety, and welfare of the member while allowing for additional flexibility in the location and timeliness of the critical incident reporting due to the emergent need. The member's case manager will enter the member's critical incident and any identified follow-up to the critical incident utilizing existing timelines identified by the Department and may request an extension in timelines for entry from the Department to the urgent nature of the evacuation.

In cases of emergency or evacuation, the case manager may authorize needed services using a temporary interim Person Centered Support Plan (PCSP), not to exceed 60 days. This plan will be developed when additional services, essential to the member's health and safety, related to the emergency situation are identified. The case manager will authorize the services using the most effective means of written communication. Service providers may provide services authorized in this manner until the case manager can complete a PCSP revision which will backdate to the date of the temporary interim PCSP. This type of interim temporary plan will only be used for already enrolled waiver participants who have been determined eligible for the waiver according to the eligibility process in the waiver.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The Case Management Agency (CMA) provides information about mistreatment, abuse, neglect, and exploitation to the participants, guardians, involved family members, and authorized representatives at initial enrollment and annually thereafter. The information is provided to participants, guardians, involved family members, and authorized representatives in the form of a packet. The packet is provided by the CM and explained verbally at initial enrollment and annually thereafter.

This includes information on:
--the right to be free from mistreatment, abuse, neglect, and exploitation, how to recognize signs of mistreatment, abuse, neglect, and exploitation, and how to report mistreatment, abuse, neglect, and exploitation to the appropriate authorities.
--the types and definitions of Critical Incident Reports and how to report a Critical Incident
--the requirements of service provider agencies and CMAs for detecting and follow-up to suspicions and allegations of mistreatment, abuse, neglect, and exploitation.

Members and/or legal representatives are informed by the case manager about the CMA's complaint policy and the availability of the Home Health Hotline, an 800 telephone number maintained by the Colorado Department of Public Health and Environment (CDPHE). Home health agencies are also required to provide all members with the Home Health Hotline number. Additionally, home health agencies are required to maintain an internal complaint log system under one of the conditions of licensure. CDPHE reviews the complaint log during annual surveys.

Training, orientation, and supervision are provided to In-Home Support Services (IHSS) members by the certified IHSS provider agency. The IHSS agency is responsible for providing the member and/or authorized representative with peer counseling; information and referral services; independent living skills training; and individual and systems advocacy. An IHSS agency is required to provide 24-hour backup services for scheduled visits. In addition, an IHSS provider agency is required to staff a Registered Nurse who is responsible for Attendant training, oversight, and supervision; the RN also must counsel Attendants and staff on difficult cases and potentially dangerous situations, consult with the member, Authorized Representative or Attendant in the event a medical issue arises, and investigate complaints and critical incidents within ten (10) calendar days. The agency must provide information to the member/authorized representative that includes the process for reporting abuse, neglect, and exploitation. Members can notify the IHSS agency, the case manager, and/or the appropriate authority if the member has experienced mistreatment, abuse, neglect, or exploitation.

Information and training are provided to Consumer Directed Attendant Support Services (CDASS) members and/or his/her authorized representatives by the Consumer Directed training and operations vendor. The training includes in-depth instruction about recognizing and preventing abuse, neglect, and exploitation. During the training, members 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 about how to safely terminate an attendant as well as focuses on emergency backup, safety, and prevention strategies.

CDASS members will also be encouraged to contact the proper authorities if they have been subjected to abuse, neglect, or exploitation by an attendant.

Resource materials are available through the case manager and the Department's website. This information packet developed by the Department will be distributed by case managers to members and/or member representatives at the initial intake and annual Continued Stay Review (CSR). This information includes a list of member roles and responsibilities, case management roles, and how to file a complaint or appeal outside of the CMA system.

The Department has developed regulations and contractual requirements for the Critical Incident Reporting System (CIRS). Statewide Critical Incident Reporting training is required for Provider Agencies and Case Management Agencies and includes training about emergency backup and safety and prevention strategies.

Case managers must document if mistreatment, abuse, neglect, or exploitation is suspected during the initial and annual level of care assessment process. The member and/or the member's representative participate in the development of the Person-Centered Support Plan (PCSP) and are provided a copy of the completed PCSP. The Department uses its case management IT system, to track the provision of this information. The case manager must confirm within the PCSP that the member and/or member's representative have been informed of and trained on the process for reporting critical incidents including mistreatment, abuse, neglect, and exploitation.

Members are encouraged to report critical incidents to their provider(s), case manager, Adult Protective Services (APS),

and/or any other member advocate. The information packet includes what types of critical incidents to report and to whom the critical incident should be reported.

All provider agencies are responsible for the development of backup/contingency plans to ensure there is a documented plan to address the health, safety, and welfare of the HCBS waiver member in the event that the member's health, safety, or welfare could be jeopardized.

Case Management Agencies are required to conduct monitoring activities four times throughout the member's annual certification; monitoring requirements include reviewing critical incidents and reviewing any potential health, safety, and welfare concern addressed by the member's environment or reports.

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.

The Department of Health Care Policy and Financing (the Department) provides more efficient oversight for protecting and ensuring health, welfare, and safety of HCBS waiver members by implementing and outlining clear roles and responsibilities for members, Provider Agencies, Case Management Agencies, and collaborating state agencies such as Colorado Department of Public Health and Environment (CDPHE), and Colorado Department of Human Services (CDHS) while adhering to legal responsibilities of mandated reporting laws. Incident reporting occurs at the provider level and with increased risk of health, safety, and welfare of the member, there is increased reporting, oversight, and follow-up required. The roles and responsibilities for Provider Agencies and Case Management Agencies are as follows:

Provider responsibilities for Incident Reporting:
* Provider agencies shall ensure all employees receive Critical Incident Reporting training as developed by the Department.
* Provider agencies shall complete all reporting necessary for compliance with CDPHE and the Department as outlined in Section 8.7411.
* Provider agencies shall follow all mandated reporting requirements for allegation of mistreatment, abuse, neglect, and exploitation.
* Provider agencies shall follow all regulatory requirements of timely Critical Incident Reporting to the member's CMA.
* Provider agencies shall conduct internal review of all Incident Reports to determine root causes, determine appropriate and timely follow-up necessary to ensure the health, safety, and welfare of members, immediate action taken by the provider to mitigate risk, and identify trends to prevent future incidents.All incident reports are reviewed by CDPHE at the time provider surveys are conducted.
* Provider agencies shall ensure contingency plans are developed and followed to mitigate undue health, safety, and welfare risk to HCBS waiver members. Contingency plans shall outline the immediate action necessary to provide services in the event that approved services are not available. All contingency plans are reviewed by CDPHE at the time provider surveys are conducted.
* Provider agencies shall make Incident Reports and all review and follow-up available to the CMA, the Department, and CDPHE upon request.

Case Management Agency responsibilities for Critical Incident Reporting:
* Case Management Agencies shall ensure all employees receive Critical Incident Reporting training as developed by the Department.
* Case Managers/CMAs shall follow all applicable timelines set forth in regulation and contract for Critical Incident Reporting.
* Case Managers shall conduct all Department required follow-up within assigned timelines.
* Case Managers shall follow all mandated reporting law requirements for allegation of mistreatment, abuse, neglect, and exploitation.
* Case Managers/CMAs shall report health, safety, and welfare concerns to CDPHE

The Department works collaboratively with CDPHE as they have additional reporting, oversight, and follow-up requirements of licensed Community Group Homes that overlap with the Department's incident reporting requirements, respond to complaints regarding services provided by agencies licensed by their agency, and conduct compliance surveys of provider agencies. Case Managers/CMAs reporting health, safety, and welfare concerns directly to CDPHE is necessary to ensure they are aware of concerns regarding the health, safety, and welfare of members receiving waiver services.

Critical Incidents involving providers surveyed by CDPHE which meet occurrence reporting criteria must be reported to the Department and CDPHE, and are responded to by CDPHE. A Home Health Hotline is maintained by CDPHE, Health Facilities, and Emergency Services Division. This hotline is set up for complaints about the quality of care, fraud, abuse, and misuse of personal property. CDPHE 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 member's health and welfare. Investigation results of the complaint reported to CDPHE are posted for public view on CDPHE's website at: www.colorado.gov/pacific/cdphe/find-and-compare-facilities.

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

numerous and severe deficiencies, the provider may lose its Medicaid certification.

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

For all complaints, CDPHE contacts, as appropriate, based on professional judgment and CDPHE policy and procedure, the member and or complainant, provider staff, and any other parties who were involved or who may have information regarding the complaint. Complaint investigations are maintained according to all state and federal requirements and are submitted to the Department within the monthly complaint log. Any serious findings are sent to the Department within 24 hours to the designated Department address.

Incidents involving CDASS must be reported to the Financial Management Services (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. Complaints that are reported to IHSS agencies follow the same procedures as all agencies surveyed or licensed by CDPHE.

Critical incidents reported to CDPHE are also posted for public view on CDPHE's website.

In an effort to standardize incident reporting review and evaluation and increase oversight of the review of incidents of waiver members, the Department requires a tiered review and evaluation of incident reporting dependent on the severity of the incident report and risk mitigation necessary to ensure health, welfare, and safety of the member.

The increased oversight and implementation of the Administrative Review and State Level Administrative Review, is otherwise known to CMS as incident investigation. Review and evaluation of a reported incident may occur at the lowest level which involves Provider Agency review and evaluation and does not directly imply Department involvement. The Department works collaboratively with CDPHE to review incident reporting, root cause analysis, and immediate action to ensure health, safety, and welfare of waiver members as they conduct compliance surveys of provider agencies.

If an incident meets Critical Incident criteria, subsequent review will occur as the report is entered in the Department's IT system and follow-up is required by the UR/UM vendor based on timelines and criteria set by the Department as outlined in Appendix G-1. As incidents fall into the category of Administrative Review, as defined below, further follow-up, documentation, and action may be required at the discretion of the Department.

As incidents fall into the category of the State Level Administrative Review, as defined below, there is increased collaboration of Provider Agencies, CMAs, the Department, and other state agencies to determine appropriate action needed to ensure the review process and documentation is standardized for all waiver members, there is appropriate oversight related to each agency's roles and responsibilities, and the investigative process meets the expectations of CMS.

Administrative Review -means the investigation process for the expressed purpose to review the health, safety, and welfare protections taken by provider agencies of HCBS waiver members in reference to a critical incident. Administrative Reviews will be requested at HCPF's discretion and completed by the Case Management Agency for incidents meeting the following criteria including, but not limited to: (1) allegations of mistreatment, abuse, neglect, or exploitations that are reported to be of suspected malicious intent; (2) root causes have not been determined through provider agency review; (3) other state or legal entity has not investigated.

The Administrative Review will include the following:
1. Review of reports and relative documentation obtained by CMAs from Provider Agencies.
a. Provider Agencies must follow all roles and responsibilities outlined above and in Section 8.7000 to ensure rights, health, safety, and welfare of HCBS waiver members.
2. At HCPF's discretion, CMAs and Provider Agencies shall be required to obtain additional documentation to complete a review of a member's health, safety, and welfare through Critical Incident Reporting follow-up.

State Level Administrative Review-means the state level investigation process for the expressed purpose to review Critical Incident Reports that require cross-state entity review.

The State Level Administrative Review will include the following:
1. Review of applicable documentation of Provider Agencies, CMAs, CDPHE, and as allowed under Colorado statutory

allowance, CDHS.
2. HCPF findings and action recommendations necessary to ensure member's health, safety, and welfare within the purview of HCPF and CDPHE.
* HCPF findings and recommendations shall not supersede member choice and autonomy. HCBS waiver services will continue to be obtained voluntarily.

The Department - The Department contracts with a Long Term Care Utilization Review/Utilization Management (LTC UR/UM) to review all Critical Incidents. The LTC UR/UM monitors Critical Incidents for the completion of necessary follow-up to ensure the health, safety, and welfare of waiver participants. The LTC UR/UM provides monthly reports to the Department on the number and types of Critical Incidents, a summary of Critical Incidents, and follow-up action completed. There is an immediate notification process for the LTC UR/UM to notify the Department of high-risk or priority Critical Incidents.

CMAs must complete processes for waiver members as outlined in Section 8.701.D. The Department shall review the Complaint procedure and logs annually to ensure appropriate resolution of Complaints and provide feedback and follow-up to CMAs as necessary. As outlined in 8.701.C. each CMA must establish and maintain a community advisory committee for the purpose of providing public input for CMA operations.

Provider Agencies must have grievance policies and procedures that comply with standards set forth in Section 8.7408.A.8.

The Department takes remedial action to address with service providers and/or CMAs when needed for deficient practice in reporting and management of Critical Incidents to ensure the health, safety, and/or welfare of waiver participants. This includes a formal request for response, technical assistance, Department investigation, the imposition of corrective action, termination of the CMA contract, and termination of a service provider's Colorado Provider Participation Agreement/Program Approval for the HCBS waiver.

The Department provides each CMA with a quarterly and annual report outlining identified CIR trends for that CMA coverage area. The CMA utilizes this information to target case management action to mitigate trends.

More information can be found in Main-B-Optional

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.

On-going oversight of Critical Incidents is the responsibility of the Department. The Department conducts oversight through the following methods:

The Department contracts with a Quality Improvement Organization, LTC UR/UM, to review all Critical Incidents. The LTC UR/UM monitors Critical Incidents for the completion of necessary follow-up to ensure the health, safety, and welfare of waiver participants. The LTC UR/UM provides monthly reports to the Department on the number and types of Critical Incidents, a summary of Critical Incidents, and follow-up action completed. There is an immediate notification process for the LTC UR/UM to notify the Department of high-risk or priority Critical Incidents.

The LTC UR/UM will also support the Department in the analysis of CIR data, understanding the root cause of identified issues, and providing recommendations for changes in CIR and other waiver management protocols aimed at reducing/preventing the occurrence of future critical incidents.

CIR TRIAGE is as follows: assignment of levels of priority to Critical Incidents Types to determine the most effective order in which to process each report.

HIGH PRIORITY: those which need immediate attention and must be addressed when received as no indication of ensuring health and safety is demonstrated. CIRs that would be considered High Priority would be those categorized as:
* Mistreatment (abuse, neglect, exploitation) in which immediate action must be taken to ensure an individual's health and safety, or if law enforcement has not been notified per Mandatory Reporting Requirements.
* Missing Person in which an individual with the line of sight support/high care needs has not been found when CIR is submitted.
* Unsafe housing or displacement from a natural disaster, fire, or stemming from caretaker neglect, which leaves the individual without housing and needs immediate attention and housing to ensure health and safety.
* Death under suspicious circumstances that needs investigation, involves mistreatment, law enforcement, or where the cause of death is unknown and autopsy must be performed by a coroner.
* Injury/Illness in which no treatment has been sought, trends imply mistreatment or those which have no immediate intervention noted to ensure the health and safety of the individual receiving services. DIDD Waivers also include Safety and Emergency Control Procedures resulting in serious injury caused by staff with no least restrictive measures utilized before holds/restraints or if mistreatment by staff is suspected.
* Medication Mismanagement in which error leads to an adverse medical crisis (or death) and needs immediate attention to ensure health and safety or mistreatment or theft/mistreatment by staff is a concern.
* Criminal Activity in which an individual receiving services is incarcerated for a major serious offense such as homicide and needs immediate follow-up due to the seriousness of the charge and notification to the Department for possible media coverage of the event.
* Damage/Theft of Property to an individual receiving services self or property which results in a need for immediate action to ensure health and safety or must be reported to Law Enforcement
* Any other CIR in which immediate assurance of health and safety is crucial and has not been addressed by CMA/Agency/staff.
* Any CIR in which there is media involvement or coverage

It should also be noted that Critical Incidents vary greatly, and the priority level may be subjective. This is also not an all-inclusive list due to variance in events.

MEDIUM PRIORITY: those Critical Incidents that may have some immediate follow-up documented, but still need some sort of actions to ensure the health and safety of an individual receiving services or other questions relating to more immediate follow-up. These may be subjective and can vary in documentation and need for clarification.

LOW PRIORITY: those Critical Incidents that have been remediated by CMA/agencies, have addressed immediate and long-term needs, have implemented services or supports to ensure health and safety, and those have protocols in place to prevent a recurrence of a similar CIR. Critical Incidents that would be Low Priority would be:
* Death, expected. Resulting from long term illness or natural causes, hospice or palliative care was utilized and documented.
* Missing Person in which the person was immediately found, had no injury and a plan was implemented to prevent a recurrence.

The Department takes remedial action to address with service providers and/or CMAs when needed for deficient practice

in reporting and management of Critical Incidents to ensure the health, safety, and/or welfare of waiver participants. This includes a formal request for response, technical assistance, Department investigation, the imposition of corrective action, termination of the CMA contract, and termination of a service provider's Colorado Provider Participation Agreement/Program Approval for the HCBS-CIH waiver.

The Department provides each CMA with a quarterly and annual report outlining identified CIR trends for that CMA coverage area. The CMA utilizes this information to target case management action to mitigate trends

The Department maintains an Interagency Agreement (IA) Colorado Department of Public Health and Environment (CDPHE) to conduct on-site licensure and re-certification and complaint surveys waiver provider agencies. CDPHE submits a report monthly to HCPF on the number and type of providers surveyed and the findings. If a deficient practice is detected with critical incident reporting, the agency must correct the practice to obtain licensure or recertification.

In addition, case managers are required to maintain records for all critical incidents that are reported or are known to case managers. The Department performs CMA monitoring through a review of critical incident and complaint reporting. All case managers must complete training on Critical Incident Reporting requirements within 120 days of the hire date per contract requirements.

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).

Under HCPF's codification of the HCBS Settings Final Rule, "Restraint means any manual method or direct bodily contact or force, physical or mechanical device, material, or equipment that restricts normal functioning or movement of all or any portion of a person's body, or any drug, medication, or other chemical that restricts a person's behavior or restricts normal functioning or movement of all or any portion of their body. Physical or handover-hand assistance is a Restraint if the individual verbally or non-verbally expresses that they do not want the assistance or if the assistance limits an individual's autonomy or other rights protected in Section 8.7001.B." 10 CCR 2505 Section 8.7001.A.15.

Under this codification, Rights Modification means any situation in which an individual is limited in the full exercise of their rights. Rights Modifications include, but are not limited to, the use of Restraints. 8.7001.A.17.

If Restraints are used at an HCBS Setting, their use must be based on an assessed need after all less restrictive interventions have been exhausted; be documented in the individual's Person-Centered Support Plan as a modification of the generally applicable rights, consistent with the Rights Modification process (which includes documentation of Informed Consent, among other criteria); and be compliant with any applicable waiver. Prone Restraints are prohibited in all circumstances. 8.7001.B.4.e.

The Department has provided members 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 is only permitted in the delivery of the respite service at Nursing Facilities.

As set forth in 6 CCR 1011-1, Chapter VII, Part 12.13 et seq, and at 10 CCR 2505-10, Section 8.7506, an Alternative Care Facility (ACF) is prohibited from the use of restraints and seclusion. Upon admission to an ACF for residence or respite care, members are provided a list of member rights including the prohibition against restraint procedures. To detect any unauthorized use of restraints, the Department has added a signature section to the service plan that allows members to indicate that he/she was provided information regarding member rights (including the prohibition on restraints), complaint procedures, and who to contact to report critical incidents. The member's signature is confirmation that the member has been provided this information and understands their rights regarding restraints.

HCBS waiver members may only use Nursing Facilities for periods of respite care. Nursing Facilities are subject to the following regulations: as set forth in 6 CCR 1011-1, Chapter V, Part 9.9 et seq. A Nursing Facility may only use 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, punishment, or to reduce the need for care of residents during periods of understaffing.

In all instances of restraint, there must be evidence that the restraint is used only after the failure of less restrictive alternatives or that such alternatives would be ineffective under the circumstances. As an additional safeguard, an intervention strategy must be developed if the behavior necessitating the restraint recurs more than once within a week or two times within a month. The intervention strategy should be documented in the PCSP and reviewed with the resident or resident's representative.

Whenever restraints are used, a method of communication shall be provided to the resident, in the form of a call signal switch or similar device that is within reach. Restraints are initiated either through the evaluation of professional staff or on the written authorization of a physician. Restraints are authorized only when there is a documented danger of injury to self or others. Restraints shall only be used when other more positive interventions have failed. The needed use for restraints must be documented in the health record and PCSP. If the restraint was not initiated by a physician's authorization, a physician's order for the restraint must be obtained no later than 24 hours after the restraint is first used.

The education and training requirements that personnel who are involved in the administration of restraints are outlined in 6 CCR 1011-1, Chapter V, Part 6.1 and 6.3. All persons assigned to direct resident care shall be prepared through formal education or on-the-job training in the principles, policies, procedures, and appropriate techniques of resident care. The facility shall provide educational programs for employees to be informed of new methods and techniques. Additional annual in-service education for staff includes a variety

of topics such as accident prevention, behavior management, and person-centered care.

The nature of the emergency shall be documented in the health record and a physician'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:

Restrictive interventions that have not been authorized through a detailed plan approved through the case management agency which results in an occurrence that places a member's health/safety at risk (injury, neglect) are entered into the Department Critical Incident Management System for review by a contracted quality improvement organization vendor and escalation to the Department for follow up with the case management agency and the provider. CDPHE performs an inspection and survey of providers every three years. During those surveys, CDPHE conducts on-site and records reviews to determine approval of restrictive interventions, as well as compliance with the HCBS Settings Final Rule. However, restraints are not permitted in Alternative Care Facilities.

A survey of an Alternative Care Facility (ACF) and Nursing Facility (NF) by the Colorado Department of Public Health and Environment (CDPHE) includes an environmental tour of the facility in which surveyors tour the entire facility looking for the use of restraints. ACFs are inspected on a three-year cycle by CDPHE. CDPHE has one team of surveyors, and the surveyors inspect ACFs for the ACF Volume 8 regulations as well as the regulations in licensure, including Chapter II, VII and medication administration Chapter 24. A facility may be inspected more often should CDPHE receive a complaint. Any issues or concerns regarding Life Safety Code found during an inspection are forwarded to the Colorado Department of Fire Prevention and Control.

The survey is conducted every three years or more frequently if CDPHE has received a complaint about the facility. The surveyors review the members they have identified during the tour as having restraints, or for larger facilities, the surveyors review a random sample of members who have restraints.

The review involves interviewing the member and/or legal guardian to determine if the member and/or legal guardian understand why the restraint is being used and that he/she has chosen and/or given permission for the restraint. After the interview has been conducted the surveyor reviews the member's PCSP to assess that the member has been assessed for safety and looks to see that the use of less restrictive measures was documented as being unsuccessful. The member's file will also be reviewed to ensure that the restraint has been developed with and based on a physician's order and that the member and/or legal guardian has signed a form giving the facility the permission to use the restraint. If problems or inconsistencies are noted, it is noted as a deficiency by CDPHE.

The Department provides each CMA with a quarterly and annual report outlining identified CIR trends for that CMA coverage area. The CMA utilizes this information to target case management action to mitigate trends.

A third of the total ACFs are inspected every fiscal year by CDPHE. The CDPHE fiscal year runs from July 1 to June 30th. During inspections, the health team inspects each facility for compliance with Chapter VII operating licensing, Chapter 24 medication administration regulations, and Volume 8 - ACF regulations. Therefore, two deficiency lists are generated if there are citations under each regulation set. The health inspections focus on resident care and treatment, resident rights, and the delivery of services, including medication administration, etc. In between survey cycles, should CDPHE receive a complaint, this will be investigated as well. Should an ACF demonstrate a pattern of non-compliance or be issued an outcome level deficiency, CDPHE will consider enforcement action in the form of intermediate conditions. Any issues or concerns regarding Life Safety Code found during an inspection are forwarded to the Colorado Department of Fire Prevention and Control.

The CDPHE survey of ACFs includes an environmental tour of the facility in which surveyors tour the entire facility looking for the use of restraints or restrictive interventions. The Department has developed and implemented an additional survey tool that is administered by CDPHE during its survey process to ensure that ACFs comply with the home-like and person-centered environment requirements and support community integration.

The Department maintains an Interagency Agreement (IA) that delegates CDPHE the authority to survey and investigate complaints against ACFs. CDPHE 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, 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 recommendation and survey results. Agencies denied licensure or recommendation for certification by CDPHE are not approved as Medicaid providers.

The Department relies on information from the survey completed by CDPHE 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.

In Colorado, all restrictive interventions within the meaning of item b are encompassed within the regulatory definition of Rights Modifications.

Under HCPF's codification of the HCBS Settings Final Rule, "Rights Modification means any situation in which an individual is limited in the full exercise of their rights." 10 CCR 2505 8.7001.A.17. Rights Modifications include, but are not limited to: the use of Intensive Supervision if deemed a Rights Modification under the definition in Section 8.7001.A.6; the use of Restraints; the use of Restrictive or Controlled Egress Measures; modifications to the other rights in Section 8.7001.B.2 (basic criteria applicable to all HCBS Settings) and Section 8.7001.B.3 (additional criteria for HCBS Settings); any provider actions to implement a court order limiting any of the foregoing individual rights; and rights suspensions under Section 25.5-10-218(3), C.R.S.

Under this codification (8.7001.B.4.a), any modification of an individual's rights must be supported by a specific assessed need and justified in the Person-Centered Support Plan. Rights Modifications may not be imposed across-the-board and may not be based on the convenience of the Provider Agency/its independent Contractor. The Provider Agency/its independent Contractor must ensure that a Rights Modification does not infringe on the rights of individuals not subject to the modification. Wherever possible, Rights Modifications should be avoided or minimized, consistent with the concept of dignity of risk.

Under 8.7001.B.4.c, for a Rights Modification to be implemented, the following information must be documented in the individual's Person-Centered Support Plan, and any Provider Agency/its independent Contractor implementing the Rights Modification must maintain a copy of the documentation: 1. The right to be modified. 2. The specific and individualized assessed need for the Rights Modification. 3. The positive interventions and supports used prior to any Rights Modification, as well as the plan going forward for the provider to support the individual in learning skills so that the modification becomes unnecessary. 4. The less intrusive methods of meeting the need that were tried but did not work. 5. A clear description of the Rights Modification that is directly proportionate to the specific assessed need. 6. A plan for regular collection of data to measure the ongoing effectiveness of and need for the Rights Modification, including specification of the positive behaviors and objective results that the individual can achieve to demonstrate that the Rights Modification is no longer needed. 7. An established timeline for periodic reviews of the data collected under the preceding paragraph. The Rights Modification must be reviewed and revised upon reassessment of functional need at least every 12 months, and sooner if the individual's circumstances or needs change significantly, the individual requests a review/revision, or another authority requires a review/revision. 8. The Informed Consent of the individual (their Guardian or other Legally Authorized Representative) agreeing to the Rights Modification. 9. An assurance that interventions and supports will cause no harm to the individual, including documentation of the implications of the modification for the individual's everyday life and the ways the modification is paired with additional supports to prevent harm or discomfort and to mitigate any effects of the modification. 10. Alternatives to consenting to the Rights Modification, along with their most significant likely consequences. 11. An assurance that the individual will not be subject to retaliation or prejudice in their receipt of appropriate services and supports for declining to consent or withdrawing their consent to the Rights Modification.

Additional Rights Modification process requirements under 8.7001.B.4.d: 1. Prior to obtaining Informed Consent, the case manager must offer the individual the opportunity to have an advocate, who is identified and selected by the individual, present at the time that Informed Consent is obtained. The case manager must offer to assist the individual, if desired, in identifying an independent advocate who is not involved with providing services or supports to the individual. These offers and the individual's response must be documented by the case manager. 2. Any Provider Agencies that desire or expect to be involved in implementing a Rights Modification may supply to the case manager information required to be documented under this rule, except for documentation of Informed Consent and the offers and response relating to an advocate, which may be obtained and documented only by the case manager. The individual determines whether any information supplied by the provider is satisfactory before the case manager enters it into their Person-Centered Support Plan.

Under 8.7001.B.4.g, if there is a serious risk to anyone's health or safety, a Rights Modification may be implemented or continued for a short time without meeting all the requirements of this rule, so long as the Provider Agency/its independent Contractor immediately (a) implements staffing and other measures to

deescalate the situation and (b) reaches out to the case manager to set up a meeting as soon as possible, and in no event past the end of the third business day following the date on which the risk arises. At the meeting, the individual can grant or deny their Informed Consent to the Rights Modification. The Rights Modification may not be continued past the conclusion of this meeting or the end of the third business day, whichever comes first, unless all the requirements of this rule have been met.

The Department has provided members 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:

Any method or device used to involuntarily limit freedom of movement, including but not limited to bodily physical force, mechanical devices, or chemicals.

The member rights established in 6 CCR 1011-1, Chapter VII, Part 13 et seq. provide safeguards concerning the use of restrictive interventions. These rights include, but are not limited to:

The right to privacy and confidentiality.
The right to socialize with other residents and participate in facility activities in accordance with the applicable PCSP
The right to be free from sexual, verbal, physical, or emotional abuse, humiliation, intimidation, or punishment.
The right to live free from involuntary confinement or financial exploitation and to be free from physical or chemical restraints as defined within these regulations
The right to full use of the facility's common areas in compliance with the documented house rules.
The right to have visitors at any time, including privacy during such visits.
The right to participate in activities outside the facility, wherein the administrator and the resident shall share responsibility for coordinating such activities.
The right to exercise choice in attending and participating in religious activities.

6 CCR 1011-1, Chapter VII, Part 7.8 requires that the facility document personnel's receipt of all required training, including on-the-job training. 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.

Members 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 9.9 et seq. A Nursing Facility may only use 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, punishment, or to reduce the need for resident care during periods of understaffing.

In all instances of restraint, there must be evidence that the restraint is used only after less restrictive alternatives fail or that such alternatives would be ineffective under the circumstances. As an additional safeguard, an intervention strategy must be developed if the behavior necessitating the restraint recurs more than once within a week or two times within a month. The intervention strategy should be documented in the PCSP and reviewed with the resident or representative.

Whenever restraints are used, a method of communication shall be provided to the resident in the form of a call signal switch or similar device that is within reach. Restraints are initiated either through the evaluation of professional staff or on a physician's written authorization. Restraints are authorized only when there is a documented danger of injury to self or others. Restraints are a measure of last resort when other, more positive interventions have failed. If the restraint was not initiated by a physician's authorization, a physician's order must be obtained no 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 Department of Health Care Policy & Financing (the Department) is responsible for oversight as the single state Medicaid agency. State oversight of the use of restrictive interventions (or Rights Modifications to use Colorado regulatory terminology) is the responsibility of the Department. The Department conducts oversight through the following methods to detect unauthorized use or inappropriate/ineffective Rights Modifications.

The Department maintains an Interagency Agreement with the Colorado Department of Public Health & Environment (CDPHE) to survey certain provider types, as detailed above in Appendix C (service descriptions; HCBS Settings Final Rule ongoing monitoring).

A survey of an Alternative Care Facility (ACF) and Nursing Facility (NF) by CDPHE 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 every three years or more frequently if CDPHE has received a complaint about the facility. The surveyors review the members they have identified during the tour as having restrictive interventions. For larger facilities, the surveyors review a random sample of members who have restrictive interventions.

The review involves interviewing the member and/or legal guardian to determine if the member and/or legal guardian understands why the restrictive interventions are being used and that he/she has chosen and/or given permission for the restrictive intervention. After the interview has been conducted the surveyor reviews the member's PCSP to assess that the member has been assessed for safety and looks to see that the use of less restrictive measures was documented as being unsuccessful. The member's file will also be reviewed to ensure that the restrictive interventions have been developed with and based on a physician's order and that the member and/or legal guardian has signed a form giving the facility the permission to use the restrictive intervention. If problems or inconsistencies are noted the error is noted as a deficiency by CDPHE.

Members living in an ACF are subject to the following regulation (6 CCR 1011-1, Chapter VII, Section 14.9 (B) in regard to the use of behavior-modifying drugs:
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 drugs in this manner is appropriate.

A third of the total ACFs are inspected every fiscal year by CDPHE. The CDPHE fiscal year runs from July 1 to June 30th. During inspections, the health team inspects each facility for compliance with Chapter VII operating licensing, Chapter 24 medication administration regulations, and Volume 8 - ACF regulations. Therefore, two deficiency lists are generated if there are citations under each regulation set. The Health inspections focus on resident care and treatment, resident rights, and the delivery of services, including medication administration, etc. In between survey cycles, should CDPHE receive a complaint, this will be investigated as well. Should an ACF demonstrate a pattern of non-compliance or be issued an outcome level deficiency, CDPHE will consider enforcement action in the form of intermediate conditions. Any issues or concerns regarding Life Safety Code found during an inspection are forwarded to the Colorado Department of Fire Prevention and Control.

The survey is conducted annually or more frequently if CDPHE has received a complaint about a facility. Complaints may come in from facility staff, family, or the member directly. CDPHE investigates complaints to detect unauthorized or inappropriate use of restrictive procedures. CDPHE will issue any needed corrective action plans to the provider as issues are identified.

The Department relies on information from the survey completed by CDPHE 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 Department has rules which prohibit the use of seclusion in all settings where a waiver's participants receive services.
The Department has provided members safeguards concerning the use of seclusion 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.

As set forth in 6 CCR 1011-1, Chapter II, 7.1.1(J) et seq. and at 10 CCR 2505-10, Section 8.7505.F.2, an Alternative Care Facility is prohibited from the use of seclusion. For an ACF to meet the criteria for HCBS waiver participation, the setting must facilitate community integration, protect the health, welfare, and safety of the member, and be home-like and person-centered. Upon admission, members provided respite care in an alternative care facility are provided a list of member 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 members to indicate that he/she was provided information regarding member rights, complaint procedures, and who to contact to report critical incidents.

Nursing Facilities are subject to the regulations: as set forth in 6 CCR 1011-1, Chapter V, Part 9.9 et seq.

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.

Alternative Care Facilities (ACF) and Nursing Facilities (NF) include an environmental tour of the facility in which surveyors tour the entire facility looking for the use of seclusions. According to Federal guidelines, this survey is conducted every three years or more frequently if CDPHE has received a complaint about the facility. The surveyors review the members they have identified during the tour as having seclusions, or for larger facilities, the surveyors review a random sample of members who have seclusions.

In accordance with the State Operations Manual, the Department maintains an Interagency Agreement that delegates CDPHE the authority to survey and investigate complaints against Alternative Care Facilities (ACFs). 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 does not comply with the licensing or certification 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.

CDPHE has delegated authority for Life Safety Code to the Colorado Division of Fire Protection through an interagency agreement.

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 recommendation and survey results. Agencies denied licensure or recommendation for certification by CDPHE are not approved as Medicaid providers.

In accordance with the State Operations Manual, a survey of Life Safety Code issues is delegated through an interagency agreement to the Colorado Division of Fire Protection.

The Department relies on information from the survey completed by CDPHE in order to certify or decertify/ revoke the certification of these providers.

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)*

- **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.

In ACFs and nursing facilities, qualified medication administration staff may administer or assist the member in administration of medication. For members whose medications are administered by facility staff, a current record of the member's medications will be maintained. That record must include the name of the drug, the dosage, route of administration and directions for administering the medication. The facility will only administer medications upon the written order of a licensed physician or other authorized practitioner.

As part of the health inspection and survey process, CDPHE reviews medication administration procedures, storage of all medication, including controlled substances, medication audit and disposal practices, and reporting requires for drug reactions and medication errors. If deficiencies are cited in any of these areas, CDPHE will follow-up with the provider to ensure compliance with the regulations.
In addition, the Department monitors Critical Incident Reports submitted by providers for instances of a critical incident resulting from a medication management issue.

Under Colorado's statute, Colorado Department of Public Health and Environment (CDPHE) has established minimum requirements for course content, including competency evaluations, for medication administration. CDPHE approves and maintains a list of approved training entities of medication administration courses. CDPHE also maintains a current list of persons who have passed the competency evaluation by an approved training entity. CDPHE reviews the medication policies, procedures, and practices of each ACF and nursing facility to ensure compliance with state and federal regulations. CDPHE conducts standard surveys of ACFs once every three years, on a regular 9-15 month certification cycle for nursing facilities. ACF providers and nursing facilities with past or present deficiencies which impact direct member care may be surveyed earlier in the certification cycle.

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.

Colorado State Board of Health regulations (6 CCR 101 I-I, Chapter XXIV) specify the requirements for medication administration in ACFs. Colorado State Board of Health regulations (6 CCR 1011-I Chapter V) specify requirements for medication administration in Nursing Facilities. Prescription and non-prescription medications shall be administered only by qualified medication administration staff and only upon written order of a licensed physician or other licensed authorized practitioner. Such orders must be current for all medications. Non-prescription medications must be labeled with a resident's full name. No resident shall be allowed to take another's medication nor shall staff be allowed to give one resident's medication to another resident. The contents of any medication container having no label or with an illegible label shall be destroyed immediately. Medication that has a specific expiration date shall not be administered after that date. Each facility shall document the disposal of discontinued, out-dated, or expired medications.

Facilities using medication reminders for persons who are not self-administering must have qualified medication administration staff member available to assist with or administer from the medication reminder. The facility shall ensure that if a licensed nurse fills the medication reminder or a family member or friend gratuitously fills the medication reminder, a label shall be attached to the medication reminder box showing the resident's name, each medication, the dosage, the quantity, the route of administration, and the time that each medication is to be administered. Each medication reminder shall have a medication record or sheet on which all administrations are recorded. If medications in the medication reminder are not consistent with the labeling, assistance to the resident shall not proceed and the qualified medication administration staff member shall immediately notify the proper persons as outlined in the facility's policies and procedures. Once the issue is resolved and the medications are correctly assigned to the various compartments of the medication reminder, the qualified medication administration staff member may resume the administration or assistance to the resident from the medication reminder. All medication problems must be resolved prior to the next administration.

PRN or "as needed" medications of any kind shall not be placed in medication reminders. Only medications intended for oral ingestion shall be placed in the medication reminder. Medications that must be administered according to special instructions, including but not limited to such instructions as "30 minutes or an hour before meals", rather than administered routinely (unspecified--one, two, three, or four times a day, etc.), may not be placed in a medication reminder. Medications in the medication reminder box may only be used at the time specified on the box. Medication reminder boxes may not be filled for more than two weeks at a time. All prescription and non-prescription medication shall be maintained and stored in a manner that ensures the safety of all residents.

The Colorado Department of Public Health and Environment is responsible for the oversight of medication management in ACFs, Nursing Facilities, IHSS agencies, Adult Day Centers, and Respite through certification and licensure surveys, as well as complaint surveys.

In addition, the Department monitors Critical Incident Reports submitted by providers for instances of a critical incident resulting from a medication management issue
CDPHE conducts regular surveys of ACFs, IHSS agencies, Adult Day Centers, Respite providers, and Nursing Facilities. The survey includes review of medication storage procedures, medication administration procedures, documentation procedures, and review of credentialing of all staff, including those who administer medication. If during a survey there is a finding that rises to the level of deficiency, the Department will receive the Deficiency List (DL), which outlines the cited deficiency and let level of each citation.

The Department works with CDPHE to monitor the submitted Plan of Correction (POC) by the facility and any remediation for deficiencies cited.
State monitoring is conducted on behalf of the Department By CDPHE. A third of the total ACFs are inspected every fiscal year by CDPHE. The CDPHE fiscal year runs from July 1 to June 30th. During inspections, the health team inspects each facility for compliance with Chapter VII operating licensing, Chapter 24 medication administration regulations and Volume 8 - ACF regulations. Therefore, two deficiency lists are generated if there are citations under each regulation set. Any issues or concerns regarding Life Safety Code found during an inspection are forwarded to Colorado Department Fire Prevention and Control (DFPC). Nursing Facilities are surveyed every 9-15 months.

The Department reviews and tracks ongoing critical incidents to ensure that a resolution is reached and the member's health and safety is maintained. Should an ACF demonstrate a pattern of non-compliance or be issued

an outcome level deficiency, CDPHE will consider enforcement action in the form of intermediate conditions. Additionally, if information concerning potentially harmful practices is identified by CDPHE, they will conduct either a desk or on-site revisit of the facility to ensure compliance with the POC and/or intermediate condition.

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

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

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

• **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).

All qualified medication administration staff are required to take the medication administration course designed to teach unlicensed staff to safely administer medications in settings authorized by law. Staff who successfully complete the medication administration course are not certified or licensed in any way and are not trained or authorized to make any type of judgment, assessment or evaluation of a member. Staff who successfully complete the course are considered Qualified Medication Administration Persons.

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

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

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

  Medication errors are currently required to be reported to the Department of Public Health and Environment for members receiving services from an ACF, IHSS agency or Home Health agency are monitored by DPHE. DPHE compiles the deficiencies and provides the Department with monthly and annual reports of DPHE survey findings.

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

  The following is a list of Medication errors that are required to be recorded and reported by a Qualified Medication Administration Person (QMAP):
  1. wrong member
  2. wrong time
  3. wrong medication
  4. wrong dose
  5. wrong route

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

The following is a list of Medication errors that are required to be recorded and reported by a Qualified Medication Administration Person (QMAP):

1. wrong member
2. wrong time
3. wrong medication
4. wrong dose
5. wrong route

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:

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

The annual Colorado Department of Public Health and Environment (CDPHE) surveys of Alternative Care Facilities (ACFs) and nursing facilities include a medication review, focused on a random sample of at least five members, or more than five for the larger facilities.

CDPHE samples member records according to the following formula:
• 3-20 residents = minimum of 3 and up to 5 sample member records
• 21-30 residents = 6 sample member records
• 31-40 residents = 7 sample member records
• 41-50 residents = 8 sample member records
• 51-60 residents = 9 sample member records
• 61-70 residents = 10 sample member records
• More than 71 residents = 10 + 10% sample member records (e.g. 100 residents = 10 + (10% of 100) = 20 sample members records)

The medication review involves reviewing the physicians' orders, comparing those to medication administration records, looking at the medication bottles, and then observing staff administering the medication to the member. If problems or inconsistencies are noted, for example if a prescription directs that the drug is to be dosed twice a day and records indicate that it is has only been dosed once, the medication error is noted as a deficiency by CDPHE.

The Department reviews and tracks ongoing critical incidents to ensure that a resolution is reached and the member's health and safety is maintained. Should a provider demonstrate a pattern of non-compliance or be issued an outcome level deficiency, CDPHE will consider enforcement action in the form of intermediate conditions. Additionally, if information concerning potentially harmful practices is identified by CDPHE, they will conduct either a desk or on-site revisit of the facility to ensure compliance with the POC and/or intermediate condition.

The LTC UR/UM will support the Department in the analysis of CIR data, understanding the root cause of identified issues, and providing recommendations to changes in CIR and other waiver management protocols aimed at reducing/preventing the occurrence of future critical incidents. The Department reviews and tracks ongoing critical incidents to ensure that a resolution is reached and the member's health and safety is maintained.

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.

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.***

Performance Measures

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:
G.a.1 # and % of waiver participants &/or family/guardians (F/G) who received info/education on how to identify & report mistreatment, abuse, neglect, exploitation (MANE), unexplained death & other critical incidents (CI) N: # of wvr participants &/or F/G who rcvd info/ed on how to id & report MANE, unexplained death & other CI D: Total # of wvr participants &/or F/G in the sample

Data Source (Select one):
Other
If 'Other' is selected, specify:
State's case management IT System

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% confidence level 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:
G.a.6 Number and percent of newly enrolled and revalidated waiver providers trained on how to identify, address, and seek to prevent critical incidents N: # of newly enrolled and revalidated waiver providers trained on how to identify, address, and seek to prevent critical incidents D: Total # of newly enrolled and revalidated waiver providers

Data Source (Select one):
Training verification records
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:
G.a.3 Number and percent of all critical incidents that were remediated N: Number of all critical incidents that were remediated D: Total number of critical incidents

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 =
☐ **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:
G.a.2 Number and percent of all critical incidents that were reported by the CMA within required timeframe as specified in the approved waiver N: Number of all critical incidents reported by the CMA within the required timeframe as specified in the approved waiver D: Total number of all critical incidents reported by the CMA

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 =
☐ **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:
G.a.4 # and % of complaints against licensed wvr providers reported to CDPHE re: allegations of MANE that were resolved according to CDPHE regs N: # of complaints against lic. providers reported to CDPHE re: allegations of MANE resolved according to CDPHE regs D: Total complaints against lic. wvr providers reported to CDPHE re: allegations of MANE

Data Source (Select one):
Other
If 'Other' is selected, specify:
Monthly Complaint Reports provided by CDPHE

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
G.b.6 Number and percent of critical incidents where the root cause has been identified N: Number of critical incidents where the root cause has been identified D. Total number of critical incidents

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 =
☐ **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:
G.b.3 Number and percent of annual reports provided to CMAs on identified trends in critical incidents N: Number of annual reports provided to the CMAs on identified trends in critical incidents D: Total number of annual reports required to be provided to CMAs

Data Source (Select one):
Other
If 'Other' is selected, specify:
State's case management IT system /Record Reviews

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

Data 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 =
☐ **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**

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

Performance Measure:
G.b.4 Number and percent of preventable critical incidents reported that have been effectively resolved N: Number of preventable critical incidents reported that have been effectively resolved D: Total number of preventable critical incidents reported

Data Source (Select one):
Other
If 'Other' is selected, specify:
state's case management IT system/Critical Incident Reports

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the

method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
G.c.4 Number and percent of providers surveyed that met the requirements for the use of training and support plans with restrictive procedures Numerator: Number of providers surveyed that met the requirements for use of training and support plans with restrictive procedures Denominator: Total number of providers surveyed

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: CDPHE	☐ **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:
G.c.6 Number and percent of waiver participants with Restrictive Intervention Plan where proper procedures were followed in initially establishing the Restrictive Intervention Plan N:# of wvr participants w/ Restrictive Intervention Plan where proper procedures were followed in initially establishing the Restrictive Intervention Plan D:# of wvr participants w/ a Restrictive Intervention Plan

Data Source (Select one):
Other
If 'Other' is selected, specify:
State's case management IT system/Critical incident reports

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

☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
G.c.3 Number and percent of providers surveyed in the performance period that met requirements for implementing Rights Modification Numerator: Number of providers surveyed in the performance period that met the requirements for implementing Rights Modification Denominator: Total number of providers surveyed during the performance period

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: CDPHE	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

Performance Measure:
G.d.3 Number and percent of waiver participants who received care from a medical professional within the past 12 months Numerator: The number of participants who received care from a medical professional within the last 12 months Denominator: The total number of participants reviewed

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

Data Aggregation and Analysis:

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

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The Dept. uses information entered into the State's case management IT system and the Critical Incident Reporting System (CIRS) and/or complaint logs as the primary method for discovery for the Health and Welfare assurance and performance measures.

CMAs must report critical incidents to the state-prescribed Critical Incident Reporting System (CIRS) and follow up on each Critical Incident Report (CIR) through the CIRS. Following receiving the initial critical incident report, the LTC UR/UM reviews the documentation to determine if the instance was substantiated. The LTC UR/UM requests a follow-up by the CMA to gather the needed information from the parties involved If the documentation does not clearly state whether the instance was substantiated.

G.a.1
An information packet developed by the Department must be provided to participants during initial intake and annual CSR. The information includes participant rights, procedures for filing a complaint outside the system, details about the CIRS, and time frames for initiating an investigation, completing the investigation, and informing the participant or complainant of the investigation results. Participants are encouraged to report critical incidents to their provider(s), case manager, protective services, local ombudsman, and/or advocate. The information also includes what types of incidents to report and to whom the incident should be reported.
Compliance with this performance measure requires that the signature section in the service plan indicate that participants (and/or their families or guardians) have been provided information regarding rights and complaint procedures and have received information/education on how to report mistreatment, abuse, neglect, exploitation (MANE), and other critical incidents.

G.a.2
Critical incidents are reported to the Dept. via the web-based CIRS. CMAs and waiver service providers are required to report critical incidents within specific timeframes. The Department monitors critical incident reporting through the CIRS and/or complaint logs.

G.a.3
All follow-up action steps must be documented in the participant's CIRS record. The documentation must include a description of any mandatory reporting to Adult Protective Services, referral to law enforcement, notification to the ombudsperson, or additional follow-up with the participant. The CIR Administrator determines whether adequate follow-up was conducted and all appropriate actions were taken. If needed, additional follow-up or investigation may be required.

G.a.4
Critical incidents involving providers surveyed by the CDPHE must be reported to the Department and the CDPHE and responded to by the CDPHE. A hotline has been established for reporting complaints about the quality of care, fraud, abuse, and misuse of personal property. CDPHE evaluates the complaint and initiates an investigation if warranted. Depending on the nature of the complaint and the risk to the participant's health and welfare, the investigation begins within twenty-four hours or up to three days.

G.a.6
Providers are required to attend preventative strategies training. The Department maintains training records for preventive strategy training.

G.b.3
The Department examines data for specific trends, including individuals with multiple CIRs. It identifies participants who have more than one CIR in 30 days, more than three CIRs in six months, and more than five CIRs in 12 months. The Dept.

produces critical incident trend reports to be provided to all CMAs at least annually. The Dept maintains records of the reports and dates provided.

G.b.4
The Dept. examines data in the CIRS to determine when critical incidents were preventable and whether resolutions were effective.

G.b.6
The CIR Team tracks and analyzes root causes identified, and trends reduced due to systemic intervention data on a monthly and quarterly basis, including through the mortality review committee.

G.c.3, G.c.4, G.c.6
The Department monitors restrictive interventions to ensure that all participants who require a restrictive intervention plan have one. The Department also monitors the inappropriate or ineffective use of restrictive interventions through the CIRS and provider survey reports. These incidents receive additional scrutiny by the Department staff, which includes a review of the original written incident report to ensure that restrictive intervention was used in compliance with statutory and regulatory requirements. CIRS monitoring operates on a daily/continuous basis.
Oversight and discovery of restrictive interventions where proper procedures were not followed are completed through reviewing complaints regarding services and supports, as well as conducting surveys of CMAs by Department staff and providers by the CDPHE.

During the survey process, providers must demonstrate that they fulfilled the due process requirements for implementing restrictive interventions, and complied with the requirements for utilizing training and support plans in conjunction with restrictive interventions.

G.d.3
The Department reviews electronic participant records to verify that a medical professional has filed a Medicaid claim within the last 12 months.

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 and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

Issues or problems identified during annual program evaluations will be directed to the CMA administrator or director and reported in the individual's annual report of findings. CMAs who are deficient in completing accurate and required critical incident reports will receive technical assistance and/or training from department staff. CMAs are required to submit individual remediation action plans for all deficiencies identified within 30 days of notification. Following receipt of the CMA's remediation action plan, the Dept reviews the plan and confirms the appropriate steps have been taken to correct the deficiencies.
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 issue or the nature of the compliance problem. For issues or concerns that arise at any other time throughout the year, technical assistance may be provided to the CMA case manager, supervisor, or administrator. A confidential report will be documented in the waiver recipient's care file when appropriate. The Department reviews and tracks ongoing referrals and complaints to ensure that a resolution is reached and that the participant's health and safety are maintained.

G.a.1
The Department provides remediation training to CMAs annually to help improve compliance with this measure. The remediation process includes a standardized template for individual CMA Corrective Action Plans (CAPs), ensuring that all essential elements, including a root-cause analysis, are addressed in the CAP. Time-limited CAPs are required for each performance measure below the 86% CMS compliance standard. The CAPs must also include a detailed account of the actions to be taken, the staff responsible for implementing these actions, the timeframes, and a completion date. The Department reviews the CAPs and either accepts or requires additional remedial action. The Department follows up with each CMA quarterly to monitor the progress of the action items outlined in their CAP.

G.a.2
The Department takes remedial action to address waiver service providers and/or CMAs when needed for deficient practice

in reporting and managing Critical Incidents. This remedial action includes formal requests for response, technical assistance, Dept investigation, imposition of corrective action, termination of CMA contract, and termination of waiver service providers.

G.a.3
CMAs who are deficient in completing accurate and required follow-ups will receive technical assistance and/or training from Department staff. CMAs are required to submit individual remediation action plans for all deficiencies identified within 30 days of notification. Following receipt of the CMA's remediation action plan, the Dept reviews the plan and confirms the appropriate steps have been taken to correct the deficiencies.

G.a.4
In instances where, upon reviewing the complaint or occurrence report, the Department identifies individual provider issues, the Department will address these issues directly with the provider and the participant/guardian. If the Department identifies trends or patterns affecting multiple providers or participants, it will communicate any changes or clarifications of rules to all providers through monthly provider bulletins. If existing rules require amendment, the Department will develop regulations or policies to resolve widespread issues.

G.a.6
The Department requires agencies that do not attend preventive strategies training to submit a corrective action plan. If remediation does not occur in a timely or appropriate manner, the Department issues a "Notice to Cure" the deficiency to the provider. This notice requires the agency to take specific action within a designated timeframe to achieve compliance.

G.b.3, G.b.4
The Dept utilizes this information to develop statewide training and determine the need for individual agency technical assistance for case management and service provider agencies. In addition, the Department uses this information to identify problematic practices with individual CMAs and/or providers and to take additional action, such as investigating, referring the provider agency to CDPHE for complaint investigation, or directing the provider agency to take corrective action. If the Department identifies problematic trends in the reports, it will require a written plan of action from the CMA and/or the provider agency to mitigate future occurrences.

G.b.6
Specific provider trends are relayed to the Benefits & Services Management division to address and determine what additional remediation or improvement strategies need to be implemented.

G.c.6
The Dept takes remedial action to address waiver service providers and/or CMAs when needed for deficient practice in following the proper procedures of restrictive interventions. This remedial action includes formal requests for a response, technical assistance, a department investigation, imposition of corrective action, termination of the CMA contract, and termination of waiver service providers.

G.c.2, G.c.3, G.c.4
CDPHE notifies the agencies of deficiencies and determines the appropriate remedial actions, including training, technical assistance, a plan of correction, and license revocation.

G.d.3
The Department provides remediation training for CMAs annually to improve compliance and ensure an accurate regional accountable entity (RAE) and CMA care coordination. The Department compiles and analyzes CMA CAPs to determine the root cause of deficiencies statewide. Based on the analysis, the Department identifies the need to provide policy clarifications and/or technical assistance, design specific training, and determine whether current processes require modification to address statewide systemic issues.

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**

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

- ◉ **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 3)

Under Section 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 (QIS) 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; and
- 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 QIS is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its QIS, 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 QIS 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 QIS. 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 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

This Quality Improvement Strategy (QIS) encompasses all services provided under the CIH waiver. The waiver-specific requirements and assurances are included in the appendices.
The Department draws from multiple sources when determining the need for and methods to accomplish system design changes. Using data gathered from Colorado Department of Public Health and Environment (CDPHE), Critical Incident Reporting System (CIRS), annual programmatic and administrative evaluations, and stakeholder input, the Department's Office of Community Living (OCL) Benefits and Services Management Division, in partnership with the Case Management Quality and Performance unit 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 state's case management IT system. Workgroups form as necessary to discuss prioritization and selection of system design changes.
Discovery and Remediation Information:
The Department maintains oversight over the (specify waiver) waiver in its contracts/interagency agreements through tracking contract deliverables on a monthly, quarterly, semi-annually, and yearly basis, depending on the details of each agreement. The Department reviews all required reports, documentation, and communications. Delegated responsibilities of these agencies/vendors are monitored, corrected, and remediated by the Office of Community Living.
Colorado selects a representative random sample (unless otherwise noted in the waiver application) of waiver participants for annual review, with a confidence level of 95% margin of error +/-5%, from the total population of waiver participants. The results reflect systemic performance to ensure the waiver is responsive to the needs of all individuals served. The Department trends, prioritizes, and implements system improvements (i.e., design changes) prompted by an analysis of the discovery and remediation information obtained.
To ensure the quality review process is completed accurately, efficiently, and following federal standards, the Department contracts with an independent Long Term Care Utilization Review/Utilization Management (LTC UR/UM) to complete the QIS Review Tool for the annual Case Management Agency (CMA) program case evaluations. Additionally, the Department performs an inter-rater reliability study of results provided by the LTC UR/UM to determine the accuracy of LTC UR/UM reviews.

The Department uses standardized tools for level of care (LOC) eligibility determinations, person-centered support planning, and critical incident reporting for waiver populations. Through the use of the state's case management system, the data generated from LOC eligibility determinations, person-centered support plans, critical incident reports, and concomitant follow-up are electronically available to CMAs and the Department, allowing 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 and waiver programs and allow ongoing analysis. In addition, the Department implemented a new case management system in the Spring of 2023 to streamline processes for identifying member needs and coordinating support. This new system reduces the need for case managers to complete documentation in multiple systems, which in turn reduces chance of errors and/or missing information.

Waiver providers required by Medical Assistance Program regulations to be surveyed by CDPHE must complete the survey before certification to ensure compliance with licensing, qualification standards, and training requirements. The Department is provided with monthly and annual reports detailing the number and types of agencies that have been surveyed, the number of agencies that have deficiencies and types of deficiencies cited, the date deficiencies were corrected, the number of complaints received, and complaints investigated, substantiated, and resolved. Providers not complying with CDPHE and other state standards receive deficient practice citations. Department staff reviews all provider surveys to ensure deficiencies have been remediated and identify patterns and/or problems statewide by service area and the program. The results of these reviews assist the Department in determining the need for technical assistance, training resources, and other needed interventions. The Department initiates termination of the provider agreement for any provider who violates any applicable certification standard, licensure requirements, or provision of the provider agreement and does not adequately respond to a plan of correction within the prescribed time.
Following Medicaid provider certification, the fiscal agent enrolls all providers in accordance with program regulations and maintains provider enrollment information in the Colorado Medicaid Management Information System (MMIS), the interchange. The fiscal agent verifies all provider qualifications upon initial enrollment and in a revalidation cycle at least every five years.
The MMIS, interChange, is designed to meet federal certification requirements for claims processing. Submitted claims are adjudicated against interChange edits prior to payment. Claims are submitted through the Department's fiscal agent for reimbursement. The Department also engages in a post-payment review of claims to ensure the

integrity of provider billings.
The information gathered from the Department's monitoring processes is used to determine areas that need additional training/technical assistance, system improvements, and quality improvement plans.
Trending:
The Department uses performance results to establish baseline data and to trend and analyze over time. The Department's aggregation and root cause analysis of data are incorporated into annual reports, which provide information to identify aspects of the system that require action or attention.
Prioritization:
The Department relies on various resources to prioritize changes in the state's case management IT system. In addition to using information from annual reviews, analysis of performance measure data, and feedback from case managers, the Department factors in funding appropriation, legislation, and federal mandates.
For changes to the MMIS, interChange, the Department has 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 and 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 canceled. If an order of magnitude is requested, it is reviewed at the next Board meeting. If selected for continuance, the Board decides where the project is ranked in the priority list.
The Department continually works to enhance coordination with CDPHE. The Department engages in quarterly meetings with CDPHE to oversee delegated responsibilities, report findings and analysis, provider licensure/certification and surveys, provider investigations, corrective actions, and follow-up. Inter-agency meeting minutes, decisions, and agreements will be documented following state record maintenance protocol.
Benefit administrators, case management specialists, and critical incident administrators review and analyze quality improvement activities and results.
Implementation:

Implementation of System-Level Improvements:
Before implementation, the Department ensures the following are in place:

- A defined process addressing the identified need
- Policies and instructions to support the new process
- A compliance monitoring strategy with clearly assigned responsibilities
- A communication plan
- An evaluation plan to measure post-implementation success
- A comprehensive implementation strategy

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.

Monitoring and Analyzing System Design Changes:
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 created on baseline data once the baseline data has been collected.
Roles and Responsibilities:
The Office of Community Living Benefit and Services Management Division and the Case Management and Quality Performance Division are primarily responsible for monitoring and assessing the effectiveness of system design changes to determine whether the desired effect has been achieved. This includes incorporating feedback from waiver participants, advocates, CMAs, providers, and other stakeholders.

ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

The Department is continuously assessing and improving processes and systems on an ongoing basis. OCL's Waiver Administration and Compliance Unit evaluates the QIS annually as part of the data collection and analysis for CMS 372 reporting. A formal review of the program occurs again after Waiver Year 3, when three years of data has been collected and causes of trends have been analyzed. This review informs the waiver renewal process. The results of the annual 372 analysis and the formal review are shared with leadership as they occur.

Evaluation of the QIS is the responsibility of the Benefit and Services Management Division, Waiver Administration and Compliance Unit and the Case Management and Quality Performance Division, Quality Performance Section. This evaluation will consider 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 H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- (•) **No**
- ( ) **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ( ) **HCBS CAHPS Survey :**
- ( ) **NCI Survey :**
- ( ) **NCI AD Survey :**
- ( ) **Other** *(Please provide a description of the survey tool used):*

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).*

(a) According to 2 CFR Part 200 - Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards Subpart F - Audit Requirements §200.502 (i), Medicaid payments to a sub-recipient for providing patient care services to Medicaid-eligible individuals are not considered federal awards expended under this part unless a State requires the funds to be treated as federal awards expended because reimbursement is on a cost-reimbursement basis. Therefore, the Dept does not require an independent audit of waiver service providers.

Case Management Agencies (CMAs) are subject to the audit requirements within 2 CFR Part 200 for all Medicaid administrative payments. To ensure compliance with components detailed in the OMB Uniform Guidance, CMAs contract with external Certified Public Accountant (CPA) firms to independently audit their annual financial statements and conduct a Single Audit when applicable. The Dept is responsible for overseeing the performance of the CMAs, reviewing the Single Audits of all CMAs who meet the $1,000,000 threshold, and issuing management decisions on any relevant audit findings.

(b) & (c) Title XIX of the Social Security Act, federal regulations, the Colorado Medicaid State Plan, state regulations, and contracts establish record maintenance and retention requirements for Medicaid services. A case record, medical record, or file must be maintained for each participant receiving a waiver. Providers must retain records documenting the services provided and supporting the claims submitted for six years. Records may be retained for over six years when necessary to resolve any pending matters, such as ongoing audits or litigation.

The Department maintains documentation of provider qualifications to furnish specific waiver services submitted during the provider enrollment process and updates it according to applicable licensure and survey requirements. This documentation includes copies of the Medicaid Provider Participation Agreement, copies of the Medicaid certification, verification of applicable State licenses, and any other documentation necessary to demonstrate compliance with the established provider qualification standards. All providers are screened monthly against the exclusion lists. Providers are compared against the List of Excluded Individuals and Entities (LEIE), the System for Award Management (SAM), the Medicare Exclusion Database (MED), the Medicare for Cause Revocation Filed (MIG), and the state Medicaid Termination file. Comparing providers against these lists allows the Dept to determine if a provider has been excluded by the Office of the Inspector General (OIG), terminated by Medicare, or terminated from another state's Medicaid or Children's Health Insurance Program.

Additionally, the Department monitors the actions of licensing boards to ensure that Medicaid providers are in good standing.

Claims are submitted to the Department's fiscal agent for reimbursement. Claims data is maintained through the Medicaid Management Information System (MMIS), which is designed to meet federal certification requirements for claims processing. Submitted claims are adjudicated against MMIS edits before payment is made.

The duties of providers include the requirement to document care, in/out times, and confirm that care was provided per state rules and regulations. Additionally, appropriate service notes regarding service provision must be completed on each visit. Documentation shall contain services provided, date and time in and out, and a confirmation that care was provided. Such confirmation shall be per agency policy. The Department specifies provider requirements, which are then surveyed and certified by the Colorado Department of Public Health and Environment (CDPHE).

Regarding the post-payment review of claims:

The Compliance Division within the Department is responsible for monitoring the compliance of providers and members with state and federal regulations, as well as Department policies. Internal reviewers conduct post-payment reviews of provider claims submissions to ensure provider billing accuracy and compliance with rules and Department billing policies. Auditing under the Program Integrity and Contract Oversight (PICO) Section, housed within the Division, varies with the review project conducted-including the number and frequency of providers reviewed, the percentage of claims reviewed, and the period of the claims reviewed. Review projects range in size and focus (i.e., whether on provider type or service type) and can either claim data-only reviews or include records submitted by providers. PICO Section reviewers are responsible for conducting research and creating annual work plans for the review projects that will be completed. Data samples and documents to be reviewed are typically selected at random.

Additionally, the PICO Section accepts and evaluates all referrals regarding possible fraud, waste, and abuse by a provider or member. The PICO Section also works with law enforcement agencies on all possible fraud investigations and suspensions and terminations of provider agreements.

The PICO Section oversees post-payment claims review contracts, specifically the Recovery Audit Contractor (RAC)

program. As with the PICO Section's internal reviewers, the RAC is responsible for conducting research and creating annual work plans that outline the review projects to be completed within their respective scope of work. Data samples and records to be reviewed are typically selected randomly; however, the RAC can use proprietary algorithms to choose providers and claims for audit.

All audit and compliance monitoring activities conducted by the PICO Section and the RAC program aim to ensure provider compliance with the requirements of the Provider Participation Agreement and the Health First Colorado Program, specifically the HCBS Waivers Program, as well as those required under §1915(c) of the Social Security Act. Each year, PICO Section reviewers will select a provider claims sample of Medicaid-paid services provided to individuals receiving benefits under the Department's HCBS Waivers program. The sample will include 5,000 or more HCBS waiver claims from a single state fiscal year, pulled at the claim header level and reviewed annually. Individual claim lines that fall under each header are included in the review. The provider claims sample will be a statistically valid sample, reflecting a 95 percent confidence level with a margin of error of no more than 5 percent; however, the sample may exceed the 95 percent confidence level with a margin of error of no more than 5 percent at the discretion of the Department.

HCBS waivers and procedure codes are governed by different state and federal rules, regulations, and policies; each claim will be reviewed for compliance following the applicable laws, regulations, and policies. PICO Section reviewers will audit the provider claims sample by conducting a medical records review to verify that provider documentation substantiates the claims submitted to the Department. The PICO Section will utilize the RAC to conduct audits when practical, ensuring that all reviews for the claims sample are conducted in a timely and efficient manner. The scope of a review is determined by appropriate means such as state and federal rules, referrals, internal and RAC resources, prioritization of work plans, and other reviews that may require immediate attention (such as fraud investigations) as well as data analysis and mining to determine the extent of an issue.

All PICO Section reviews and the RAC utilize multiple regulation sources at the state and federal levels to create review projects as part of the Department's overall compliance monitoring of providers. The research and creation of annual work plans are informed by multiple sources, including the review of fraud, waste, and abuse trends occurring both locally and nationally, preliminary review of claims data, examination of referrals and provider self-disclosures, and the use of data analytics tools and algorithms to identify potential anomalies. Per 10 C.C.R. 2505-10 8.076.2, provider compliance monitoring includes, but is not limited to:

- *Conducting prospective, concurrent, and/or post-payment reviews of claims.*
- *Verifying Provider adherence to professional licensing and certification requirements.*
- *Reviewing goods provided and services rendered for fraud and abuse.*
- *Reviewing compliance with rules, manuals, and bulletins issued by the Department, board, or the Department's fiscal agent.*
- *Reviewing compliance with nationally recognized billing standards and those established by professional organizations including, but not limited to, Current Procedural Terminology (CPT), Current Dental Terminology (CDT), and Healthcare Common Procedure Coding System (HCPCS).*
- *Reviewing adherence to the terms of the Provider Participation Agreement.*

Additional criteria are included in the review project's guidelines depending on the type of review project completed. For instance, audits of HCBS Waiver services rendered by Medicaid providers, as reviewed by PICO Section reviewers and the RAC, will include whether providers comply with multiple HCBS Waiver programs. All PICO Section and RAC reviews are required to follow audit and recovery rules outlined in C.R.S. 25.5-4-301 and 10 C.C.R. 2505-10 Section 8.076.3.

All reviews will be desk reviews; however, the Department and its vendors must perform reviews as required under Colorado regulations. Under 10 C.C.R. 2505-10 Section 8.076.2.E., providers can inspect or reproduce the records by the Department or its designees at the providers' site. All identified overpayment recoveries, suspected false claims, and/or fraud will be reported to the PICO Section for review and to any additional agencies, including the Colorado Medicaid Fraud Control Unit. Any identified overpayments stemming from the reviews will follow the rules outlined in 10 C.C.R. 2505-10 Section 8.076.3.

Additional information on Appendix I is in Main B. Optional.

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 Assurance:

The state must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program.

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

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:
I.a.3 Number and percent of paid waiver claims with adequate documentation that services were rendered N: Number of claims with adequate documentation of services rendered D: Total number of claims in the sample

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

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

	Ongoing	*Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

Performance Measure:
I.a.1. Number and percent of waiver claims coded and paid according to the reimbursement methodology in the waiver N: Number of waiver claims coded and paid according to the reimbursement methodology in the waiver D: Total number of paid waiver claims in this sample

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

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

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

Data Aggregation and Analysis:

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

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

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

Performance Measure:
I.b.2 Number and percent of rates adjusted that demonstrate the rate was built in accordance with the approved rate methodology. N: Number of rates adjusted that demonstrate the rate was built in accordance with the approved rate methodology D: Total number of rates adjusted reviewed

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
MMIS data and Rates Tables

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% confidence level 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:
I.b.1 Number and percent of claims paid where the rate is consistent with the approved rate methodology in the approved waiver N: Number of claims paid where the rate is consistent with the approved rate methodology in the approved waiver D: Total number of paid waiver claims reviewed

Data Source *(Select one):*
Other

If 'Other' is selected, specify:
MMIS data

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

Data Aggregation and Analysis:

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

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

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's primary method of discovery is the information gathered for the annual reporting of the performance measures.

The state ensures that claims are coded correctly through several mechanisms:
1. Rates are loaded with procedure code and modifier combinations; thus, any use of incorrect coding results in a claim paid at $0.00 or a denied claim,
2. System edits exist to ensure that only specific (appropriate provider types) can bill for waiver services; and
3. Lastly, reviewing claims in conjunction with the Department's published billing manual identifies any incorrect coding that resulted in a paid claim.

Providers' duties include documenting care, in/out times, and confirming that care was provided by state rules and regulations. Additionally, appropriate service notes regarding service provision must be completed for each visit. The documentation shall contain the services provided, the date and time of entry and exit, and a confirmation that care was provided. Such confirmation shall be in accordance with agency policy. CDPHE then reviews this upon survey.

All waiver services included in the participant's service plan must be authorized by case managers prior. Approved Prior Authorization Requests (PARs) are electronically uploaded into the MMIS. The MMIS validates the prior authorization of submitted claims. Claims submitted without prior approval are denied.

When a claim is billed to Medicaid, in addition to the five elements above, the MMIS is configured to check for a Prior Authorization Request (PAR) that matches the procedure code, allowed units, date span, and billing/attending provider before rendering payment. The claims data reported in the quality performance measures were pulled and analyzed from the MMIS.

I.a.1
This performance measure ensures that claims paid for waiver services are coded correctly for each waiver service. Correct coding is defined as using the proper procedure code and modifier combination for each service determined by the Department. Correct coding ensures that services are paid only when approved, authorized, and billed correctly.

I.a.3
The Department utilizes the member's Prior Authorization Request (PAR) to document services rendered. Case managers monitor service provision to ensure services are provided according to the service plan. Case managers inform the Department of discrepancies between a provider's claim and what the participant reports have occurred or if the participant reports that the provider is not providing services according to the service plan. The Department initiates an investigation to determine if an overpayment occurred.

I.b.1
This performance measure ensures paid claims for waiver services are paid at or below the rate specified in the Provider Bulletin and HCBS Billing Manual. Additionally, the Department posts all rates in the Provider Fee Schedule section of the

external website, allowing providers to access them at their convenience. This performance measure enables the Department to identify system issues or errors that result in incorrect reimbursement for services rendered.

I.b.2
The Benefits and Services Management Division staff review the rate adjustments to ensure that the rates comply with the approved rate methodology outlined in the waiver.

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 and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.*

Benefits and Services Management Division (BSM) staff initiate any edits to the Medicaid Management Information System (MMIS) that are necessary for the remediation of any deficiencies identified by the annual reporting of performance measures. Any inappropriate payments or overpayments identified are referred to the Program Integrity (PI) Section for investigation, as detailed in Appendix I-1 of the application.

I.a.1
The Department remediates any incorrect coding that results in paid claims. The BSM Division staff collaborates with the Department's Rates Division and Health Information Office to initiate any necessary edits to the MMIS for the remediation of deficiencies identified through annual performance measure reporting.
In the event an overpayment is discovered, an accounts receivable balance is established with the provider. Overpayments are referred to the PICO Section for investigation, as detailed in Appendix I-1 of the waiver application.

I.a.3
In the event an overpayment is discovered, an accounts receivable balance is established with the provider. Overpayments are referred to the PI Section for investigation, as detailed in Appendix I-1 of the waiver application.

I.b.1
Errors identified during claims data analysis, such as paying more than the Department's allowable rate, may be attributed to incorrect rates in prior authorization forms or additional system safeguards not being in place by the Department. PAR entry errors are addressed with CMAs to prevent future billing errors. The providers receiving overpayments are notified of payment errors, and the Department establishes an accounts receivable balance to recover the overpayments. The Department reviews errors to determine what additional safeguards are needed to prevent future overpayments.

I.b.2
The BSM Division staff coordinate with the Department's Claims Systems and Operations Division staff to initiate any necessary edits to the MMIS for the remediation of deficiencies identified during performance measure reporting.

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***

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
	☑ ***Other*** *Specify:* *As needed based on severity of occurrence or compliance issue.*

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ ***No***

○ ***Yes***

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

Appendix I: Financial Accountability

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

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

The HCBS Waiver for Complementary and Integrative Services (CIH) utilizes Fee-for-Service (FFS), negotiated market price, and public pricing rate methodologies. Each rate has a corresponding unit designation, and reimbursement is calculated as the rate multiplied by the number of units utilized. HCBS-CIH rate schedules are published annually through the Department's Provider Bulletin and made available for waiver participants and stakeholders on the Department's website. Notification of changes to the fee schedule is sent out in the Provider Bulletin and can also be found on the Department's website.

The rate methodology for these services was last reviewed in 2024. The Department examined the rates and rate methodology for the CIH waiver in conjunction with waiver renewal. The state measures sufficiency and compliance with CMS regulations, assessing the sufficiency, economy, and quality of care to enlist providers through an analysis of paid claims, showing both increases in service utilization and the number of providers yearly. In conjunction with the Department's rate methodology, these services are also reviewed through the Medicaid Provider Rate Review Advisory Committee, which conducts geographic analyses related to waiver services. These analyses include the abovementioned measures to determine if rates are sufficient to maintain or improve access to care. This report incorporates a stakeholder feedback period, which is also integrated into the rate review, claims data analysis, and future rate updates to ensure the methodology encompasses all elements of service delivery and quality of care.

The Department's Waiver and Fee Schedule Rates Section determines rates for waiver services. The rate determination process is supervised by reviewing state and federal regulations, which ensure that the regulations inform the process.

The Department has adopted a rate methodology incorporates the following factors for all services not included in the negotiated price or public pricing methodology described below:

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

B. Minimum Wage Consideration:
The state will prospectively implement a differential in the rate structure to account for variances in minimum wage requirements, as directed by state legislation or local ordinances, to acknowledge unique geographical considerations that impact access to care. Distinct rates by locality, county, metropolitan area, and other regional boundaries will be considered and implemented as the Department reviews potential access to care considerations that impact rates. The Department will update the corresponding rates per the approved rate methodology upon the subsequent waiver amendment or renewal. Any state rate methodology changes will be reviewed and amended per 42 CFR 441.304.

C. Facility Expense Expectations:
Incorporates the facility type using existing property records, which list square footage and actual cost. Facility expenses include estimated repair and maintenance, utility, and phone and internet services. Industry standards determine repair and maintenance prices per square foot and vary depending on whether the facility is leased or owned. Utility pricing includes gas and electricity, which are determined annually by the Public Utility Commission. This commission provides summer and winter rates, as well as therm conversions, for appropriate pricing. Finally, internet and phone services are determined using the Comcast Business Class website's Build Your Own Bundle tool.

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

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

All Facility, Administrative, and Capital Overhead expenses are reduced to a per-employee cost multiplied by the total full-time equivalent (FTE) required to provide services to each Medicaid member. A budget neutrality adjustment is applied to the final determined rate to ensure rates do not exceed funds appropriated by the Colorado State Legislature.

HCBS CIH FFS rates utilizing the methodology described above include:

- *Adult Day Health - Adult Day Tier 1*
  - *Adult Day Health - Adult Day Tier 2*
  - *Adult Day Health - Adult Day Tier 3*
  - *Adult Day Health - Adult Day Specialized*
- *Homemaker (ended 6/30/26)*
  - *Homemaker Remote Supports (ended 6/30/26)*
- *Personal Care (ended 6/30/26)*
  - *Personal Care Remote Supports (ended 6/30/26)*
- *Relative Personal Care (ended 6/30/26)*
- *Respite-Alternative Care Facility*
- *Respite-In Home*
- *Respite-Skilled Nursing Facility*
- *Complementary & Integrative Health-Acupuncture*
- *Complementary & Integrative Health-Chiropractor*
- *Complementary & Integrative Health-Massage*
- *Consumer Directed Attendant Support Services (ended 6/30/26)*
- *Home Delivered Meals (ended 6/30/26)*
- *In-Home Support Services (IHSS)-Health Maintenance (ended 6/30/26)*
- *In-Home Support Services (IHSS)-Homemaker (ended 6/30/26)*
- *In-Home Support Services (IHSS)-Personal Care (ended 6/30/26)*
- *Life Skills Training*
- *Life Skills Training - Telehealth*
- *Non-Medical Transportation-(Mobility Van, Wheelchair Van)*
- *Peer Mentorship*
- *Peer Mentorship - Telehealth*
- *Transition Setup (ended 6/30/26)*
  - *Wellness Education Benefit*

The HCBS CIH waiver utilizes a negotiated market price methodology for services, where reimbursement varies based on the member, product, and frequency of use. The services utilizing the negotiated market price methodology include:

- *Home Modifications*
- *Medication Reminder (ended 6/30/26)*
- *Non-Medical Transportation-(Taxi)*
- *Personal Emergency Response System (PERS) (ended 6/30/26)*
  - *Remote Support Technology (ended 6/30/26)*

The HCBS CIH waiver utilizes a public pricing methodology for public services. Services with public pricing methodology are reimbursed at the price paid by the public for the same service. Non-Medical Transportation (NMT)-Public Transit uses a public pricing methodology. NMT-Public Transit will be reimbursed at the RTD discounted rates for seniors 65 and above, individuals with disabilities, and Medicare recipients. The RTD rates can be found at the following link: http://www.rtd-denver.com/Fares.shtml. The discounted rates reimbursed by Medicaid are denoted by a single asterisk (*). RTD rates are updated annually in January. The Department will update the rates and fee schedules annually in January to align with annual changes.

For the above-listed services, case managers coordinate with providers to determine a market price that incorporates the member's required products and the frequency of use. Home Modification services require two (2) competitive bids, which are reviewed by the case manager and approved by the Department of Housing. Home Modification services are limited to $14,000 for a lifetime. All services are prior authorized, and service reimbursement may not exceed prior authorized amounts.

The state's process for soliciting public comment on rate determination methods involves a standardized and documented process consisting of the Presentation of Rate Setting Methodology to stakeholders before or during rate-setting and

solicitation of feedback on methodology, 30 days to receive feedback from providers, and community stakeholders, publishing of the rates as determined by the state's methods in conjunction with a stakeholder presentation reviewing the methodology, providing guidance on documents that would be provided to stakeholders, stakeholder deliverable sent to providers following presentation included all services and the direct/indirect care hours, wage, BLS position, and capital equipment included and offered providers an extended (60 day) period to provide feedback. All feedback is reviewed, and feedback that can be validated is incorporated into the rates. All information from the stakeholder process is posted on the Department's external website. Additional information on public input is in Main 6-I

After the rate is implemented, only legislative increases or decreases are applied. These legislative rate changes are often annual and reflect inflationary increases or decreases. The rates for the HCBS CIH waiver are reviewed for appropriateness every five years during the waiver renewal.

Additional information is in Main B. Optional.

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:*

Billing validation is accomplished primarily by the Department's Medicaid Management Information System (MMIS). The MMIS is designed to meet federal certification requirements for claims processing, and submitted claims are adjudicated against MMIS edits before payment. The Department also validates billings by conducting a post-payment review on a representative sample of claims.

(a) The Colorado Benefits Management System (CBMS) is a unified data collection and eligibility system. It allows for improved access to public assistance and medical benefits by permitting faster eligibility determinations and increasing accuracy and consistency in eligibility determinations statewide. The electronic files from CBMS are downloaded daily into the MMIS to ensure updated eligibility verification for dates of service claimed. When a claim is filed, the first edit in the MMIS ensures that the waiver member is eligible for Medicaid services. Claims submitted for members who do not qualify on the service date are denied.

(b) All waiver services included in the participant's PCSP must be prior authorized by case managers. Approved Prior Authorization Requests (PARs) are electronically uploaded into the MMIS. The MMIS validates the prior authorization of submitted claims. Claims submitted without prior authorization are denied.

(c) The Department engages in a post-payment review of claims to ensure provider billings' integrity. Annually, a statistically valid, random sample of claims (95% confidence level and 5% margin of error) is identified for an audit. These audits include a review of whether required prior authorizations were obtained; PCSPs included the services, and provider documentation (e.g., timesheets, supervisory visit notes, provider training, and case management notes) supports the service billed. The Department undertakes recovery action for any identified overpayments, and the federal share of identified overpayments is returned to the Federal Government.

Case managers monitor service provision to ensure services are provided according to the service plan. If a discrepancy between a provider's claim and what the member reports occurs or the member reports that the provider is not providing services according to the service plan, the case manager reports the information to the Department for investigation.

The Department operates an Electronic Visit Verification (EVV) system to document that a defined set of HCBS services are provided to members.

Electronic Visit Verification (EVV) is a technology used to verify that home-or community-based service visits occur. The purpose of EVV is to ensure that services are delivered to people needing those services and that providers only bill for services rendered. EVV typically verifies visit information through a mobile application on a smartphone or tablet, a toll-free telephone number, or a web-based portal.

EVV captures six points of data as required by the 21st Century Cures Act: the individual receiving the service, the attendant providing the service, the service provided, the location of the service, the date of service, and the time that service provision begins and ends.

The Department implemented a hybrid or open EVV model. The State contracts with an EVV vendor for a state-managed solution. This solution is available to providers at no cost. Providers may also utilize an alternate EVV system procured and managed by the agency. The State's EVV Solution and Data Aggregator for alternate vendor data transfer are available.

Services that must be electronically verified: As of August 3, 2020, the Department implemented EVV for federally mandated and additional services that are similar in nature and service delivery. The Department mandates Electronic Visit Verification (EVV) per CCR 2505-10 Section 8.001. Required EVV waiver services include:
Life Skills Training (LST)
Respite

The Department also mandates EVV for the following State Plan Services:
Home Health
Occupational Therapy
Pediatric Behavioral Therapies
Pediatric Personal Care
Physical Therapy
Private Duty Nursing

Speech Therapy
Consumer Directed Attendant Support Services
Homemaker
In-Home Support Services
Personal Care

On February 1, 2022, the Department activated a pre-payment EVV claim edit. EVV-required services, excluding CDASS, require corresponding EVV records before payment. This has resulted in improved provider compliance and better oversight of service provision.

Provider agencies utilizing the State EVV Solution have access to a portal to view and modify visit activity and, in limited circumstances, create EVV records. All information entered via the provider portal is notated as manual entry or edit and is subject to Department audit.

If the caregiver cannot collect EVV data at the time of service delivery, provider agencies will need to enter missing data. Within the State EVV Solution, an agency administrator may complete visit maintenance in the EVV Solution provider portal. The administrator will enter the missing data and select a reason code for why a manual entry was made. Manual entry may be entered on a case-by-case basis. Manual entries are subject to increased scrutiny by the Department, and providers must maintain service records for these visits.

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

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

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

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

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

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

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

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

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

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

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

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☑ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☐ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

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

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

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

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

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

◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***

○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

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

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

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

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

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

Select County Departments of Public Health provide home health and personal care services for waiver members. The amount of 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:

The member can select from any enrolled provider, including the OHCDS. The case manager is agnostic about the choice of service provider and does not have any financial incentive for the choice a member makes. Case managers are not directly compensated for acting as the OHCDS. The administrative payment for the OHCDS is a flat rate; it does not fluctuate based on the number of services provided by an OHCDS direct service provider. The case manager and their family members are prohibited from having direct ownership in a provider agency that contracts under the OHCDS. The case manager is not involved in direct service provision; they facilitate access to the direct service only.

(a) Each Case Management Agency (CMA) is designated as an OHCDS, as outlined in their contract with the Department.

(b) Department regulations require that case managers inform members, guardians, and/or authorized representatives about all choices that may address the needs and outcomes identified in the person-centered (PCSP). This includes providing information for all qualified providers in the area, including those enrolled with Medicaid or those available through the OHCDS. The Department's website also contains a statewide list of qualified providers for waiver services accessible to any community member.

If a member wishes to utilize a specific direct service provider that is not enrolled with Medicaid, the case manager will encourage the provider to enroll with Medicaid. If the direct service provider does not agree to complete the enrollment process, the case manager may contract with the direct service provider under the OHCDS if it is an allowable service under this model. The CMA will ensure that the direct service provider meets the provider's qualifications. The Department maintains documentation of qualifications for all providers. This documentation includes copies of the Medicaid Provider Agreement, copies of the Medicaid certification, verification of applicable State licenses, and any other documentation necessary to demonstrate compliance with the established provider qualification standards. The CMA will then complete a contract with the provider, outlining the OHCDS's pass-through responsibilities.

(c) Case managers are critical to ensuring members receive the supports and services included in their PCSP in a manner consistent with what is important to and essential for the individual. The case manager presents the member with all the choices for direct service provision. If there are no willing or qualified direct service providers, the member may elect to receive direct services through an OHCDS provider for an allowable service. Members have free choice of all qualified and enrolled providers across the state, including those not affiliated with an OHCDS.

The case manager or their family members are not permitted to be conflicted or have a financial interest in any entity paid to provide care to the member. Case management activities must be independent of service provision. An entity agency or organization (or their employees) cannot provide both direct service and case management activities to the same individual except in those cases where a rural exception has been granted, which does not apply to OHCDS.

(d) The OHCDS agencies subcontract with providers or independent contractors, for which the OHCDS has verified to have met all applicable licensing and/or established provider qualification standards. The Department ensures that OHCDS subcontractors meet provider qualifications through administrative monitoring. Verifying and monitoring the service delivery of enrolled participants receiving a defined service from a qualified provider is the responsibility of the OHCDS. These standards are detailed at 10 CCR 2505-10 8.7202.W.

(e) The Department will provide a standard base contract that the CMA can use to contract with direct service providers. This will ensure that all requirements are met within the contract.

(f) Financial accountability is assured for services delivered in the OHCDS arrangement through the same methods and processes used for services delivered in a direct service provider arrangement, as described in Appendix I-1 and Appendix I-2.d of this application.

iii. Contracts with MCOs, PIHPs or PAHPs.

- ***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 section 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 section 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 section 1915(b)/section 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 section 1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ***This waiver is a part of a concurrent section 1115/section 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 section 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

  In the text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 1915(a)(1) of the Act to furnish waiver 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 section 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.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☑ ***Appropriation of State Tax Revenues to the State Medicaid Agency***

☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

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

☑ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

The Department of Health Care Policy and Financing (HCPF) has established the Colorado Health Care Affordability and Sustainability Fee Cash Fund, created by the Colorado Legislature, to fund the Medicaid Buy-In Program for Working Adults with Disabilities. Eligible Members pay a monthly premium. The funds are transferred to HCPF's operating bank account. The funds are expended as part of ongoing operations at HCPF and are treated in the same way the Department would pay other expenditures.
There are no IGTs or CPEs, as no other Colorado state departments are involved.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable****. There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***

○ ***The following source(s) are used***

Check each that applies:

☐ ***Health care-related taxes or fees***

☐ ***Provider-related donations***

☐ ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

● ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***

○ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

● ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***

○ ***Yes. Per 42 CFR § 441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- ◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ ***Nominal deductible***
- ☐ ***Coinsurance***
- ☐ ***Co-Payment***
- ☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- (●) ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ( ) ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: Hospital, Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	48047.80	43912.36	91960.16	169375.28	45532.19	214907.47	122947.31
2	3823.87	65001.29	68825.16	112107.72	37544.95	149652.67	80827.51
3	3821.03	71797.17	75618.20	115430.00	38192.60	153622.60	78004.40
4	3887.92	79303.56	83191.48	118850.74	38851.42	157702.16	74510.68
5	4007.07	87594.75	91601.82	122372.85	39521.61	161894.46	70292.64

Appendix J: Cost Neutrality Demonstration

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

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

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
		Hospital	Nursing Facility
Year 1	544	110	434
Year 2	672	136	536

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 3	831	169	662
Year 4	831	169	662
Year 5	831	169	662

Appendix J: Cost Neutrality Demonstration

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

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

The Department estimated the average length of stay (ALOS) on the waiver by reviewing historical data and data included in the CMS-372 reports for fiscal years 2021-22 and 2022-23. Because the ALOS has declined over FY 2022-23, the Department maintained the exact estimate as in the previous amendment, assuming a constant growth rate of 0.00% for the first two fiscal years. For the following years, the Department estimated a 1.33% growth rate, which is the average growth rate from FY 2018-19. The Department has used the average growth rate from SFY 2018-19 to forecast SFY 2025-26 and onward. This growth rate is used because this waiver has experienced growth in recent years (specifically between SFY 2019-20 and SFY 2020-21), and the Department expects that the trend will continue.

Update for WY 2-5 in Amendment with the requested effective date of 7/1/2026:
The Department estimated the average length of stay (ALOS) on the waiver by reviewing historical data and data included in the 372 data report for FY 2022-23 and FY 2023-24. Because the ALOS has declined over FY 2022-23 and increased over FY 2023-24, the Department took the average of the FY 2022-23 and FY 2023-24 trend factors and is applying the average of 0.84% annually to the ALOS from FY2023-24 through WYs 2 through WY 5.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

Update for WYs 1-5 for renewal application with a requested effective date of 7-1-2025:
The department forecasts the number of clients utilizing each service and the number of units per user. The Department examined historical growth rates, the fraction of the total waiver population that utilizes each service, and graphical trends to select appropriate trends. The number of users, units per utilizer, and cost per unit are all multiplied together to calculate the total expenditure for each service, and those expenditures are added together to derive Factor D. The updated data source is the SFY 2022-23 372 waiver report, which includes data from July 2022 through June 2023.

Number of Users: The data sources are the 372 waiver reports, and the most recent data utilized is the FY 2022-23 372 waiver report. Services are forecasted individually based on historical growth rates determined by the average number of users. The primary trend used is the average of the past two fiscal years (SFY 2021-22 and SFY 2022-23). For services with decreasing utilization, the Department has maintained the FY 2022-23 CMS-372 actuals at a constant level. For services with no utilization, the Department has assumed one unit of utilization.

The number of utilizers for Home Modification has been forecasted by multiplying the average growth between FY 2021-22 and FY 2022-23 by 4, based on regulatory changes to the service explained further below. During the PHE, an additional $10,000 in funding through ARPA was available to all members on the CIH waiver. This additional amount of available funding made it more challenging to anticipate the increase in how much each member would spend per year once the PHE and ARPA funding ended. Since 2021, we have seen an increase of approximately $1,500 per member per year in spending on home modification projects. Given the regulatory change, as well as the continued rise in inflation and current rates for contractors across the state, we anticipate that the total amount each member spends per year will be closer to the full $14,000 available. Over the past year, we have also increased outreach to Case Management Agencies and Stakeholders regarding the home modification benefit. With the upcoming regulation change, we will continue this outreach, which we anticipate will increase the overall number of projects completed.

For Personal Emergency Response Systems - Monthly, this trend is constant at 2, based on actual FY 2022-23 data. The units per utilizer are trended using the main trend, which is the average of the past two years, SFY 2021-22 and SFY 2022-23.

Average Units per User: The data source is the CMS-372 waiver reports, and the most recent data utilized is the FY 2022-23 372 waiver report. Services are forecasted individually based on historical growth rates determined by the average number of units per user. The primary trend is the average of the previous two fiscal years (SFY 2021-22 and 2022-23).

Average Cost per Unit: The data source is the CMS-372 waiver reports, and the most recent data utilized is the FY 2022-23 372 waiver report. Rates are developed using the rate methodology in I-2-a. The rate methodology for these services was last reviewed in 2024. All rate increases and decreases are subject to legislative appropriations.

For the Home Modification service, the Department has increased the expected cost per user based on several factors. Due to inflation, the Department expects that total costs will continue to rise. Also, there have been changes in the regulations for non-IDD waivers, which change the access to services for members. Previously, the service was billed as a lifetime allowance, meaning a member had a maximum amount of money to use for home modification throughout their lifetime. The service has now shifted, so the lifetime allowance will reset when the waiver is reset. The Department expects this to increase utilization and thus increase the service's total cost.

For the Non-Medical Transportation service, there are two subcategories of transportation members are authorized to use. The first is basic Non-Medical Transportation, which includes access to transportation options such as RTD Access-A-Ride, taxis, and Wheelchair Vans. This service portion has a unit cap of 208 trips (or 104 round trips) per member. The second subcategory of this service is limited to rides to and from Adult Day services. Members have a unit cap of 730 trips (or up to 7 round trips per week).

Due to the end of the Public Health Emergency (PHE), the Department forecasts all services based on actual utilization and the number of users identified in the SFY 2022-23 CMS-372 report. Most services are forecasted using the primary trend, the average percent growth over the previous two years (SFY 2021-22 to SFY 2022-23).

Services where users are forecasted differently due to recently observed trends include Massage Therapy, Life Skills Training, IHSS Health Maintenance, IHSS Personal Care, Medication Reminder (Service), Relative Personal Care, Non-Medical Transportation, and Personal Emergency Response System - Monthly. Services where the units per utilizer are forecasted differently due to recently observed trends include Chiropractic, Massage Therapy, Consumer-Directed Support Services, Homemaker, Home Modifications, IHSS Health Maintenance, IHSS Homemaker, IHSS Personal Care, Personal Care, and Relative Personal Care. Certain years of data are excluded because they are considered outliers based on outdated policies, sudden changes in utilization, new service limits, or other reasons. By policy and procedure, these characteristics are used to determine when data is an outlier.

Life Skills Training and Life Skills Training Telehealth units per utilizer and utilizers are both held constant, as there was no utilization in FY 2021-22; therefore, the Department is unable to forecast using the previous two years' average growth.

Relative Personal Care utilizers have been forecasted differently, as the number of utilizers has been held constant for FY 2024-25 and onward. This is due to the lack of growth observed between FY 2021-22 and FY 2022-23.

Update for WY 1-5 with requested amendment effective date of January 1, 2026.
The Department is updating Appendix J Avg. Cost/Unit to reflect rate increases received through the 2025 legislative session. The following services received a 1.6% increase effective July 1, 2025:
Adult Day Tier 1 1.60%
Adult Day Tier 2 and Adult Day Tier 3 1.60%
Adult Day Specialized 1.60%
Complimentary and Integrative Health Services (CIH) - Acupuncture 1.58%
Complimentary and Integrative Health Services (CIH) - Chiropractic 1.61%
Complimentary and Integrative Health Services (CIH) - Massage Therapy 1.62%
Consumer Directed Attendant Support Services 1.60%
Homemaker 1.60%
Life Skills Training 1.61%
Life Skills Training - Telehealth 1.61%
Home Delivered Meals 1.59%
Transition Coordinator 1.54%
Peer Mentorship 1.54%
Peer Mentorship - Telehealth 1.54%
IHSS - Health Maintenance 1.60%
IHSS - Homemaker 1.60%
IHSS - Personal Care 1.60%
Non-Medical Transportation 1.59%
Personal Care 1.60%
Relative Personal Care 1.60%
In-Home Respite 1.69%
Remote Support 8.97%
Respite NF 1.60%
Respite ACF 1.89%

The State estimates rates based on a weighting of the location in which services are rendered and the rates in each location. The State received an Across the Board (ATB) increase of 1.6% for services inside and outside Denver County. The State updated the weighted rates for services based on new utilization trends. Due to this weighting, rate increases may not align with the 1.6% increase.

Update for WYs 2-5 in Amendment with the requested effective date of 7/1/2026:
The Department forecasts the number of clients utilizing each service and the number of units per user. To select appropriate trends, the Department examined historical growth rates, the fraction of the total waiver population

that utilizes each service, and graphical trends. The number of users, units per user, and cost per unit are multiplied together to calculate the total expenditure for each service, and those expenditures are added together to derive Factor D. The updated data source is the SFY 2023-24 CMS 372 data report, which includes data from July 2023 through June 2024.

Number of Users: The source of the data is the CMS 372 data reports, and the most recent data utilized is the FY 2023-24 CMS 372 data report. Services are forecasted individually based on historical growth rates determined by the average number of users. The main trend used is the average of the past two fiscal years. For services with no utilization, the Department has assumed one user. Beginning in FY 2026-27 and ongoing, the Department assumes zero users for Community First Choice services.

Average Units per User: The source of the data is the CMS 372 data reports, and the most recent data utilized is the FY 2023-24 CMS 372 data report. Services are forecasted individually based on historical growth rates determined by the average number of units per user. The main trend used is the average of the previous three fiscal years.

Average Cost per Unit: The source of the data is the CMS 372 data reports, and the most recent data utilized is the FY 2023-24 CMS 372 data report. The rates have been updated to reflect the new rates for FY 2025-26. The rates for Adult Day Tier 1, Adult Day Tier 2 and Tier 3, Adult Day Specialized, and Wellness Education Benefit are weighted between separate rates for Denver and non-Denver. The percentage change in the rates reflects a 1.6% decrease. However, there is a different percentage change due to the weight of services between Denver and non-Denver changing between the two waiver years.

Due to the end of the Public Health Emergency (PHE), the Department is now forecasting all services based on the actual utilization and number of users found in SFY 2023-24. Most services are forecasted using the main trend, which is the average percentage growth over the previous three years, from SFY 2021-22 to SFY 2023-24.

Services for which users are forecasted differently due to recently observed trends are Adult Day Tier 2 and Adult Day Tier 3, Adult Day Tier 3, Acupuncture, Massage Therapy, Homemaker - In Person, Home Delivered Meals, Peer Mentorship, Peer Mentorship - Telehealth, Homemaker - Remote Support, Personal Care - Remote Support, Remote Support, IHSS - Personal Care, Non-Medical Transportation, Personal Care - In Person, Personal Emergency Response Systems - Monthly, Respite - In-Home, Respite - NF, and Respite - ACF.

Beginning in FY 2026-27 and ongoing, the Department assumes zero units per user for Community First Choice services. The CFC services are Consumer Directed Attendant Support Services (CDASS), Homemaker - In Person, Home Delivered Meals, Transition Setup Coordinator, Transition Setup Expense, Homemaker - Remote Support, Personal Care - Remote Support, IHSS - Health Maintenance, IHSS - Homemaker, IHSS - Personal Care, Medication Reminder, Personal Care - In Person, Relative Personal Care - In Person, Personal Emergency Response Systems - Install, Personal Emergency Response Systems - Monthly, and Remote Support.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

To calculate State Plan services costs associated with CIH waiver clients, the Department analyzed historical D' values, which are found in previous 372 waiver reports. D' has been increasing from SFY 2020-21 through SFY 2022-23, with a larger increase in SFY 2022-23. The growth rate selected is the same as the SFY 2020-21 through SFY 2022-23 average growth rate, which is 8.71%. This was calculated using the Departments Cost Per Client Forecast. For WY 3, an 8.71% growth rate was applied to the SFY 2022-23 actuals from the CMS data report. This same trend was then applied on the estimated total for each waiver year, which is how WY 5 was estimated. The Department is assuming that this growth trend will continue, as utilization and users continue to increase.

The WY 1 estimate was calculated through the average growth rate between FY 2019-20 and FY 2022-23. This data is from the CMS 372 actual data from FY 2019-20 through FY 2022-23. The growth rate has been updated to hold the 8.30% growth rate constant for all waiver years.

Update for WY 2-5 in Amendment with the requested effective date of 7/1/2026:
To calculate State Plan services costs associated with CIH waiver clients, the Department analyzed historical D' values, which are found in previous 372 waiver reports. D' has been increasing from SFY 2020-21 through SFY 2023-24, with a larger increase in SFY 2023-24. The growth rate selected is the average of growth rate between FY 2021-22 and FY 2022-23 divided by two which is 10.46%. This amount was selected based on recent trends in claims data. This was calculated using the Departments Cost Per Client Forecast. For WY 5, a 10.46% growth rate was applied to the SFY 2023-24 actuals from the CMS data report. This same trend was then applied on the estimated total for each waiver year. The Department is assuming that this growth trend will continue, as utilization and users continue to increase.

The WY 1 estimate was calculated through the average growth rate between FY 2021-22 and FY 2022-23 divided by 2. This data is from the CMS 372 actual data from FY 2021-22 and FY 2022-23. The growth rate has been updated to hold the 10.46% growth rate constant for all waiver years. Starting in FY 2026-27, the Department is adding the assumed Community First Choice Services to D' as these services will then be fully on the State Plan.

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 the average state plan costs for CIH waiver members the Department updated the base cost estimate from FY 2022-23 using actual reported state plan expenditures and trended the costs forward in each year of the amendment by the state plan average growth rate from FY 2019-20 through FY 2023-24 (17.32%). State plan costs refer to the institutional costs associated with Hospital and Nursing Facility costs that would be incurred by CIH waiver participants without the CIH waiver. The Factor G estimates are collected by using claims data on actual members on each waiver and claims for members with comparable level of care on the state plan receiving institutionalized care. The state estimates factor G based on actual data of comparable members and estimates the alternative cost of care based on those claims. The base year that the Factor G estimate is based on is the FY 2022-23 actual. The Factor G trend is selected using the actual FY 2019-20 through FY 2023-24 growth rate. The data pulled for the CIH waiver resulted in the following Factor G figures: SFY 2023-24 $123,052.23, SFY 2022-23 $105,179.99, SFY 2021-22 $117,002.48, SFY 2020-21 $114,705.12, and SFY 2019-20 $105,447.15. The State trended utilizing this data with Factor G growing by 17.32%.

Update for WY 2-5 in Amendment with the requested effective date of 7/1/2026:
To calculate the average state plan costs for CIH waiver members the Department updated the base cost estimate from FY 2023-24 using actual reported state plan expenditures, and trended the costs forward in each year of the amendment by the state plan average growth rate from FY 2021-22 through FY 2023-24 (2.96%). State plan costs refer to the institutional costs associated with Hospital and Nursing Facility costs that would be incurred by CIH waiver participants without the CIH waiver.

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:*

To calculate the state plan costs for institution-level clients on the CIH waiver, the Department updated the annual growth factor to equal the average percent increase in per-client state plan costs from FY 2020-21 to FY 2023-24, which was 4.44%. The data source is actual Factor G' costs pulled internally by the Department's Data Analytics Section. The Department applied this trend based on the estimated institutional costs for CIH waiver members, as reported in FY 2023-24, and forward to each subsequent year in the renewal. The Factor G' base year is FY 2023-24. The data pulled for the CIH waiver resulted in the following G' figures: SFY 2023-24 $41,745.11, SFY 2022-23 $35,820.53, SFY 2021-22 $35,532.68, SFY 2020-21 $36,681.96, and SFY 2019-20 $35,430.84. The State trended utilizing this data with Factor G' growing by 4.44%.

Update for WY 2-5 in Amendment with the requested effective date of 7/1/2026:
To calculate Factor G' for the CIH waiver, the Department used the estimated state plan/non-institutional Medicaid costs for the comparable institution-level population, consistent with the purpose of Factor G' in the 1915(c) waiver cost-neutrality calculation. The Factor G' base year is FY 2023-24. The Department updated the annual growth factor using the average percentage increase in per-client state plan costs from FY 2023-24 to FY 2024-25, which was 1.73%. This 1.73% trend factor was applied to the FY 2023-24 estimated state plan/non-institutional Medicaid costs for CIH waiver members and carried forward to each year in the amendment.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Adult Day Health	
Homemaker (Ended 6/30/2026)	
Personal Care (Ended 6/30/2026)	
Respite	
Complementary and Integrative Health Services - Acupuncture	
Complementary and Integrative Health Services - Chiropractic	
Complementary and Integrative Health Services - Massage Therapy	
Consumer Directed Attendant Support Services (CDASS) (Ended 6/30/26)	
Home Delivered Meals (Ended on 6/30/26)	
Home Modification	
In Home Support Services (IHSS) (Ended 6/30/26)	
Life Skills Training	
Medication Reminder (Ended 6/30/26)	
Non Medical Transportation	
Peer Mentorship	
Personal Emergency Response Systems (PERS) (Ended 6/30/26)	
Remote Support (Ended 6/30/2026)	
Transition Setup (Ended 6/30/2026)	
Wellness Education Benefit	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other authorities utilizing capitated arrangements (i.e.,

1915(a), 1932(a), Section 1937). *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. If applicable, check the capitation box next to that service. 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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							**52312.43**
Adult Day Tier 1	☐	15 Minutes	1	1.00	4.22	**4.22**	
Adult Day Tier 2 and Tier 3	☐	3-5 Hours	1	318.23	51.51	**16392.03**	
Adult Day Specialized	☐	3-5 Hours	4	139.21	64.50	**35916.18**	
Homemaker (Ended 6/30/2026) Total:							**331123.25**
Homemaker (in person)	☐	15 Minutes	34	1453.57	6.70	**331123.25**	
Personal Care (Ended 6/30/2026) Total:							**1150646.33**
Relative Personal Care (in person)	☐	15 minutes	20	1416.27	7.17	**203093.12**	
Personal Care (in person)	☐	15 Minutes	30	4399.04	7.18	**947553.22**	
Respite Total:							**5383.18**
Respite - In-Home	☐	15 Minutes	1	678.67	7.44	**5049.30**	
Respite - ACF	☐	Day	1	1.00	136.72	**136.72**	
Respite - NF	☐	Day	1	1.00	197.16	**197.16**	
Complementary and Integrative Health Services - Acupuncture Total:							**188635.44**
Complementary and Integrative Health Services - Acupuncture	☐	15 Minutes	107	85.58	20.60	**188635.44**	
Complementary and Integrative Health Services - Chiropractic Total:							**107352.96**

GRAND TOTAL: ***26138000.82***

Total: Services included in capitation:

Total: Services not included in capitation: ***26138000.82***

Total Estimated Unduplicated Participants: ***544***

Factor D (Divide total by number of participants): ***48047.80***

Services included in capitation:

Services not included in capitation: *48047.80*

Average Length of Stay on the Waiver: 311

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Complementary and Integrative Health Services - Chiropractic	☐	15 Minutes	92	44.00	26.52	107352.96	
Complementary and Integrative Health Services - Massage Therapy Total:							384270.61
Complementary and Integrative Health Services - Massage Therapy	☐	15 Minutes	161	111.95	21.32	384270.61	
Consumer Directed Attendant Support Services (CDASS) (Ended 6/30/26) Total:							13891418.78
Consumer Directed Attendant Support Services (CDASS)	☐	15 minutes	142	11758.04	8.32	13891418.78	
Home Delivered Meals (Ended on 6/30/26) Total:							1686.96
Home Delivered Meals (Ended on 6/30/26)	☐	Per Meal	2	66.00	12.78	1686.96	
Home Modification Total:							208000.00
Home Modification	☐	Per Project	16	2.00	6500.00	208000.00	
In Home Support Services (IHSS) (Ended 6/30/26) Total:							9275844.26
IHSS - Homemaker	☐	15 Minutes	56	1905.28	6.72	716994.97	
IHSS - Health Maintenance	☐	15 Minutes	108	7881.48	9.45	8043838.49	
IHSS - Personal Care	☐	15 Minutes	48	1461.77	7.34	515010.81	
Life Skills Training Total:							102718.41
Life Skills Training - Telehealth	☐	15 Minutes	1	1.00	13.29	13.29	
Life Skills Training	☐	15 Minutes	6	1288.00	13.29	102705.12	

GRAND TOTAL: 26138000.82

Total: Services included in capitation:

Total: Services not included in capitation: 26138000.82

Total Estimated Unduplicated Participants: 544

Factor D (Divide total by number of participants): 48047.80

Services included in capitation:

Services not included in capitation: 48047.80

Average Length of Stay on the Waiver: 311

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Medication Reminder (Ended 6/30/26) Total:							**16455.98**
Medication Reminder (Ended 6/30/26)	☐	1 Month	17	13.03	74.29	**16455.98**	
Non Medical Transportation Total:							**329375.24**
Non Medical Transportation	☐	One Way Trip	53	211.31	29.41	**329375.24**	
Peer Mentorship Total:							**13.22**
Peer Mentorship	☐	15 Minutes	1	1.00	6.61	**6.61**	
Peer Mentorship - Telehealth	☐	15 Minutes	1	1.00	6.61	**6.61**	
Personal Emergency Response Systems (PERS) (Ended 6/30/26) Total:							**72578.33**
Personal Emergency Response Systems - Install	☐	1 Installation	3	1.00	57.40	**172.20**	
Personal Emergency Response Systems - Monthly	☐	1 Month	77	12.74	73.81	**72406.13**	
Remote Support (Ended 6/30/2026) Total:							**5200.00**
Remote Support	☐	15 Minutes	10	200.00	2.55	**5100.00**	
Remote Support Technology	☐	Per Purchase	2	1.00	50.00	**100.00**	
Transition Setup (Ended 6/30/2026) Total:							**2342.00**
Transition Setup Coordinator	☐	15 Minutes	1	40.00	8.55	**342.00**	
Transition Setup Expense	☐	Per Transition	1	1.00	2000.00	**2000.00**	
Wellness Education Benefit Total:							**12643.44**

GRAND TOTAL: **26138000.82**

Total: Services included in capitation:

Total: Services not included in capitation: *26138000.82*

Total Estimated Unduplicated Participants: **544**

Factor D (Divide total by number of participants): **48047.80**

Services included in capitation:

Services not included in capitation: *48047.80*

Average Length of Stay on the Waiver: 311

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Wellness Education Benefit	☐	1 Item	278	12.00	3.79	12643.44	

GRAND TOTAL: 26138000.82
Total: Services included in capitation:
Total: Services not included in capitation: 26138000.82
Total Estimated Unduplicated Participants: 544
Factor D (Divide total by number of participants): 48047.80
Services included in capitation:
Services not included in capitation: 48047.80
Average Length of Stay on the Waiver: 311

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *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. If applicable, check the capitation box next to that service. 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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							138557.95
Adult Day Tier 1	☐	15 Minutes	1	32.00	4.22	135.04	
Adult Day Tier 2 and Tier 3	☐	3-5 Hours	4	271.33	51.51	55904.83	
Adult Day Specialized	☐	3-5 Hours	9	142.15	64.50	82518.08	
Homemaker (Ended 6/30/2026) Total:							0.00
Homemaker (in person)	☐	15 Minutes	0	0.00	0.01	0.00	
Personal Care (Ended 6/30/2026) Total:							0.00
Relative Personal Care (in person)	☐	15 Minutes	0	0.00	0.01	0.00	
Personal Care (in person)	☐					0.00	

GRAND TOTAL: 2569642.69
Total: Services included in capitation:
Total: Services not included in capitation: 2569642.69
Total Estimated Unduplicated Participants: 672
Factor D (Divide total by number of participants): 3823.87
Services included in capitation:
Services not included in capitation: 3823.87
Average Length of Stay on the Waiver: 331

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		15 Minutes	0	0.00	0.01		
Respite Total:							**341.32**
Respite - In-Home	☐	15 Minutes	1	1.00	7.44	**7.44**	
Respite - ACF	☐	Day	1	1.00	136.72	**136.72**	
Respite - NF	☐	Day	1	1.00	197.16	**197.16**	
Complementary and Integrative Health Services - Acupuncture Total:							**376035.70**
Complementary and Integrative Health Services - Acupuncture	☐	15 Minutes	243	75.12	20.60	**376035.70**	
Complementary and Integrative Health Services - Chiropractic Total:							**276288.01**
Complementary and Integrative Health Services - Chiropractic	☐	15 Minutes	210	49.61	26.52	**276288.01**	
Complementary and Integrative Health Services - Massage Therapy Total:							**736757.80**
Complementary and Integrative Health Services - Massage Therapy	☐	15 Minutes	338	102.24	21.32	**736757.80**	
Consumer Directed Attendant Support Services (CDASS) (Ended 6/30/26) Total:							**0.00**
Consumer Directed Attendant Support Services (CDASS)	☐	15 Minutes	0	0.00	0.01	**0.00**	
Home Delivered Meals (Ended on 6/30/26) Total:							**0.00**
Home Delivered Meals (Ended on 6/30/26)	☐	Per Meal	0	0.00	0.01	**0.00**	

GRAND TOTAL: **2569642.69**

Total: Services included in capitation:

Total: Services not included in capitation: 2569642.69

Total Estimated Unduplicated Participants: **672**

Factor D (Divide total by number of participants): **3823.87**

Services included in capitation:

Services not included in capitation: 3823.87

Average Length of Stay on the Waiver: 331

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Modification Total:							**460005.00**
Home Modification	☐	Per Project	21	3.37	6500.00	**460005.00**	
In Home Support Services (IHSS) (Ended 6/30/26) Total:							**0.00**
IHSS - Homemaker	☐	15 Minutes	0	0.00	0.01	**0.00**	
IHSS - Health Maintenance	☐	15 Minutes	0	0.00	0.01	**0.00**	
IHSS - Personal Care	☐	15 Minutes	0	0.00	0.01	**0.00**	
Life Skills Training Total:							**150693.98**
Life Skills Training - Telehealth	☐	15 Minutes	1	0.00	13.29	**0.00**	
Life Skills Training	☐	15 Minutes	5	2267.78	13.29	**150693.98**	
Medication Reminder (Ended 6/30/26) Total:							**0.00**
Medication Reminder (Ended 6/30/26)	☐	1 Month	0	0.00	0.01	**0.00**	
Non Medical Transportation Total:							**400387.15**
Non Medical Transportation	☐	One-way trip	122	111.59	29.41	**400387.15**	
Peer Mentorship Total:							**13.22**
Peer Mentorship	☐	15 Minutes	1	1.00	6.61	**6.61**	
Peer Mentorship - Telehealth	☐	15 Minutes	1	1.00	6.61	**6.61**	
Personal Emergency Response Systems (PERS) (Ended 6/30/26) Total:							**0.00**
Personal Emergency Response Systems - Install	☐	1 Installation	0	0.00	0.01	**0.00**	

GRAND TOTAL: 2569642.69

Total: Services included in capitation:

Total: Services not included in capitation: 2569642.69

Total Estimated Unduplicated Participants: 672

Factor D (Divide total by number of participants): 3823.87

Services included in capitation:

Services not included in capitation: 3823.87

Average Length of Stay on the Waiver: 331

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Emergency Response Systems - Monthly	☐	1 Month	0	0.00	0.01	0.00	
Remote Support (Ended 6/30/2026) Total:							0.00
Remote Support	☐	15 Minutes	0	0.00	0.01	0.00	
Remote Support Technology	☐	Per Purchase	0	0.00	0.01	0.00	
Transition Setup (Ended 6/30/2026) Total:							0.00
Transition Setup Coordinator	☐	15 Minutes	0	0.00	0.01	0.00	
Transition Setup Expense	☐	Per Transition	0	0.00	0.01	0.00	
Wellness Education Benefit Total:							30562.56
Wellness Education Benefit	☐	1 Item	672	12.00	3.79	30562.56	

GRAND TOTAL: 2569642.69
Total: Services included in capitation:
Total: Services not included in capitation: 2569642.69
Total Estimated Unduplicated Participants: 672
Factor D (Divide total by number of participants): 3823.87
Services included in capitation:
Services not included in capitation: 3823.87
Average Length of Stay on the Waiver: 331

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *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. If applicable, check the capitation box next to that service. 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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							**175646.59**
Adult Day Tier 1	☐	15 Minutes	1	32.00	4.22	**135.04**	
Adult Day Tier 2 and Tier 3	☐	3-5 Hours	5	271.00	51.51	**69796.05**	
Adult Day Specialized	☐	3-5 Hours	11	149.00	64.50	**105715.50**	
Homemaker (Ended 6/30/2026) Total:							**0.00**
Homemaker (in person)	☐	15 Minutes	0	0.00	0.01	**0.00**	
Personal Care (Ended 6/30/2026) Total:							**0.00**
Relative Personal Care (in person)	☐	15 Minutes	0	0.00	0.01	**0.00**	
Personal Care (in person)	☐	15 Minutes	0	0.00	0.01	**0.00**	
Respite Total:							**341.32**
Respite - In-Home	☐	15 Minutes	1	1.00	7.44	**7.44**	
Respite - ACF	☐	Day	1	1.00	136.72	**136.72**	
Respite - NF	☐	Day	1	1.00	197.16	**197.16**	
Complementary and Integrative Health Services - Acupuncture Total:							**463500.00**
Complementary and Integrative Health Services - Acupuncture	☐	15 Minutes	300	75.00	20.60	**463500.00**	
Complementary and Integrative Health Services - Chiropractic Total:							**344760.00**
Complementary and Integrative Health Services - Chiropractic	☐	15 Minutes	260	50.00	26.52	**344760.00**	
Complementary and Integrative Health Services - Massage Therapy Total:							**906824.88**

GRAND TOTAL: **3175279.85**

Total: Services included in capitation:

Total: Services not included in capitation: 3175279.85

Total Estimated Unduplicated Participants: **831**

Factor D (Divide total by number of participants): **3821.03**

Services included in capitation:

Services not included in capitation: 3821.03

Average Length of Stay on the Waiver: 334

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Complementary and Integrative Health Services - Massage Therapy	☐	15 Minutes	417	102.00	21.32	906824.88	
Consumer Directed Attendant Support Services (CDASS) (Ended 6/30/26) Total:							0.00
Consumer Directed Attendant Support Services (CDASS)	☐	15 Minutes	0	0.00	0.01	0.00	
Home Delivered Meals (Ended on 6/30/26) Total:							0.00
Home Delivered Meals (Ended on 6/30/26)	☐	Per Meal	0	0.00	0.01	0.00	
Home Modification Total:							546000.00
Home Modification	☐	Per Project	21	4.00	6500.00	546000.00	
In Home Support Services (IHSS) (Ended 6/30/26) Total:							0.00
IHSS - Homemaker	☐	15 Minutes	0	0.00	0.01	0.00	
IHSS - Health Maintenance	☐	15 Minutes	0	0.00	0.01	0.00	
IHSS - Personal Care	☐	15 Minutes	0	0.00	0.01	0.00	
Life Skills Training Total:							203018.04
Life Skills Training - Telehealth	☐	15 Minutes	1	0.00	13.29	0.00	
Life Skills Training	☐	15 Minutes	6	2546.00	13.29	203018.04	
Medication Reminder (Ended 6/30/26) Total:							0.00
Medication Reminder (Ended 6/30/26)	☐	1 Month	0	0.00	0.01	0.00	
Non Medical							497381.92

GRAND TOTAL: 3175279.85

Total: Services included in capitation:

Total: Services not included in capitation: 3175279.85

Total Estimated Unduplicated Participants: 831

Factor D (Divide total by number of participants): 3821.03

Services included in capitation:

Services not included in capitation: 3821.03

Average Length of Stay on the Waiver: 334

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transportation Total:							
Non Medical Transportation	☐	One-Way Trip	151	112.00	29.41	**497381.92**	
Peer Mentorship Total:							**13.22**
Peer Mentorship	☐	15 Minutes	1	1.00	6.61	**6.61**	
Peer Mentorship - Telehealth	☐	15 Minutes	1	1.00	6.61	**6.61**	
Personal Emergency Response Systems (PERS) (Ended 6/30/26) Total:							**0.00**
Personal Emergency Response Systems - Install	☐	1 Installation	0	0.00	0.01	**0.00**	
Personal Emergency Response Systems - Monthly	☐	1 Month	0	0.00	0.01	**0.00**	
Remote Support (Ended 6/30/2026) Total:							**0.00**
Remote Support	☐	15 Minutes	0	0.00	0.01	**0.00**	
Remote Support Technology	☐	Per Purchase	0	0.00	0.01	**0.00**	
Transition Setup (Ended 6/30/2026) Total:							**0.00**
Transition Setup Coordinator	☐	15 Minutes	0	0.00	0.01	**0.00**	
Transition Setup Expense	☐	Per Transition	0	0.00	0.01	**0.00**	
Wellness Education Benefit Total:							**37793.88**
Wellness Education Benefit	☐	1 Item	831	12.00	3.79	**37793.88**	

GRAND TOTAL: 3175279.85
Total: Services included in capitation:
Total: Services not included in capitation: 3175279.85
Total Estimated Unduplicated Participants: 831
Factor D (Divide total by number of participants): 3821.03
Services included in capitation:
Services not included in capitation: 3821.03

Average Length of Stay on the Waiver: 334

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.*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. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							**176391.42**
Adult Day Tier 1	☐	15 Minutes	1	32.00	4.22	**135.04**	
Adult Day Tier 2 and Tier 3	☐	3-5 Hours	5	271.33	51.51	**69881.04**	
Adult Day Specialized	☐	3-5 Hours	11	149.93	64.50	**106375.34**	
Homemaker (Ended 6/30/2026) Total:							**0.00**
Homemaker (in person)	☐	15 Minutes	0	0.00	0.01	**0.00**	
Personal Care (Ended 6/30/2026) Total:							**0.00**
Relative Personal Care (in person)	☐	15 Minutes	0	0.00	0.01	**0.00**	
Personal Care (in person)	☐	15 Minutes	0	0.00	0.01	**0.00**	
Respite Total:							**341.32**
Respite - In-Home	☐	15 Minutes	1	1.00	7.44	**7.44**	
Respite - ACF	☐	Day	1	1.00	136.72	**136.72**	
Respite - NF	☐	Day	1	1.00	197.16	**197.16**	
Complementary and Integrative Health Services - Acupuncture Total:							**464241.60**
Complementary and Integrative Health Services - Acupuncture	☐	15 Minutes	300	75.12	20.60	**464241.60**	
Complementary							**353241.10**

GRAND TOTAL: ***3230858.37***

Total: Services included in capitation:

Total: Services not included in capitation: *3230858.37*

Total Estimated Unduplicated Participants: ***831***

Factor D (Divide total by number of participants): ***3887.92***

Services included in capitation:

Services not included in capitation: *3887.92*

Average Length of Stay on the Waiver: 337

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
and Integrative Health Services - Chiropractic Total:							
Complementary and Integrative Health Services - Chiropractic	☐	15 Minutes	260	51.23	26.52	**353241.10**	
Complementary and Integrative Health Services - Massage Therapy Total:							**908958.59**
Complementary and Integrative Health Services - Massage Therapy	☐	15 Minutes	417	102.24	21.32	**908958.59**	
Consumer Directed Attendant Support Services (CDASS) (Ended 6/30/26) Total:							**0.00**
Consumer Directed Attendant Support Services (CDASS)	☐	15 Minutes	0	0.00	0.01	**0.00**	
Home Delivered Meals (Ended on 6/30/26) Total:							**0.00**
Home Delivered Meals (Ended on 6/30/26)	☐	Per Meal	0	0.00	0.01	**0.00**	
Home Modification Total:							**566475.00**
Home Modification	☐	Per Project	21	4.15	6500.00	**566475.00**	
In Home Support Services (IHSS) (Ended 6/30/26) Total:							**0.00**
IHSS - Homemaker	☐	15 Minutes	0	0.00	0.01	**0.00**	
IHSS - Health Maintenance	☐	15 Minutes	0	0.00	0.01	**0.00**	
IHSS - Personal Care	☐	15 Minutes	0	0.00	0.01	**0.00**	
Life Skills Training Total:							**227841.10**
Life Skills	☐					**0.00**	

GRAND TOTAL: 3230858.37

Total: Services included in capitation:

Total: Services not included in capitation: 3230858.37

Total Estimated Unduplicated Participants: 831

Factor D (Divide total by number of participants): 3887.92

Services included in capitation:

Services not included in capitation: 3887.92

Average Length of Stay on the Waiver: 337

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Training - Telehealth		15 Minutes	1	0.00	13.29		
Life Skills Training	☐	15 Minutes	6	2857.30	13.29	227841.10	
Medication Reminder (Ended 6/30/26) Total:							0.00
Medication Reminder (Ended 6/30/26)	☐	1 Month	0	0.00	0.01	0.00	
Non Medical Transportation Total:							495561.15
Non Medical Transportation	☐	One-Way Trip	151	111.59	29.41	495561.15	
Peer Mentorship Total:							13.22
Peer Mentorship	☐	15 Minutes	1	1.00	6.61	6.61	
Peer Mentorship - Telehealth	☐	15 Minutes	1	1.00	6.61	6.61	
Personal Emergency Response Systems (PERS) (Ended 6/30/26) Total:							0.00
Personal Emergency Response Systems - Install	☐	1 Installation	0	0.00	0.01	0.00	
Personal Emergency Response Systems - Monthly	☐	1 Month	0	0.00	0.01	0.00	
Remote Support (Ended 6/30/2026) Total:							0.00
Remote Support	☐	15 Minutes	0	0.00	0.01	0.00	
Remote Support Technology	☐	Per Purchase	0	0.00	0.01	0.00	
Transition Setup (Ended 6/30/2026) Total:							0.00
Transition Setup Coordinator	☐	15 Minutes	0	0.00	0.01	0.00	
Transition	☐					0.00	

GRAND TOTAL: 3230858.37

Total: Services included in capitation:

Total: Services not included in capitation: 3230858.37

Total Estimated Unduplicated Participants: 831

Factor D (Divide total by number of participants): 3887.92

Services included in capitation:

Services not included in capitation: 3887.92

Average Length of Stay on the Waiver: 337

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Setup Expense		Per Transition	0	0.00	0.01		
Wellness Education Benefit Total:							**37793.88**
Wellness Education Benefit	☐	1 Item	831	12.00	3.79	**37793.88**	

GRAND TOTAL: 3230858.37
Total: Services included in capitation:
Total: Services not included in capitation: 3230858.37
Total Estimated Unduplicated Participants: 831
Factor D (Divide total by number of participants): 3887.92
Services included in capitation:
Services not included in capitation: 3887.92
Average Length of Stay on the Waiver: 337

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *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. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:							**178917.24**
Adult Day Tier 1	☐	15 Minutes	1	32.00	4.22	**135.04**	
Adult Day Tier 2 and Tier 3	☐	3-5 Hours	5	271.33	51.51	**69881.04**	
Adult Day Specialized	☐	3-5 Hours	11	153.49	64.50	**108901.16**	
Homemaker (Ended 6/30/2026) Total:							**0.00**
Homemaker (in person)	☐	15 Minutes	0	0.00	0.01	**0.00**	
Personal Care (Ended 6/30/2026) Total:							**0.00**

GRAND TOTAL: 3329871.17
Total: Services included in capitation:
Total: Services not included in capitation: 3329871.17
Total Estimated Unduplicated Participants: 831
Factor D (Divide total by number of participants): 4007.07
Services included in capitation:
Services not included in capitation: 4007.07
Average Length of Stay on the Waiver: 340

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Relative Personal Care (in person)	☐	15 Minutes	0	0.00	0.01	0.00	
Personal Care (in person)	☐	15 Minutes	0	0.00	0.01	0.00	
Respite Total:							341.32
Respite - In-Home	☐	15 Minutes	1	1.00	7.44	7.44	
Respite - ACF	☐	Day	1	1.00	136.72	136.72	
Respite - NF	☐	Day	1	1.00	197.16	197.16	
Complementary and Integrative Health Services - Acupuncture Total:							464241.60
Complementary and Integrative Health Services - Acupuncture	☐	15 Minutes	300	75.12	20.60	464241.60	
Complementary and Integrative Health Services - Chiropractic Total:							359033.06
Complementary and Integrative Health Services - Chiropractic	☐	15 Minutes	260	52.07	26.52	359033.06	
Complementary and Integrative Health Services - Massage Therapy Total:							908958.59
Complementary and Integrative Health Services - Massage Therapy	☐	15 Minutes	417	102.24	21.32	908958.59	
Consumer Directed Attendant Support Services (CDASS) (Ended 6/30/26) Total:							0.00
Consumer Directed Attendant Support Services (CDASS)	☐	15 Minutes	0	0.00	0.01	0.00	
Home Delivered Meals (Ended on 6/30/26) Total:							0.00

GRAND TOTAL: 3329871.17

Total: Services included in capitation:

Total: Services not included in capitation: 3329871.17

Total Estimated Unduplicated Participants: 831

Factor D (Divide total by number of participants): 4007.07

Services included in capitation:

Services not included in capitation: 4007.07

Average Length of Stay on the Waiver: 340

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Delivered Meals (Ended on 6/30/26)	☐	Per Meal	0	0.00	0.01	0.00	
Home Modification Total:							629265.00
Home Modification	☐	Per Project	21	4.61	6500.00	629265.00	
In Home Support Services (IHSS) (Ended 6/30/26) Total:							0.00
IHSS - Homemaker	☐	15 Minutes	0	0.00	0.01	0.00	
IHSS - Health Maintenance	☐	15 Minutes	0	0.00	0.01	0.00	
IHSS - Personal Care	☐	15 Minutes	0	0.00	0.01	0.00	
Life Skills Training Total:							255746.11
Life Skills Training - Telehealth	☐	15 Minutes	1	0.00	13.29	0.00	
Life Skills Training	☐	15 Minutes	6	3207.25	13.29	255746.12	
Medication Reminder (Ended 6/30/26) Total:							0.00
Medication Reminder (Ended 6/30/26)	☐	1 Month	0	0.00	0.01	0.00	
Non Medical Transportation Total:							495561.15
Non Medical Transportation	☐	One Way Trip	151	111.59	29.41	495561.15	
Peer Mentorship Total:							13.22
Peer Mentorship	☐	15 minutes	1	1.00	6.61	6.61	
Peer Mentorship - Telehealth	☐	15 Minutes	1	1.00	6.61	6.61	
Personal Emergency Response Systems (PERS) (Ended 6/30/26) Total:							0.00
Personal Emergency	☐					0.00	

GRAND TOTAL: 3329871.17

Total: Services included in capitation:

Total: Services not included in capitation: 3329871.17

Total Estimated Unduplicated Participants: 831

Factor D (Divide total by number of participants): 4007.07

Services included in capitation:

Services not included in capitation: 4007.07

Average Length of Stay on the Waiver: 340

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Response Systems - Install		1 Installation	0	0.00	0.01		
Personal Emergency Response Systems - Monthly	☐	1 Month	0	0.00	0.01	0.00	
Remote Support (Ended 6/30/2026) Total:							0.00
Remote Support	☐	15 Minutes	0	0.00	0.01	0.00	
Remote Support Technology	☐	Per Purchase	0	0.00	0.01	0.00	
Transition Setup (Ended 6/30/2026) Total:							0.00
Transition Setup Coordinator	☐	15 Minutes	0	0.00	0.01	0.00	
Transition Setup Expense	☐	Per Transition	0	0.00	0.01	0.00	
Wellness Education Benefit Total:							37793.88
Wellness Education Benefit	☐	1 Item	831	12.00	3.79	37793.88	

GRAND TOTAL: 3329871.17
Total: Services included in capitation:
Total: Services not included in capitation: 3329871.17
Total Estimated Unduplicated Participants: 831
Factor D (Divide total by number of participants): 4007.07
Services included in capitation:
Services not included in capitation: 4007.07
Average Length of Stay on the Waiver: 340