DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
(Office of Community Living)
AND
DEPARTMENT OF HUMAN SERVICES
(Office of Operations and Services for People with Disabilities)

FY 2017-18 JOINT BUDGET COMMITTEE HEARING AGENDA

Thursday, January 5, 2016
1:30pm – 4:30pm

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

1:30-1:40 INTRODUCTIONS AND OPENING COMMENTS

1:40-1:45 FY 2017-18 DEPARTMENT BUDGET PRIORITIES FOR OFFICE OF COMMUNITY LIVING

1:45-2:05 INTELLECTUAL AND DEVELOPMENT DISABILITIES (IDD) SERVICES OVERVIEW

IDD Waivers General Questions

1 Please discuss what other states are similar to how Colorado funds waiver services for individuals with intellectual and developmental disabilities and what states are similar to Colorado in terms of the number of people served.
2 Please discuss if there is a similar set of standards for how each state creates a waiver. Please discuss how the federal government deals with each state's unique set of waivers.
3 Please discuss how providers will be impacted by the passage of the minimum wage increase.
4 Please discuss how the increased employee pay at the Regional Centers compares to the pay for community-based direct service providers.
5 Please discuss the impact the Centers for Medicare and Medicaid Services (CMS) Final Rule will have on Colorado's IDD service providers. Please include a discussion about the Department's work to date on implementation of the Final Rule requirements, and the cost analysis of implementing of the Final Rule requirements.
6 Please provide the total number of individuals in the correctional system that have an intellectual and developmental disability. Please include an explanation for how this figure compares to the 900 number cited in prior years, and what the Department learned about how individuals are identified and assessed when they are in the correctional system.
7 Please discuss the feasibility of implementing the CMS Independence at Home Demonstration project for the IDD waivers and whether the Department would consider pursing this project for the IDD waivers.

IDD Waivers Waiting List

8 Please discuss the Department's long-term goal for addressing the waiting list and how the redesign of the adult IDD waivers figures into that long-term goal.
9 Please provide a breakdown of the types/programs of services individuals are currently receiving while waiting for Comprehensive waiver services.

IDD Waivers Caseload and Provider Availability

10 Please discuss why providers are not providing services available through the Supported Living Services waiver, and why the Department did not request an increase in rates for these services.
11 Please discuss the purpose of the Intellectual and Developmental Disability Services Cash Fund and why the waivers continue to under-expend the appropriation.

2:05-2:25 CONFLICT FREE CASE MANAGEMENT

12 Please discuss the future of Community-Centered Boards, including the future of rural Community-Centered Boards.
13 Please provide documented instances of conflicted case management that has resulted in the failure to provide the appropriate services.
14 Please discuss the reasons behind the federal rule requiring conflict free case management, and whether the federal government considered the impact of the rule on case management agencies like Community-Centered Boards in Colorado.
15 Please discuss the Department's response to the plan presented in the December 19, 2016 staff briefing document for achieving conflict free case management (pages 22 and 23 of the staff briefing document), including the feasibility of the plan, and if the Department supports the plan.
16 Please discuss whether the plan in the staff briefing document protects mill levy dollars Community-Centered Boards receive.

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING AND DEPARTMENT OF HUMAN SERVICES

2:25-2:35 REGIONAL CENTERS AND DEPARTMENT OF HEALTH CARE POLICY AND FINANCING R10

17 Please discuss what metrics the Departments use to track how an individual is doing once they transition from the Regional Center. How do the Departments track if an individual is thriving, or just surviving in the community, and whether their needs are being met?
18 Please discuss what agencies provide case management to individuals in the Regional Centers and what type of case management is currently provided. Please include a discussion about how the case management services provided in the Regional Centers compare to the case management service provided to individuals receiving community-based services.
19 Please discuss the cost to bring the Grand Junction Regional Center and Pueblo Regional Center into compliance with the Final Settings Rule.

2:35-2:50 BREAK

DEPARTMENT OF HUMAN SERVICES

2:50-3:00 INTRODUCTIONS AND OPENING COMMENTS

3:00-3:10 FY 2017-18 DEPARTMENT BUDGET PRIORITIES FOR OFFICE OF OPERATIONS AND SERVICES FOR PEOPLE WITH DISABILITIES

3:10-3:25 GRAND JUNCTION REGIONAL CENTER

20 Please discuss what residential options are available on the Western Slope for individuals currently receiving services on the Grand Junction Regional Center campus.

21 Please discuss the Department of Human Services' response to the letter from Disability Law Colorado regarding the recommendations from the Grand Junction Regional Center Campus Advisory Group.

22 Please discuss whether the Department of Health Care Policy and Financing has done a cost benefit analysis of the recommendations made by the Advisory Group and the other options for housing individuals currently receiving services on the Grand Junction Regional Center campus. Please include the findings of any analysis that has been done.

3:25-3:55 PUEBLO REGIONAL CENTER

Employee Pay Increase

23 Please discuss the Department's reasoning for increasing employee pay at the Regional Centers without an associated budget request.

24 Please provide, by Regional Center, the number of vacancies as compared to the staff turnover rates for the past three fiscal years.

25 Please discuss why the Department has under-utilized the spending authority for FY 2011-12 through FY 2015-16.

26 Please discuss how costs are reported to the Centers for Medicare and Medicaid Services, and why there are discrepancies between the actual costs of the Regional Centers and the appropriation. Please discuss why the Department did not submit adjustments to the appropriation.

27 Please provide performance metrics on the impact of the pay and staffing increases. Please discuss whether the pay increases are having an impact on the Regional Centers and how these impacts are being measured.

28 Please discuss why the Department's July 2015 responses to the Joint Budget Committee did not mention pay or staffing issues at the Regional Centers.

Incident Reporting

29 Please provide an overview of the findings, and actions taken to correct the issues at the Pueblo Regional Center concerning critical incident reporting. Please include how the Departments of Human Services, Health Care Policy and Financing, and Public Health and Environment are involved in the corrective actions.

30 Please discuss the development of the information technology system by the Office of Information Technology for incident reporting at the Regional Centers.

31 Please discuss in light of the requirements for mandatory reporting pursuant to S.B. 15-109, how services are being coordinate for incident reporting and what agencies (state and local) are involved in reporting requirements.

3:55-4:15 DEPARTMENT INDIRECT COSTS

32 Please provide, for the past four fiscal years, how the Department has spent the hold-out portion of Child Welfare funds. Please list the amounts by program/purpose.

33 For the past four fiscal years, please provide the amounts, by the following purposes the Department used to pay for indirect costs:

a. Year-end accounting adjustments;
b. Conversion of Medicaid Funds to General Fund;
c. Transfer of funds appropriated for POTS line items to indirect cost pool line items; and
d. Federal Child Welfare Funds transfer.

34 Please provide the impact, by county and fund source, of the Department's proposed change to the Child Welfare funding to pay for Department indirect costs.

35 Please discuss which counties will be able to absorb the reduction of child welfare funding based on the Department's request.

36 Please discuss the federal guidelines for calculating indirect costs for Regional Centers and whether the Department has followed these guidelines. Please discuss why the Department has under collected indirect costs from the Regional Centers and under what authority the Department has been allowed to convert Medicaid Funds to General Fund.

37 Please discuss why the Department did not identify these issues in last year's request for General Fund and why there is a growth in the need for General Fund from the FY 2016-17 request to the FY 2017-18 request.

4:15-4:25 COMMISSION FOR THE DEAF AND HARD OF HEARING

38 Please discuss the results of the Department conversations regarding services for children who are deaf and hard of hearing with the Special Education Unit in the Department of Education. If the Department has not yet had these conversations, please provide a timeframe when the Committee will be notified of the results/findings of these conversations.

39 Please discuss the responsibilities of the following Departments for ensuring that services are available to children who are deaf and hard of hearing: Department of Human Services, Department of Labor and Employment, and Department of Education.

40 Please discuss why the Commission for the Deaf and Hard of Hearing is located in the Department of Human Services and whether a different department is better suited to house the Commission.

41 Please discuss why the Department has not begun providing services to individuals who are deaf blind and when services will be available.

4:25-4:30 VETERANS COMMUNITY LIVING CENTERS

42 Please provide an update on the implementation of H.B. 16-1397 regarding the Fitzsimons Veterans Community Living Center.

DEPARTMENT OF HEALTH CARE POLICY & FINANICNG

(Office of Community Living)

and the

DEPARTMENT OF HUMAN SERVICES

(Office of Operations and Services for People with Disabilities)

FY 2017-18 JOINT BUDGET COMMITTEE HEARING ON SERVICES FOR INDIVDUALS WITH INTELLCUTAL AND DEVEOPMENTAL DISABILITIES AGENDA

Thursday, January 5, 2017

1:30pm – 4:30pm

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

1:30-1:40 INTRODUCTIONS AND OPENING COMMENTS

- Reggie Bicha, Executive Director, Colorado Department of Human Services
- Sue Birch, Executive Director, Colorado Department of Health Care Policy and Financing
- Jed Ziegenhagen, Director for the Office of Community Living
- Mark Wester, Director, Office of Community Access and Independence, Colorado Department of Human Services
- Sarah Sills, Director, Division of Budget and Policy, Colorado Department of Human Services

1:40-1:45 FY 2017-18 DEPARTMENT BUDGET PRIORITIES FOR OFFICE OF COMMUNITY LIVING

1:45-2:05 INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (IDD) SERVICES OVERVIEW

<u>IDD Waivers General Questions</u>

1 **Please discuss what other states are similar to how Colorado funds waiver services for individuals with intellectual and developmental disabilities and what states are similar to Colorado in terms of the number of people served.**

The diversity of service arrays in waivers operated nationwide reflect each state's unique funding priorities, participant targeting criteria, and particular continuum of care. For example, differences may include rate setting methodologies, participant assessment, service plan development, benefit packages, conflict of interest guidelines, and the intersection of quality and direct service support capacity. As such, it is difficult to provide meaningful data to compare Colorado's Home and Community Based Services (HCBS) waivers to other states' HCBS waivers for quality, comparability, or comprehensiveness of client care.

For example, while Kansas is similar to Colorado in terms of the number of people served, services are funded via a managed care waiver, rather than the fee-for-service basis used in Colorado. Another fee-for service state, Ohio, receives approximately 65 percent of its state share from local funds, while Colorado uses General Fund for the state match. Tennessee serves a similar number of individuals as Colorado, and like Colorado is fee-for-service, but uses state operated regional centers as the entry door for eligibility determination, assessments, service planning, incident reporting, investigations and quality assurance. In Colorado, the Community Centered Boards are currently funded for these activities. Another state serving a similar number of people, Connecticut, employs state personnel to provide case management.

A download from the Centers for Medicare and Medicaid Services (CMS) Waiver Management System includes a basic list of services offered by states across the nation under the HCBS waiver authority.[1] For the purposes of this response, the Department chose four states similar to Colorado in terms of the number of people served and identified how those states fund their waiver systems, and is displayed in Table 1.

Table 1
States serving number of people similar to Colorado, and the funding method for their HCBS waivers serving individuals with Intellectual and Developmental Disabilities

State	HCBS Waiver Participants with Intellectual or Developmental Disabilities[2]	Funding Mechanism
Colorado	8,072	Fee-for Service
Connecticut	9,346	Fee-for-Service
Kansas	8,424	Managed Care
Tennessee	7,689	Fee-for-Service

Source: State websites for agencies serving individuals with intellectual and developmental disabilities, December 22, 2016

[1] http://tinyurl.com/h28u7u9

[2] "The State of the States in Intellectual and Developmental Disabilities: Emerging from the Great Recession 2015", Braddock, David et al. www.stateofthestates.org

2 **Please discuss if there is a similar set of standards for how each state creates a waiver. Please discuss how the federal government deals with each state's unique set of waivers.**

Operating a program of services under the authority of section 1915(c) of the Social Security Act permits a state to waive certain Medicaid requirements in order to furnish an array of Home and Community Based Services (HCBS) that promote community living for Medicaid beneficiaries and, thereby, avoid institutionalization. Waiver services complement and/or supplement the services that are available through the Medicaid State Plan and other federal, state and local public programs as well as the supports that families and communities provide to individuals.

States have flexibility in designing waivers, including the latitude to:

- Determine the target group(s) of Medicaid beneficiaries who are served through the waiver.
- Specify the services that are furnished to support waiver participants in the community.
- Incorporate opportunities for participants to direct and manage their waiver services.
- Determine the qualifications of waiver providers.
- Design strategies to assure the health and welfare of waiver participants.
- Manage a waiver to promote the cost-effective delivery of Home and Community Based Services.
- Link the delivery of waiver services to other state and local programs and their associated service delivery systems, and
- Develop and implement a quality improvement strategy to ensure that the waiver meets essential federal statutory assurances and to continuously improve the effectiveness of the waiver in meeting participant needs.

The HCBS waiver authority permits a state to offer Home and Community Based Services to individuals who: (a) are found to require a level of institutional care (hospital, nursing facility, or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID)) under the State Plan; (b) are members of a target group that is included in the waiver; (c) meet applicable Medicaid financial eligibility criteria; (d) require one or more waiver services in order to function in the community; and, (e) exercise freedom of choice by choosing to enter the waiver in lieu of receiving institutional care. The cost of service must be less than or equal to the cost of service provided in an institution. It is optional for states to offer waiver services through their Medicaid programs.

The Centers for Medicare and Medicaid Services (CMS) approves the state's waiver application, which specifies the operational features of the waiver. A state must implement

the waiver as specified in the approved waiver application. If the state wants to change the waiver while it is in effect, it must submit an amendment to CMS for review and approval.

3 **Please discuss how providers will be impacted by the passage of the minimum wage increase.**

The Department is not aware of service providers that have terminated Medicaid program participation due to the passage of Amendment 70. However, some services and staff work in agencies and facilities that will be impacted by the wage increase. The Department will engage with contractors, providers, and industry groups to further analyze and understand the impact of Amendment 70 on members and providers. Further, the Department will utilize the Medicaid Provider Rate Review process (under SB 15-228), to determine whether "payments are sufficient to provide for provider retention and client access."[3] The Department will also work to identify specific providers that may be affected as the minimum wage continues to rise in the future. Any changes that the Department identifies that require additional funding will follow the standard budgeting process.

[3] Section 25.5-4-401.5 (2) (a), C.R.S.

4 **Please discuss how the increased employee pay at the Regional Centers compares to the pay for community-based direct service providers.**

[The following response was provided by the Department of Human Services (DHS).]

In developing the plan to increase pay, the Department of Human Services reviewed the market-rate pay for job classifications utilized by the Regional Centers. The Department of Personnel and Administration' s data from its FY 2017-18 Annual Compensation Report indicates that Regional Center staff were paid on average 20 percent below the midpoint of their salary range. The Department of Personnel and Administration considers the midpoint of a salary range to be the prevailing market rate for that job classification. Please note that the FY 2017-18 Annual Compensation Report does not contain information specific to community -based providers who serve individuals with developmental disabilities.

The salary data from the Department of Personnel and Administration is consistent with anecdotal information about salary that we've received. For example, information found at job fairs and websites in the Denver metropolitan area in the last year indicates that hospitals, nursing homes, home health organizations, etc., offer starting salaries to Certified Nursing Assistants (CNAs) of between $14-$22 per hour. Before we increased pay, the starting salary for CNAs at the Regional Centers was $11.23 per hour. With the pay increases, the starting salary for CNAs at the Regional Centers is now $14.25 per hour.

In preparing its response to this question, the Department of Human Services requested from Alliance, a nonprofit, statewide association of Community Centered Boards (CCBs) and Program Approved

Service Agencies (PASAs) any available data related to pay for community based direct service providers.

Alliance members serve over 80% of the people receiving IDD services on the IDD Comprehensive waiver and employ over 2,500 Direct Service Professionals (DSPs) and about 500 Case Managers in Colorado.

In the summer of 2016, Alliance surveyed their members and one non-member CCB (including 20 CCBs and 23 PASAs). Below is data relevant to answering the current question.

- The weighted average for DSP salary in the community is $12.04 per hour.
- Private agencies current benefit structure as a percent salary for FTE is an average of 24% of current benefits as a percentage of salary for FTE, with a range from 4% to 39%.
- The mean (average) wage paid to Direct Support Professionals has a range from $9.00 to $15.27 per hour in Colorado with a median of $12.51. (Weighted average was $12.04)."

5 **Please discuss the impact the Centers for Medicare and Medicaid Services (CMS) Final Rule will have on Colorado's IDD service providers. Please include a discussion about the Department's work to date on implementation of the Final Rule requirements, and the cost analysis of implementing of the Final Rule requirements.**

States have until March 2019 to ensure that their Home and Community Based Services (HCBS) settings are compliant with the Centers for Medicare & Medicaid Services (CMS) Final Rule. In Colorado, providers are bringing their settings into compliance with support from the Departments of Health Care Policy & Financing (HCPF) and Public Health & Environment (CDPHE). Provider support has included webinar trainings, site visits, in-person technical assistance and guidance, and Provider Transition Plans that walk providers through potential compliance issues and remedies. In the coming years, support is also expected to include revised statutes, regulations, and waivers, as well as supplemental policy issuances (e.g., Q&As).

The Department expects the impact of the Final Rule on Colorado's providers of services to individuals with intellectual and developmental disabilities (IDD) to vary by the type of setting in which services are provided. For example, the Department plans to presume that participants' homes, professional provider offices, and clinics are compliant with federal criteria, meaning Provider Transition Plans and site visits would not be necessary for these settings. On the other hand, day settings (e.g., for Specialized Habilitation) and provider-owned or operated residential settings (e.g., group homes) may need to make changes, such as revising their house rules, increasing their staffing, and installing more individualized egress alert systems. Working in collaboration with providers, the Department plans to verify the need for such changes and their successful implementation through the Provider Transition Plans and site visit process. Ultimately, these changes should promote individual autonomy and community integration for all waiver participants, regardless of where they are served.

The Department's work to date on implementation of the Final Rule has included:

- Working with stakeholders and CMS to create and revise a Statewide Transition Plan. (Attachment A.)

- Conducting site-specific assessments and planning for remediation, including: completing a provider self-assessment survey, running a survey for individuals and families, creating templates for Provider Transition Plans, and working with a contractor and CDPHE to conduct site visits.

- Analyzing how state legal authorities need to be changed to ensure compliance with the Final Rule, as set forth in a crosswalk to be implemented over the coming two years. (Attachment B.)

- Providing technical assistance, some examples of which are described above.

The Department recently submitted the attached State Transition Plan and crosswalk to CMS and is planning to publicly notice them shortly so that interested parties can comment. Prior versions have also been publicly noticed.

To date, implementation of the Final Rule has been funded through two appropriations:

- In response to Budget Request FY 2015-16 S-9, BA-9, "CLAG Recommendations and HCBS Final Rule Review" (FY 2014-15 Supplemental Request & FY 2015-16 Budget Amendment), the General Assembly approved $266,800 in total funds for FY 2014-15, $612,475 in total funds for FY 2015-16, and $100,000 in total funds for FY 2016-17 and ongoing for one or more contractors to bring the state into compliance with the Final Rule and develop a strategy for implementation of the Colorado Community Living Plan.

- In response to Budget Request FY 2016-17 BA-8, "HCBS Waiver Settings Rule Implementation" (FY 2016-17 Budget Amendment), the General Assembly approved $684,102 in total funds for FY 2016-17. This amount included costs for 1.0 FTE at the Department and $425,372 to be transferred to CDPHE for the costs of 5.4 FTEs to conduct site visits (a portion of this funding was a roll-forward of the appropriation described above for FY 2015-16), and $590,966 total funds in FY 2017-18 and ongoing, including $411,416 to be transferred to CDPHE for the costs of 5.4 FTEs. In accordance with this appropriation, CDPHE has hired five full-time site surveyors. CDPHE also hired one full-time supervisor using a combination of new and existing authority.

The Department of Health Care Policy & Financing continues to gather information about the cost impacts of compliance with the Final Rule. If the Department determines that a budget action is necessary, it will submit a request for funding during the normal budgetary process such that any authorized funds are available to ensure statewide compliance by the federal deadline of March 2019.

6 **Please provide the total number of individuals in the correctional system that have an intellectual and developmental disability. Please include an explanation for how this figure**

compares to the 900 number cited in prior years, and what the Department learned about how individuals are identified and assessed when they are in the correctional system.

[The following response was provided by the Colorado Department of Corrections (CDOC).]

The 887 offenders referenced in the 2016 JBC hearing demonstrate those prison offenders as of June 30, 2015 who were identified as needing support related to identified intellectual and developmental needs (moderate to severe). As of June 30, 2016, there were 835 offenders meeting this definition (772 male, 63 female); of those, only 72 are at the acute levels of four or five. November 30, 2016 data shows the overall number has dropped to 805 (734 male, 71 female). It is important to note that this number does not represent those offenders with an intellectual and developmental disability. Disability determination is the scope of the Social Security Administration (SSA). The Department looks at this definition from a broader perspective than just the disability determination from SSA.

The American Association on Intellectual and Developmental Disabilities indicates that an intellectual disability is characterized by significant limitations both in intellectual functioning (reasoning, learning, problem solving) and in adaptive behavior, which covers a range of everyday social and practical skills.

An initial assessment screening is conducted on all offenders upon intake, and referrals for special needs services within the Department are made when indicated. Mental health clinicians seek to obtain relevant treatment records from community providers (if applicable) with offender consent to ensure more thorough assessments. DOC provides behavioral health programming for offenders with the highest needs levels (four and five on a 5-point scale) at the Colorado Territorial Correctional Facility (CTCF) and the San Carlos Correctional Facility (SCCF). Offenders with a four or five needs level (71 males and 1 female as of June 30, 2016) are those that meet one or more of the following criteria:

- Culture Fair IQ score of 80 or below and a Test of Adult Basic Education (TABE) reading level of 5.9 or below
- History of receiving specialized state funded Intellectual and Developmental Disabilities services through another state or agency
- English speaking offender who is unable to be tested due to intellectual impairment
- Demonstration of two or more areas of deficit in adaptive functioning which interferes with the offender's ability to manage living in a prison general population setting

In preparation for DOC release, clinicians assist offenders by coordinating with identified agencies or community centered boards and/or assisting with application for disability benefits as indicated.

7 **Please discuss the feasibility of implementing the CMS Independence at Home Demonstration project for the IDD waivers and whether the Department would consider pursuing this project for the IDD waivers. **NEW**

Currently it is not possible for Colorado physicians and nurse practitioners to participate in the Centers for Medicare & Medicaid Services (CMS) Independence at Home Demonstration. The application deadline for this federal program has passed. The Department is not aware of any intent by CMS at this time to solicit more practices to participate in the demonstration.

The Department would consider implementing and administering a similar program targeted to Medicaid members. That consideration should be informed by the evaluation results of the federal demonstration, which is not complete.

IDD Waivers Waiting List

8 **Please discuss the Department's long-term goal for addressing the waiting list and how the redesign of the adult IDD waivers figures into that long-term goal.**

The Department's long-term goal for addressing the waiting list is described in the Strategic Plan for Assuring Timely Access to Services for Individuals with Intellectual and Developmental Disabilities, submitted to the General Assembly on November 1, 2014, with the most recent annual update submitted November 1, 2016. Strategies include, but are not limited to, ensuring data integrity in the information technology system where waiting list data is contained; establishing Community Centered Board requirements for contacting individuals on the waiting list at least twice each year; tracking the length of time for enrollment from the date of enrollment authorization; and the review of current waiting list and enrollment regulations to determine if revisions are needed.

In addition to the above strategies, the goal for addressing the waiting list was further supported by HB 15-1318, requiring the Department to create a single waiver, to help modernize the service delivery system for Home and Community Based Services (HCBS) for adults with intellectual and developmental disabilities (IDD). Waiver redesign for adults with IDD is a key component of the strategic plan to address the waiting list. Statute requires that the new waiver include flexible service definitions, provide services when and where they are needed, and offer services and supports based on individual needs and preferences. Waiver redesign will help increase clarity and transparency of the system, improve access to necessary services, use resources more effectively, and serve a greater number of individuals at a lower per-capita cost. The Department anticipates that with a flexible service array available in the new waiver, lower costs and increased client choice, eligible individuals will have access to, and be enrolled in, the type of services they need and want at the time they need and want them. The Department believes that this will ease the difficulty of reducing the waiting list for services.

9 **Please provide a breakdown of the types/programs of services individuals are currently receiving while waiting for Comprehensive waiver services.**

Of the 2,684[4] individuals on the HCBS-DD wait list as of September 30, 2016, 88 percent are receiving other Medicaid services. The majority (87.55 percent) are receiving medically necessary State Plan services, such as physician care, dental services, medical transportation and prescription drug coverage. An overview of Colorado Medicaid benefits can be found on the Department's website.[5]

An individual may enroll in other HCBS waivers if they meet the targeting criteria. Sixty-four percent of those individuals on the waiting list are enrolled in the HCBS-SLS waiver and another 8 percent are enrolled in other HCBS waivers. Though it's possible that these waivers may not provide the full extent of support an individual needs and benefits will vary by waiver, benefits may include support such as day habilitation, behavioral services, personal care, homemaker, respite, supported employment, community connections, environmental modifications, specialty equipment and supplies, professional services and other services needed to assist an individual with activities of daily living. An overview of all waivers and services available within each can be found on the Department's website.[6]

Additionally, some individuals are enrolled in the state funded Supported Living Services program that provides personal care, homemaker services, respite services, supported employment, community connections, environmental modifications, transportation and other support for activities of daily living.

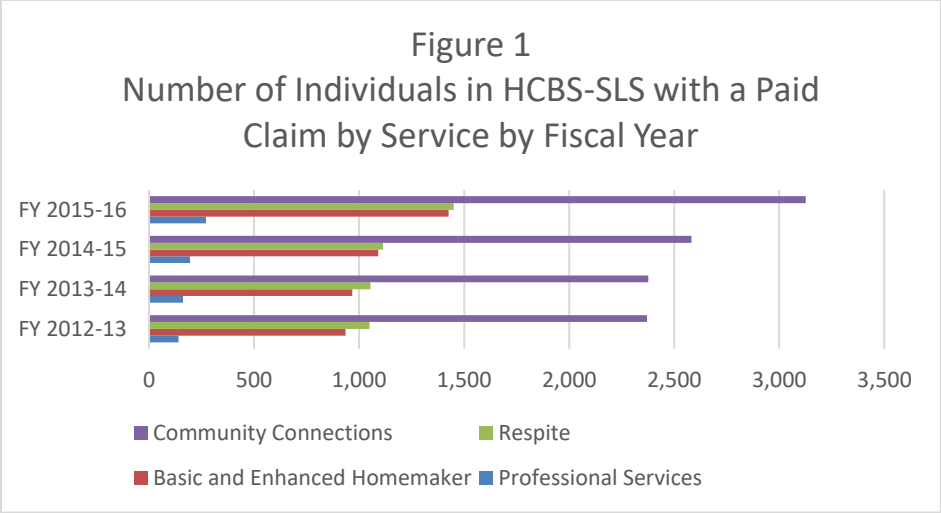
Finally, individuals and families have access to the Family Services and Supports Program, which provides reimbursement for specific needs such as medical and dental expenses, additional insurance, respite and sitter services, special equipment, clothing and diets, home or vehicle modifications, home health services and therapies, family counseling and support groups, recreation and leisure needs, transportation and homemaker services.

IDD Waivers Caseload and Provider Availability

10 **Please discuss why providers are not providing services available through the Supported Living Services waiver, and why the Department did not request an increase in rates for these services.**

Paid claims for services provided within the Home and Community Based Services Supported Living Services (HCBS-SLS) waiver have been increasing over the past four fiscal years (see Figure 1). This indicates that services are being provided to meet the needs of the increasing number of clients enrolling in the HCBS-SLS waiver. Although this significant increase in utilization is not consistent with a widespread lack of access to services, the Department recognizes potential issues with provider capacity.

[4] These numbers differ from the Department's November 1, 2016 informational-only request to eliminate the HCBS-DD waitlist (R-I-1) as the data provided here is more recent.
[5] https://www.healthfirstcolorado.com/benefits-services/
[6] https://www.colorado.gov/hcpf/long-term-services-and-supports-training



Source: Paid claims, Medicaid Management Information System (MMIS), [12/2016]
Note: Professional services includes hippotherapy, movement/music therapy, and massage therapy.

Multiple factors influence provider capacity and the provision of services within the HCBS-SLS waiver. Along with rates, other factors include the availability of providers in specific areas of the state (particularly rural and resort areas), the need to expand beyond the historical provider base, whether an individual is choosing to enroll in the HCBS-SLS waiver for a preferred provider, and other considerations related to individual and family readiness for services.

During the 2015 legislative session, the General Assembly passed Senate Bill 15-228, creating a process for the regular review of provider rates. The Department is required, under Section 25.5-4-401.5, C.R.S., to "conduct an analysis of the access, service, quality, and utilization of each service… and use qualitative tools to assess whether payments are sufficient to allow for provider retention and client access and to support appropriate reimbursement of high-value services." Rates for HCBS, including services provided through the HCBS-SLS waiver, are being reviewed by the advisory committee this fiscal year. The results of this review support the in depth analysis needed to make a recommendation through the regular budget process.

11 **Please discuss the purpose of the Intellectual and Developmental Disability Services Cash Fund and why the waivers continue to under-expend the appropriation.**

As stated in section 25.5-10-207 (5) C.R.S., "It is the intent of the general assembly that the moneys in the intellectual and developmental disabilities services cash fund be used to reduce the number of persons on the waiting lists for such services and the amount of time eligible persons wait for such services."

Section 25.5-10-207(3) C.R.S. also states that "the general assembly may annually appropriate moneys in the intellectual and developmental disabilities services cash fund to the state department for:

(a) Program costs for adult comprehensive services, adult supported living services, children's extensive support services, and family support services

for persons with intellectual and developmental disabilities provided pursuant to this article or part 4 of article 6 of this title;
(b) Administrative expenses for renewal and redesign of Medicaid Home and Community Based Services waivers relating to intellectual and developmental disabilities;
(c) Increasing system capacity for home- and community-based intellectual and developmental disabilities programs, services, and supports; and
(d) The development of an assessment tool pursuant to section 25.5-6-104 (5)."

The primary driver for the under expenditure of the appropriation over the past few years has been slower than estimated caseload growth. In FY 2012-13, the Department of Human Services requested and received funding to eliminate the waiting list for the Home and Community Based Services Children's Extensive Supports (HCBS-CES) program. In FY 2013-14, the Department of Health Care Policy & Financing requested and received funding to eliminate the waiting list for the Home and Community-Based Supported Living Services Waiver (HCBS-SLS) program. Original estimates assumed that all clients on the waiting lists would quickly enroll into the waivers; however, fewer clients than expected enrolled after the elimination of the waiting list. Reasons for this have included clients no longer needing services immediately, relocation to another state, and the Department's inability to reach the client. Additionally, experience has proven that it takes much longer to contact potential clients, complete their eligibility determination and identify service providers than had originally been anticipated. This has led to slower enrollment and lower costs than expected and reversions to the cash fund.

In FY 2015-16, the Department reverted $8,427,248 to the Intellectual and Developmental Disabilities Cash Fund. This reversion was driven primarily by under expenditure in the Home and Community Based Services for Persons with Developmental Disabilities (HCBS-DD) which was driven by two factors; lower than expected enrollment and lower cost per enrollee.

Lower than expected enrollment can be attributed to a longer than anticipated lag time between the point when the Department authorizes an individual to receive HCBS-DD services, and the point that they receive a service plan and Prior Authorization Request (PAR). In June 2016, 5,000 clients had received a PAR while 5,100 clients had been authorized to enroll in the waiver. This lag time led to fewer enrollments and lower costs than expected leading to a reversion.

Lower than expected cost per enrollee in HCBS-DD can be attributed to a technical error that inflated the expected cost of HCBS-DD clients. The cost of HCBS-DD clients who live at a regional center were included in the historical cost per client data for the waiver. The Department relies heavily on historical costs to forecast future costs and the inclusion of the additional funding led to an inflated estimate for cost per enrollee. As a result, actual cost per enrollee was less than forecasted which lead to a reversion of funding.

2:05-2:25 CONFLICT FREE CASE MANAGEMENT

12 **Please discuss the future of Community-Centered Boards, including the future of rural Community-Centered Boards.**

Private corporations, either for-profit or not-for-profit, are designated as Community Centered Boards (CCBs) by the Department according to state statute. The CCB designation includes responsibility for various functions, including eligibility determinations, targeted case management (TCM), and the provision of HCBS waiver services. These three functions will continue to be required for the system serving individuals enrolled in an HCBS waiver, including individuals with an intellectual or developmental disability (IDD).

In order to ensure that individuals receiving services and supports through the Home and Community Based Services (HCBS) waivers have full access to the benefits of community living and are able to receive services in the most integrated setting, and to comply with federal regulation requiring the separation of case management from the provision of HCBS waiver services, the Department developed a plan to separate case management from HCBS waiver services. The plan contains four options for agencies currently designated as Community Centered Boards (CCBs):

- Operate as a case management agency only
- Operate as a direct service provider only
- Continue to provide both case management and direct services, but not for the same individual
- Discontinue providing services and case management to individuals enrolled in an HCBS waiver

While the requirements for CCB designation may change, and the agencies currently designated as CCBs may have to reorganize their business operations in order to comply with federal regulation, the Department expects that those agencies and the CCB designation will continue to exist to provide essential functions for individuals enrolled in HCBS waivers.

Support for access to case management and HCBS waiver services in rural areas is crucial to both individuals receiving services and providers. In a letter dated November 1, 2016, CMS noted that accommodations can be made for states which demonstrate that the only willing and qualified agency that provides case management and/or develops service plans in a specific geographic area also provides HCBS waiver services. In these cases, the Department must submit a waiver action to CMS that substantiates the efforts made to resolve the conflict for the areas where it occurs. The waiver action must also include conflict of interest protections the Department will implement in accordance with the requirements of the federal CMS Final Rule. The Department is committed to transitioning to a conflict-free case management system in a manner that ensures continuity of services for the individuals and agencies involved.

13 **Please provide documented instances of conflicted case management that has resulted in the failure to provide the appropriate services.**

The Department investigated one formal complaint of conflicted case management in 2013 and found the complaint to be unsubstantiated. The Department has not received any other formal complaints regarding conflicted case management; however, it is common for the Department to receive informal complaints and to hear anecdotal stories regarding conflicts of interest, often presented in formal stakeholder meetings. Without receiving a formal complaint, the Department is unable to investigate and substantiate the complaint.

The Department has engaged in multiple formal stakeholder meetings regarding conflict-free case management since 2007. In 2007, the University of Southern Maine issued a report titled "Addressing Potential Conflicts of Interest, Arising from the Multiple Roles of Colorado's Community Centered Boards (CCBs)". As part of their study, the University of Southern Maine gathered stakeholder input, and some parents reported they were "guided to their CCB's services" and had a difficult time learning about other service options. In 2009, the Office of the State Auditor (OSA) conducted an audit and recommended the Department develop an implementation plan to identify specific changes to the system and controls to prevent or mitigate conflicts of interest. As a result of the OSA audit, in 2010, the Department convened a Conflict of Interest Task Force, which included parents and advocates, as well as the opportunity for public comment at each meeting. Public comment received included individuals identifying concerns they believed to be related to conflicts of interest. The Task Force submitted 11 recommendations to the Department. In 2014, the Department convened another task force, which included parents and advocates, to provide recommendations for conflict-free case management.

In addition to the multiple stakeholder meetings, the Department requires that certain processes be followed by CCB case managers to mitigate conflict. The Department has received complaints that those processes were not followed. Upon investigation, the Department was able to substantiate that errors were made by CCB staff not following the required processes.

14 **Please discuss the reasons behind the federal rule requiring conflict free case management, and whether the federal government considered the impact of the rule on case management agencies like Community-Centered Boards in Colorado.**

In the initial proposed rulemaking documents, the Centers for Medicare and Medicaid Services (CMS) expressed an interest in improving Medicaid Home and Community Based Services (HCBS) programs and providing strategies for states to meet Americans with Disabilities Act (ADA) obligations as well as the requirements of the Olmstead case [7] which obligates states to serve individuals in the most integrated setting to meet their needs. The initial HCBS rule required services to be planned and delivered in a manner based on an individual's needs rather than diagnosis, and emphasized the importance of a person-centered planning process led by the individual and/or other persons who are chosen by the individual. The rule making process was initiated in June 2009 and included a public comment period. Public comments were provided by stakeholders, including states, health

[7] United States Supreme Court's ruling in Olmstead v. L.C., 527 U.S. 14 581 (1999).

care case management and community support providers and associations, consumer groups, and social workers.

In the 2014, Final Rule document, CMS notes that comments were received asking CMS to strengthen the person-centered planning process by requiring case managers to be independent of any service provider. This separation would ensure that an individual's goals and services would be appropriate and reduce actual or potential conflicts of interest. Based on these comments, CMS added an additional requirement to the person-centered planning process to address conflicts of interest in case management (42 CFR § 441.301(c)(1)(vi)). The focus of the Final Rule is to ensure HCBS are provided in the most person-centered manner possible; which, in most cases, requires major system changes.

In a 2015, CMS webinar titled "Conflicts of Interest in Medicaid Authorities," which clarified the purpose and expectations of the Final Rule, CMS stated that case management is a "key" or "linchpin" for individuals receiving long-term services and supports. They further defined case management functions as overseeing provider performance; operating the front line on quality compliance, outcomes, safety; as well as upholding key Medicaid requirements of informed choice, freedom of choice, and assuring rights. In the webinar, CMS stated that person-centered planning depends on quality case management and that the case manager's core responsibility to help the individual identify what is important to and for him or her. CMS states "case managers must be able to act as the conduit between state authorities and the providers and the individuals who receive services." As the focus of the Final Rule is person-centered planning, CMS states a key requirement for Medicaid is full freedom of choice of types of supports and services and that the case manager's job is to help the individual and family be well-informed of all choices that may address the individual's needs. Conscious or unconscious, "guiding" or "steering" may be a result of conflict of interest and is in direct conflict with the case manager's role.

15 **Please discuss the Department's response to the plan presented in the December 19, 2016 staff briefing document for achieving conflict free case management (pages 22 and 23 of the staff briefing document), including the feasibility of the plan, and if the Department supports the plan.**

The plan for achieving conflict-free case management presented at the staff briefing aligns with the Department's plan submitted to the Joint Budget Committee (JBC) on July 1, 2016.[8] Both plans include a review and revision (as necessary) to statutes, establishment of capacity, development of case management agency qualifications, selection by Community Centered Boards (CCBs) of their choice for compliance, enrollment of new case management agencies and providers, and the transition of individuals to the new conflict-free case management system. However, the Department differs from JBC staff in the approach to rural exemptions and timelines for implementation and compliance, both of which are contingent on approval and action from the Centers for Medicare and Medicaid Services (CMS). Addressing existing statutory language that requires a single entity to

[8] The report can be found on the Department's website at https://www.colorado.gov/pacific/hcpf/conflict-free-case-management.

provide case management and allows the same entity to provide direct services to the same individual is part of the Department's 2017 legislative agenda.

With regard to the rural exemption, the plan in the staff briefing may not be feasible for the Department to implement as presented. The plan presented at the staff briefing includes establishing a rural exemption definition for CCBs, which would allow counties designated by the Colorado Rural Health Center, the State Office of Rural Health as rural or frontier to be subject to a rural exemption. Establishing a rural exemption definition in state statute or regulation may be of some benefit. However, the authority to grant or approve a rural exemption to the Final Rule lies with CMS. The Final Rule from CMS states that a rural exemption may be approved by CMS when a "state demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS. In these cases, the State must devise conflict of interest protections including separation of entity and provider functions within provider entities."[9] In addition to the Final Rule, the central CMS office informed the Department that in order to obtain a rural exemption, CMS has indicated they will be reviewing waiver applications for information regarding the number of available service providers in a geographic area as well as the number of agencies that can develop the person-centered service plan, and reviewing the qualifications for a case management agency and case manager to ensure that qualifications for both are specific to individuals' needs, such as cultural competency. CMS has noted that it stands ready to assist any state Medicaid agency in need of technical assistance with these requirements.

With regard to the timelines included in the JBC staff briefing, the plan presented at the staff briefing occurs over a five-year timeframe, while the Department's plan occurs over three-to-five years, in three phases. Both timelines extend past the 2019 deadline for compliance with the Final Rule. The Department supports pursuing a timeline that affords continuity of services and is the least disruptive to individuals as possible. In a letter from CMS to the Department regarding the Department's plan, CMS concurred with the Department's four options for CCBs to come into compliance. In response to the Department's estimated three-to-five-year compliance timeline, CMS also noted they do not have the authority to offer a transition period in which to come into compliance with the Final Rule, which was effective March 2014. While CMS did not indicate that any intention to pursue corrective actions for Colorado to come into compliance, they did state to the Department that Federal Financial Participation (FFP) may be at risk for not complying with the regulation.

16 **Please discuss whether the plan in the staff briefing document protects mill levy dollars Community-Centered Boards receive.**

The plan in the staff briefing document does not specifically address local mill levy dollars.

Community Centered Boards (CCBs) are designated by statute and determine eligibility, provide case management, and deliver services and supports for individuals with intellectual and developmental disabilities. As the Department continues to redesign how services are provided to be more person-centered and increase choice for clients, as well as come into

[9] 42 CFR 441.301(c)(1)(vi)

compliance with the Final Rule on Home and Community Based Services (HCBS), there is the potential to have more than one case management agency, one eligibility determination agency, and one service agency in a designated area. The Department could designate some, all, or none of these agencies as a CCB. However, whether or not the Department continues designating CCBs does not determine how local counties and municipalities spend their mill levy dollars.

Mill levy dollars are spent according to how local communities have voted to spend those dollars. The Department does not have the authority to specify how mill levy dollars are distributed. If there is a change to the CCB designation, the local communities with mill levy dollars for individuals with intellectual or development disabilities (IDD) will have to determine what changes, if any, will be made to their communities' mill levy dollar spending.

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING AND THE DEPARTMENT OF HUMAN SERVICES

2:25-2:35 REGIONAL CENTERS AND DEPARTMENT OF HEALTH CARE POLICY AND FINANCING R10

17 **Please discuss what metrics the Departments use to track how an individual is doing once they transition from the Regional Center. How do the Departments track if an individual is thriving, or just surviving in the community, and whether their needs are being met?**

[The following response was provided by the Department of Human Services (DHS).]

Community Centered Boards (CCBs), as the designated agencies to provide case management for individuals with intellectual and developmental disabilities (I/DD) are responsible to track and monitor the health, safety, and welfare for individuals receiving services through a Home and Community-Based Services (HCBS) waiver. Case managers are responsible for assessing the needs of the individual, working with the individual and the family or guardian to develop a Service Plan, providing referral and related activities to ensure the individual receives the appropriate services, and monitoring the implementation of the services identified in the Service Plan to ensure the individual receives the support needed to live a safe and healthy life in the community. All individuals with I/DD who transition from a Regional Center and enroll in an HCBS waiver program are tracked and monitored by these mechanisms.

When enrolled in an HCBS waiver, case managers are required to meet with the individual face-to-face at least once every quarter to ensure that services are being provided and to ensure that the individual is satisfied with the services and the provider agency. If concerns are noted during the service plan year, the case manager is responsible for assessing the individual's needs, which may include reviewing the individual's Service Plan and increasing or decreasing services, selecting new provider agencies, and reviewing the Support Level to determine if a request should be made to the Department to increase the Support Level.

In the HCBS-DD waiver, Support Levels along with additional factors determine the reimbursement rates for several services, including Residential Habilitation Services and Supports (RHSS) and Day Habilitation Services and Supports (DHSS). The increased rates for RHSS and DHSS allow the provider to provide the necessary staff support for an individual. In many cases, when an individual is transitioning from a Regional Center, the Department conducts a Support Level Review and authorizes a temporary Support Level increase, due to the complex medical or behavioral needs of the individual, which often correlates to an increased need for staff support. An increased Support Level supports the individual in securing the right provider who can meet his or her needs, which can increase the likelihood of a successful transition.

The Department's R10 request provides for additional case management to expand the scope of case management activities for individuals transitioning from the Regional Centers. One task of this case management activity will be to improve tracking of support and outcomes from individuals who transition from a Regional Center. The R10 request will allow case managers to meet with the individual more than once every quarter, while providing for increased coordination and follow-up with service providers and contact with families and guardians to maintain continuity of service and a stable transition to a new setting.

[The following response was provided by the Department of Health Care Policy and Financing (HCPF).]

HCPF employs methods for tracking all individuals enrolled in a Home and Community Based Services (HCBS) waiver, including people who transition from a Regional Center, through the case management system. Each individual enrolled in an HCBS waiver is assigned a case manager who is required to ensure that a Service Plan is developed based on the individual's assessed needs: that services are furnished in accordance with the Service Plan, services are adequate, and adjustments are made to the Service Plan when necessary to meet the needs of the individual. All case management activities are documented in HCPF's case management IT system and available to HCPF staff for monitoring and review.

Also, the Department of Human Services (CDHS), Division of Regional Center Operations (DRCO) operates the Transition Support Team (TST) team. The role of the TST is to offer support to individuals and community providers once an individual transitions from the Regional Center. The TST provides support for a minimum of 90 days, and may extend this time based on the needs of the individual by request of the service provider and/or the CCB. During the 90-day period, the TST checks in with the individual and community providers weekly for the first month, every other week the second month, and once during the third month. The TST team also offers training and/or technical support to the community providers to ensure the individual's service needs are being met and to increase the likelihood of an ongoing successful transition.

HCPF also employs metrics to measure overall system performance to ensure compliance with HCBS waiver requirements and assurances, as well as measure client satisfaction with services and supports. At this time, HCPF does not have metrics to track satisfaction with services and supports at the individual level. However, HCPF submitted a budget request to

enhance the level of tracking of support and outcomes for individuals transitioning from a Regional Center.

HCPF's R-10 budget request provides for additional case management to expand the scope of case management activities for individuals transitioning from the Regional Centers. One task of this case management activity will be to improve tracking of support and outcomes from individuals who transition from a Regional Center. The R-10 request would allow case managers to provide transition services for an extended period of time, before and after the individual transitions, while providing for increased coordination and follow-up with service providers and contact with families and guardians to maintain continuity of service and a stable transition to a new setting.

18 **Please discuss what agencies provide case management to individuals in the Regional Centers and what type of case management is currently provided. Please include a discussion about how the case management services provided in the Regional Centers compare to the case management service provided to individuals receiving community-based services.**

[The following response was provided by the Department of Human Services (DHS).]

Targeted Case Management (TCM) is a State Plan service furnished to assist individuals of a targeted population, such as individuals with intellectual and developmental disabilities, in gaining access to needed medical, social, educational and other services. TCM provides for a case manager to assess an individual to determine what type and how much support he or she needs for activities of daily living; support the individual to develop a service plan based on the assessed needs; provide referral and related activities to help the individual obtain necessary services and supports; and conduct monitoring and follow-up activities to ensure the service plan is implemented and meeting an individual's needs.

HCPF's November 1, 2016 Budget Request R-10, "Regional Center Task Force Recommendation Implementation," for comprehensive case management is for individuals transitioning from a Regional Center, which includes both ICF-IID and individuals enrolled in the HCBS-DD waiver. The R-10 request would allow case managers to provide case management while an individual resides in an ICF-IID, since they currently do not receive case management. In addition to providing case management while an individual resides in an ICF-IID, the R-10 request would increase the 240-unit cap for individuals transitioning from a Regional Center. An increase in the 240-unit cap would allow case managers to provide more intensive case management as individuals residing in a Regional Center often have more complex medical and/or behavioral needs. An increase to the TCM units for individuals transitioning would help to increase the likelihood of a successful transition.

[The following response was provided by the Department of Health Care Policy and Financing (HCPF).]

Individuals residing at a Regional Center who receive services through the Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) do not receive case management. Individuals residing at a Regional Center who receive services through the

Home and Community Based Services waiver for Persons with Developmental Disabilities (HCBS-DD) waiver receive Targeted Case Management (TCM), up to 240 units (15 minutes=1 unit) per fiscal year, per individual. The TCM provided to individuals at a Regional Center enrolled in the HCBS-DD waiver is provided by case managers employed by a Community Centered Board (CCB).

TCM is a State Plan service furnished to assist individuals of a targeted population, such as individuals with intellectual and developmental disabilities (IDD), in gaining access to medical, social, and educational services. TCM provides for a case manager to asses an individual to determine the type and extent of support he or she needs for activities of daily living; support the individual to develop a service plan based on the assessed needs; provide referrals and related activities to help the individual obtain necessary services and supports; and conduct monitoring and follow-up activities to ensure the service plan is implemented and meeting an individual's needs.

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19 Please discuss the cost to bring the Grand Junction Regional Center and Pueblo Regional Center into compliance with the Final Settings Rule.

[The following response was provided by the Department of Human Services (DHS) and the Department of Health Care Policy and Financing (HCPF).]

States have until March 2019 to ensure that their Home and Community Based Services (HCBS) settings are compliant with the Centers for Medicare & Medicaid Services (CMS) Final Rule. CMS continues to issue guidance with respect to activities needed for compliance, and the Departments continue to gather information about the cost impacts of compliance with the Final Rule. As such, the cost – if any – to bring the Regional Centers into compliance is currently unknown. If the Departments determine that a budget action is necessary to support Regional Center compliance, they would submit a request for funding during the normal budgetary process such that any authorized funds are available to ensure Regional Center compliance by the federal deadline of March 2019.

Grand Junction Regional Center (GJRC) and Pueblo Regional Center (PRC) are approved community-based providers of residential and nonresidential supports under Colorado's Home and Community-Based Services for Persons with Developmental Disabilities (HCBS-DD) waiver. In addition to serving HCBS-DD waiver clients, GJRC concurrently operates as an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), providing institutionally based services to eligible individuals who are not participants in the HCBS-DD waiver. GJRC and PRC are owned and operated by the Colorado Department of Human Services (CDHS) and must comply with all regulation, statute, and federal oversight required of all HCBS-DD waiver providers.

Because the federal HCBS Settings Rule applies to all settings where HCBS waiver participants live and receive services, it applies to GJRC and PRC in their capacity as providers of HCBS-DD waiver services. Therefore, the Department of Health Care Policy and Financing (HCPF) and CDHS are working together so that both Regional Centers achieve compliance with the Final Rule by March 2019. Were GJRC to stop serving HCBS-DD waiver participants (e.g., by moving to an ICF/IID-only model), it would no longer need to comply with the Final Rule.

HCPF and CDHS have worked together on the following process for ensuring that the Regional Centers, like other providers, comply with the Final Rule and for determining their costs of complying:

In May and June 2016, Telligen (a contractor of HCPF) visited GJRC and PRC to assess their compliance with the Final Rule and to help CDHS identify steps for coming into compliance. After the site visits, HCPF and CDHS staff met to discuss findings from the site visits. Key steps developed for the Regional Centers' compliance with the rule regarding residential and nonresidential HCBS services include:

- Reviewing and revising all practices, policies, and procedures of the Residential Habilitation group homes in order to ensure compliance with all federal requirements. This process includes changes necessary to ensure that daily activities are not regimented, that individuals are able to have visitors at any time, that individuals have access to food at any time, that restraints are not used, and that exceptions to these criteria are based on individualized, assessed need and documented in the agreed-to person-centered plan.

- Allowing individuals in both residential and nonresidential settings to have more choice in their activities. For example, GJRC's day program will implement a formalized program for ensuring that individual plans address individuals' desired community integration activities and experiences, and PRC's group homes will implement "activities meetings" to discuss individuals' preferences regarding community outings and increase their opportunities to engage in such outings.

- Training staff to better support and implement individual rights, autonomy, person-centeredness, and other values protected by the federal rule.

- Making physical modifications, such as removal and/or re-landscaping of a fence to minimize any separation from the community, adding locks to individuals' bedroom doors, and replacing exit alarm systems that operate on a setting-wide basis with more individualized egress alert systems.

A review of the information generated by this process suggests that to come into compliance with the federal HCBS Settings Rule, the Regional Centers may incur ongoing costs to (a) hire more staff to support individuals' ability to engage in less regimented, more individualized activities, including activities outside the grounds of the centers; and (b) train and supervise staff in the new requirements. GJRC's and PRC's staffing, training and supervision needs may be greater than those of other providers because of the complex medical and behavioral needs of the populations they serve. The Regional Centers may also incur one-time capital costs, such as the costs of landscaping, adding locks, and installing more individualized egress alert systems.

HCPF and CDHS expect that in January and February 2017, they will work together to prepare updated assessments of the Regional Centers' compliance status and to compile evidence for CMS of the steps taken to date to ensure compliance with the Final Rule. The Departments anticipate submitting these updated assessments to CMS in order to get CMS's feedback on the adequacy of the approach taken. CDHS is working to have a preliminary cost analysis by April 1, 2017.

Lastly, CMS has continued to issue clarifying guidance. For example, CMS issued an FAQ on December 15, 2016 regarding standards for addressing individuals with wandering/ exit-seeking behaviors. This guidance is relevant to a number of HCBS settings in Colorado, including the Regional Centers. While this FAQ is welcome and has been issued early enough to be fully addressed before March 2019, further guidance that CMS may issue down the road has the potential to delay or force a recalculation of the Departments' cost estimates.

2:35-2:50 BREAK

DEPARTMENT OF HUMAN SERVICES

2:50-3:00 INTRODUCTIONS AND OPENING COMMENTS

3:00-3:10 FY 2017-18 DEPARTMENT BUDGET PRIORITIES FOR OFFICE OF OPERATIONS AND SERVICES FOR PEOPLE WITH DISABILITIES

3:10-3:25 GRAND JUNCTION REGIONAL CENTER

20 **Please discuss what residential options are available on the Western Slope for individuals currently receiving services on the Grand Junction Regional Center campus.**

There are currently 15 program approved service providers on the Western Slope. These providers collectively offer an array of residential options for people in the HCBS waiver including:

- living in their own home or apartment
- the home of a family member
- the home of a non-related direct provider (host home)
- a home they share with 1-2 other individuals
- a group home
- individuals can also explore other service options through counseling options including other HCBS waivers

21 **Please discuss the Department of Human Services' response to the letter from Disability Law Colorado regarding the recommendations from the Grand Junction Regional Center Campus Advisory Group.**

The Department has yet to respond to the letter from Disability Law Colorado. In the letter, Disability Law Colorado is fulfilling its mission to advocate for people with disabilities by urging community integration and movement away from Federal and State operated services. The letter provides substantial background information about significant court decisions affecting the delivery of services to those who have intellectual and developmental disabilities.

On December 9, 2016, the Department submitted a letter to the Capital Development Committee outlining the planning process required to implement SB 16-178 and the Advisory Group's report. The Department is aware of the many issues and constraints affecting this project and welcomes continued conversations and stakeholder engagement to determine the best next steps. As a result, the Department will reassemble the Advisory Group and ask it to develop additional options for implementing SB 16-178. In its work, it will be directed to consider the:

- Utilization study findings and recommendations from the Regional Center Task Force;
- Concerns addressed by Disability Law Colorado and the Arc of Colorado;
- Availability of existing capacity throughout the Regional Center system; and
- Financial constraints of the State, as expressed by the Capital Development Committee.

The Department will develop a comprehensive cost analysis of each recommendation offered by the Advisory Group.

22 **Please discuss whether the Department of Health Care Policy and Financing has done a cost benefit analysis of the recommendations made by the Advisory Group and the other options for housing individuals currently receiving services on the Grand Junction Regional Center campus. Please include the findings of any analysis that has been done.**

[The following response was provided by the Department of Health Care Policy and Financing (HCPF).]

No, HCPF has not performed a cost-benefit analysis of the recommendations made by the Advisory Group or the other options for housing individuals currently receiving services on

the Grand Junction Regional Center campus. However, as described in the response to 21, CDHS is working on completing a cost analysis.

3:25-3:55 PUEBLO REGIONAL CENTER

Employee Pay Increase

23 **Please discuss the Department's reasoning for increasing employee pay at the Regional Centers without an associated budget request.**

The Department increased employee pay at the Regional Centers in response to extreme difficulties that the Regional Centers have experienced in hiring and retaining staff. Specifically, the three Regional Centers were experiencing vacancy rates as high as 50 percent and turnover rates as high as 127 percent during FY 2015-16. The vacancies and constant inflow of new personnel led to staff members being required to work multiple double shifts per week, which resulted in decreased morale, complaints from staff and significant training and recruitment costs for the Regional Centers.

Before increasing employee pay at the Regional Centers, the Department took many other steps to address this issue, including:

- Using open competitive recruitment for direct care staff positions
- Implementing hiring and new employee orientation on a weekly and/or bi-weekly basis
- Implementing referral, signing, and retention bonuses for direct care staff
- Implementing staff recognition and spot awards for staff
- Increasing recruitment efforts to include unique advertising campaigns (e.g., advertising at movie theaters), participating at local job fairs, and working with local community colleges with Certified Nurse Assistant programs
- Implementing new job classifications (e.g., Client Care Aide II) to provide career advancement opportunities
- Exploring options for tuition reimbursement and/or offering continuing education credits for licensed and certified positions
- Developing a Department-wide goal to increase the percentage of required staffing coverage that is worked using regular work hours, thereby reducing the use of overtime to ensure that employees do not have to stay later than the conclusion of their shift

Despite these efforts, the Department was unable to recruit sufficient numbers of new staff to fill vacancies at the Regional Centers. In evaluating the reasons behind these hiring difficulties, the Department ultimately concluded that inadequate pay was a primary cause.

It should be noted that implementing pay increases in this manner is allowed under State Personnel Rules. Specifically, State Personnel Director's Administrative Procedure 3-9 states that:

> "The appointing authority shall determine the hiring salary within the pay grade for a new employee, including one returning after resignation, which

is typically the grade minimum unless recruitment difficulty or other unusual conditions exist."

The Department did not seek a supplemental budget request to implement the employee pay raises at the Regional Centers because there was sufficient spending authority available in the Regional Centers' line items for Fiscal Year 2016-17. The analysis conducted by the Department, the Department of Health Care Policy and Financing, and the Department of Personnel and Administration concluded that authority existed for the Department to increase pay at the Regional Centers and that the pay increases are financially sustainable going forward because of the Regional Centers' cost-reimbursement funding model.

The Department notified the Joint Budget Committee about the pay increases in a letter dated October 19, 2016 letter and contacted each JBC member individually at the same time to discuss the plan and answer any questions.

24 **Please provide, by Regional Center, the number of vacancies as compared to the staff turnover rates for the past three fiscal years.**

The Department is unable to provide vacancy data over 3 years because vacancies exist as point-in-time data and can change daily based on new hires and separations.

Table 1 shows turnover rates for the Regional Centers by campus for Fiscal Years 2013-14 through 2015-16.

Table 1: Regional Center Staff Turnover Percentage by Campus
FY 2013-14 - FY 2015-16

Regional Center	FY 2013-14	FY 2014-15	FY 2015-16
Grand Junction	19%	20%	19%
Pueblo	18%	20%	53%
Wheat Ridge	23%	35%	36%

Source: Colorado Personnel and Payroll System

Data from the Department of Personnel and Administration for FY 2015-16 indicate that the reasons staff separated from each Regional Center were as follows:

- Grand Junction (48 total separations): 50% voluntary (24), 15% involuntary (7), and 35% retirements (17).
- Pueblo (75 total separations): 68% voluntary (51), 28% involuntary (21), and 4% retirements (3).
- Wheat Ridge (143): 73% voluntary (105), 18% involuntary (26), and 9% retirements (12).

Voluntary separations include promotions to another position within the Regional Centers.

25 **Please discuss why the Department has under-utilized the spending authority for FY 2011-12 through FY 2015-16.**

Table 2 compares the Department's actual expenditures for the Regional Centers to their appropriated amounts for Fiscal Years 2011-12 through 2016-17. The figures are not broken out by each Regional Center because the appropriation line items were not broken out by each Regional Center for Fiscal Years 2011-12 and 2012-13.

Table 2: Comparison of Actual Expenditures to Appropriations[1] for the Regional Centers
FY 2011-12 to FY 2016-17

Regional Center	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17
Appropriations	$51,777,834	$56,966,825	$55,857,980	$73,312,481	$67,687,632	$66,944,347
Expenditures	$50,463,923	$53,866,582	$54,206,783	$55,119,669	$55,850,105	TBD

Source: Schedule 3 of the Department's annual budget request submitted to OSPB and the JBC.
[1]Appropriations include the line item appropriation for each Regional Center plus each Regional Center's allocation of centrally appropriated line items (e.g., POTS). The FY 2016-17 figure includes an estimate for the amount of the centrally appropriate line items because those allocations are not usually set until February of each year.

The Department reports the Regional Centers' actual expenditures to the Joint Budget Committee each year as part of Schedule 3 in the annual budget request. The Regional Centers' expenditures are based on their resident census and cannot exceed the revenue they earn from Medicaid and from cash from resident payments. The Regional Centers' expenditures are typically less than their appropriations. Although this situation may suggest that the Regional Centers' are under-utilizing their appropriation, the Regional Centers' current appropriation provides flexibility should their census and/or Medicaid reimbursement rate increase, which would raise both their revenues and expenses.

26 **Please discuss how costs are reported to the Centers for Medicare and Medicaid Services, and why there are discrepancies between the actual costs of the Regional Centers and the appropriation. Please discuss why the Department did not submit adjustments to the appropriation.**

The Regional Centers operate on a cost based rate methodology for Medicaid services. The Department bills Medicaid monthly based on the Regional Centers' census and applicable daily rate per resident. Those services paid by HCPF are reported by HCPF to Centers for Medicare and Medicaid Services (CMS) via a quarterly reporting process. By November 30th of each year, the Department submits an annual cost report for the previous State fiscal year to the Department of Health Care Policy and Financing (HCPF). HCPF then audits the report to determine if the reimbursed expenses were allowable. HCPF usually completes the audit in March or April of the following year. Based on the results of the audit, HCPF could determine that the daily rate charged by the Regional Centers was either too high or too low for the previous State fiscal year. Any adjustments to the Department's payments by HCPF

are then reflected in HCPFs quarterly CMS reporting process. Thus, the audit findings could result in the Department having to pay funds back to Medicaid, or Medicaid owing the Department money.

Because of the timing of the HCPF audit (i.e., 9-10 months after the end of the applicable State fiscal year), it is difficult for the Department to forecast how well the Regional Centers' expenditures will line up with their appropriation. Because of this timing issue and the possibility that the HCPF audit could result in additional revenue for the Regional Centers, the Department does not submit adjustments to the Regional Centers' appropriation to the Joint Budget Committee.

27 **Please provide performance metrics on the impact of the pay and staffing increases. Please discuss whether the pay increases are having an impact on the Regional Centers and how these impacts are being measured.**

The pay raises for Regional Center staff went into effect on November 1, 2016; however, these raises were announced on October 15, 2016. The limited data that the Department has collected suggests a positive impact. Specifically, comparing vacancy data from September 12, 2016 and December 19, 2016 (about seven weeks before and after the pay raises went into effect) shows that:

- The vacancy rates have decreased for all of the Regional Centers since the pay rate went into effect:
    - Pueblo's vacancy rate decreased from 29% to 14%
    - Wheat Ridge's vacancy rate decreased from 15% to 10%
    - Grand Junction's vacancy rate decreased from 8% to 5%
- The number of staff who have separated from the three Regional Centers since the pay increases went into effect is 20 compared to 43 staff that separated from the three Regional Centers between September 12, 2016 and November 1, 2016.

The Department will continue to monitor vacancy rates to evaluate the long-term effects of the pay increases for Regional Center staff.

28 **Please discuss why the Department's July 2015 responses to the Joint Budget Committee did not mention pay or staffing issues at the Regional Centers.**

The Department's July 2015 responses to the Joint Budget Committee discussed staffing issues at the Regional Centers. Specifically:

- Questions 4 and 5 asked about Regional Center employees being "stuck" (i.e., being required to work overtime after a shift has ended without prior notice) and the consequences of that practice. In our response, we discussed how unscheduled overtime was a significant concern to the Department and what steps we were taking to address this concern.

- Question 7 asked about staffing shortages at the Regional Centers. In our response, we discussed specific staffing shortages occurring at that time at Grand Junction and Pueblo and the strategies we were using to address the shortages.

The Department respected the decision made by the General Assembly to not fund any pay increases for state employees for FY 2015-16. As a result, our responses to the questions above did not mention pay increases as a possible way to address these staffing issues. The Department took many other steps to address these issues, such as implementing new job classifications (e.g., Client Care Aide II) to provide career growth opportunities; hiring a staff consultant to improve staff scheduling; starting staff recognition awards; and implementing referral, signing, and retention bonuses. Despite these efforts, the Department was unable to recruit sufficient number of new staff to fill vacancies at the Regional Centers. In evaluating the reasons behind these hiring difficulties, the Department ultimately concluded that inadequate pay was a primary cause and initiated the pay increase plan in response because of the extreme nature of these difficulties.

29 **Please provide an overview of the findings, and actions taken to correct the issues at the Pueblo Regional Center concerning critical incident reporting. Please include how the Departments of Human Services, Health Care Policy and Financing, and Public Health and Environment are involved in the corrective actions.**

Problem Identification and Investigation

The Department of Human Services' Executive Management became aware of instances of inappropriate staff activities and allegations of physical abuse at the Pueblo Regional Center (PRC) in February of 2015. Some of the instances dated back to late 2014. Executive Management conducted a preliminary investigation into these issues and subsequently placed approximately 20 people on administrative leave.

During the formal investigation of instances of neglect, sexual and physical abuse were discovered.

Care Issues Identified

The Department's investigation revealed several quality-of-care issues, including under-reporting incidents (e.g., minimizing the harm/impact of a given incident), not reporting incidents at all, and not following up on incidents and the associated quality-of-care care issues by PRC leadership and other oversight entities.

Due to the under-reporting and lack of reporting, there were significant concerns that there may have been widespread physical and sexual abuse that went undetected. As a result, staff members external to PRC assisted in the investigation and residents were checked for signs of physical and sexual abuse.

Intervention

Executive Management ensured appropriate reporting to external regulatory and law enforcement entities including Adult Protective Services, Pueblo County Sheriff, Colorado Department of Public Health and Environment and Colorado Blue Sky.

The Department provided updates to parents and guardians through regular communications including the engagement of a contractor to be a point of contact for anyone who had questions or concerns about care. Finally, significant leadership and systemic changes were initiated and implemented within PRC and the entire Division for Regional Center Operations.

CMS Findings

CMS found that PRC failed to report incidents in which a crime may have been committed to Law Enforcement and suspected incidents of abuse and neglect to county departments of Human or social services adult protection according to the process in the approved Medicaid HCBS-DD waiver. In addition, CMS found that PRC failed to report critical incidents to the designated Community Centered Board, Blue Sky.

Findings:

- Finding 1: The PRC failed to report incidents in which a crime may have been committed to Law Enforcement and suspected incidents of abuse and neglect to county departments of human or social services adult protection according to the process in the approved waiver
- Finding 2: The PRC failed to report critical incidents to the designated Community Centered Board
- Finding 3: Colorado Bluesky failed to report critical incidents to the HCPF
- Finding 4: The Department of Health Care Policy and Financing failed to ensure that the critical incidents at PRC were reported in accordance with Appendix G-1-b of the approved waiver application
- Finding 5: There is a gap in the state's critical incident reporting system (CIRS), as HCPF relies on the CIRS in a web-based system and the CDPHE to be informed of incidents, but there is no monitoring or oversight by HCPF staff to ensure all incidents are being reported according to the approved waiver

Action Steps:

- Finding 1: On May 28 and 29, 2015, HCPF conducted on-site monitoring and met with the PRC administration to provide direction on the requirements for reporting incidents to law enforcement and Adult Protective Services. The onsite review encompassed a review of the 10 allegations of mistreatment, abuse, neglect and exploitation (MANE) identified during the March 2015 body audits to ensure each incident was reported to law enforcement and Adult Protective Services. HCPF completes on-going reviews of incidents at the PRC to ensure compliance with reporting to law enforcement and Adult Protective Services. The on-going monitoring has not resulted in a finding of deficient practice.

  CDHS identified 18 personnel responsible for failure to report to law enforcement and Adult Protective Services and took corrective action up to and including termination. All 18 personnel identified were suspended from duty April 2015, and did not have contact with residents at PRC until final action was determined and taken.

  CDHS enhanced the process for internal monitoring of reporting incidents of MANE, including separating Quality Assurance personnel from PRC administration authority. Quality Assurance personnel now report to the Division of Regional Center Operations Director.

  The processes below were implemented by April 2015, after which CDHS ensured that all allegations of crimes or MANE were reported to law enforcement and Adult Protective Services as required. Among the changes CDHS has implemented since April 2015 are, reports to law enforcement are made to dispatch and not directly to one person at the Sheriff’s office as had been the previous practice.

An electronic incident report management system that automatically notifies key PRC staff and CDHS Executive Management, up to and including the Executive Director, of serious incidents, providing greater awareness of serious incidents and ensuring improved follow-up. CDHS established a Quality Assurance Division in the Office of Performance and Strategic Outcomes that will independently review compliance with regulations and other requirements of all direct care facilities, including the three Regional Centers.

- Finding 2: On May 28 and 29, 2015 HCPF conducted on-site monitoring and met with the PRC to advise the PRC administration about the requirements for reporting critical incidents to Colorado Bluesky. HCPF completes on-going reviews of incidents at the PRC to ensure compliance with reporting requirements to Colorado Bluesky. The on-going monitoring has not resulted in a finding deficient practice since April 2015.

  Since April 2015, PRC has reported all incident reports including allegations of MANE are reported to Colorado Bluesky as required.

- Finding 3: On May 28 and 29, 2015 HCPF conducted an on-site meeting with Colorado Bluesky case management staff and provided direction on the requirements for critical incident reporting. HCPF completes on-going reviews of critical incidents reporting by Colorado Bluesky to ensure compliance with reporting requirements. The on-going monitoring has not resulted in a finding of deficient practice since April 2015.

- Finding 4: On May 28, 2015, HCPF conducted an on-site meeting with the PRC and Colorado Bluesky to provide direction on the requirements for reporting critical incidents. This joint meeting was to address concerns that neither agency understood Colorado Bluesky's role in the reporting and monitoring of critical incidents at PRC.

- Finding 5: HCPF receives all PRC incident reports from CDPHE to reconcile with critical incidents reported by Colorado Bluesky to HCPF. The analysis at Colorado Bluesky and PRC will contribute to HCPF's statewide analysis of critical event or incident procedures.

CDHS, HCPF and CDPHE will continue to work in together to address issues that arise at Pueblo Regional Center.

30 **Please discuss the development of the information technology system by the Office of Information Technology for incident reporting at the Regional Centers.**

In 2015, it was identified that the Regional Centers were not consistent with implementing Department policy with regards to reporting incidents. In addition, the Department had significant concerns regarding reporting and tracking of incidents. Prior to the system being developed, each Regional Center had paper-based incident reports, all of which contained different information and were processed in a different manner. The paper-based systems were not only inconsistent and prone to errors in reporting, but also made tracking trends or areas of concern across the Regional Centers extremely difficult.

The Department worked with OIT to develop and implement a new, interim reporting system that would:

- provide consistent reporting across the Regional Centers
- allow management to review critical incidents within 24 hours so that incidents could be addressed more timely

During this time, incidents were emailed to Department leadership for immediate review.

In 2016, the Department worked with OIT to develop a web-based incident report tracking system to improve the tracking and reporting of incidents at the Regional Centers. The Department identified this as an issue across other Divisions and will use a phased approach to implement this system across all 24/7 programs within the Department.

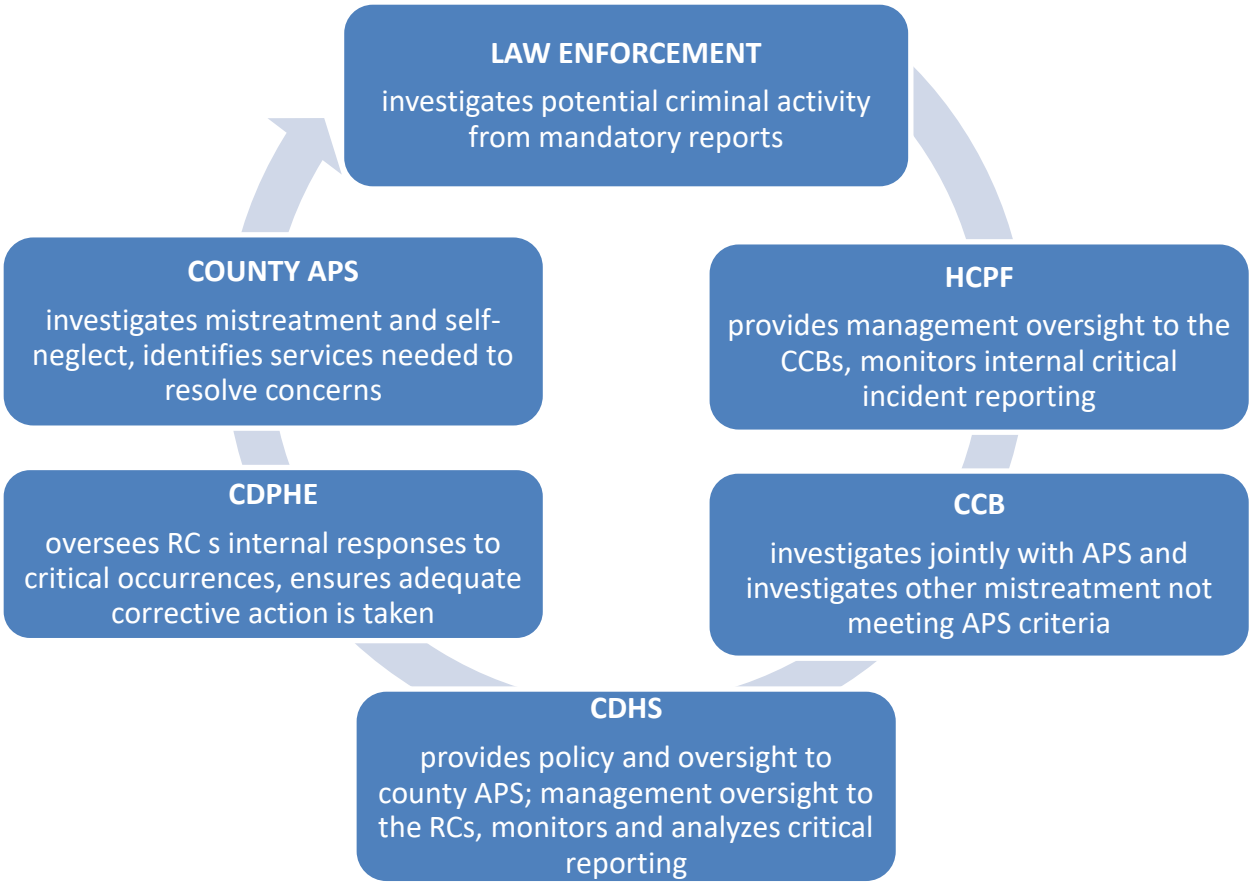
31 **Please discuss in light of the requirements for mandatory reporting pursuant to S.B. 15-109, how services are being coordinate for incident reporting and what agencies (state and local) are involved in reporting requirements.**

The following are the requirements set forth in statute for agencies involved in mandatory reporting:

- By law (18-6.5-108, C.R.S.), persons working in the IDD system, such as those working at CCBs, Regional Centers, and IDD service providers, are mandatory reporters and must report mistreatment of at-risk adults with IDD to law enforcement within 24 hours of becoming aware of it.
- Law enforcement is required by statute to share all reports of mistreatment against an at-risk adult with County Adult Protective Service (APS) programs within 24 hours of receiving them.
- In addition, County Department of Human Services APS programs are required to share reports they receive of mistreatment of an at-risk adult with law enforcement within 24 hours.

In terms of incident reporting, the mandatory reporting law does not preclude or negate the CCB or Regional Center from conducting its own investigation into an incident, per its statutory and rule requirements. Local agencies such as the APS program, CCB, Regional Center, law enforcement etc., are encouraged to work together in investigating a case of mistreatment against an at-risk adult whenever possible. At times local law enforcement asks community agencies not to interview certain individuals involved in the case due to a pending criminal investigation.

Below we outline the mandatory reporting responsibilities for the various state and local agencies that have contact with the IDD community.



3:55-4:15 DEPARTMENT INDIRECT COSTS

32 **Please provide, for the past four fiscal years, how the Department has spent the hold-out portion of Child Welfare funds. Please list the amounts by program/purpose.**

Each year, letternote 'e' to the Child Welfare Services appropriation in Long Bill Group 5, Division of Child Welfare, directs the Department to hold out specified amounts of funding prior to allocating the remainder of the appropriation to the counties. The letternote 'e' holdouts are for parental fee reimbursements, tribal child welfare services, foster care insurance and contractual services. The Child Welfare Allocations Committee (CWAC) establishes the amount of the hold out for Title IV-E waiver services. All holdouts are from the General Fund portion of the Child Welfare Services appropriation. Once holdouts have been taken out of the total amount of available Child Welfare Services funds appropriated in Long Bill Group 5 the remaining available funds are provided to the Child Welfare CWAC to allocate to counties based on their established allocation formula.

These hold outs are required for the following programs for the purposes as described:

- **Parental Fee Reimbursements ($3,208,511)—**Child support collected from parents by counties to cover the cost of out-of-home placement of children who are placed in foster care.

- **Tribal Child Welfare Services ($950,000)—**Funds are used to reimburse two federally recognized tribes in Colorado for Department-approved child welfare services that promote the safety and well-being of Native American children and youth.

- **Statewide Insurance Policy for County-Administered Foster Homes ($346,500)—**An insurance policy the State is required to provide for catastrophic coverage for county foster homes.

- **Contractual Services Related to the Allocation of Funds Among Counties ($100,000)—**Relates to the allocation of funds among counties. As an example, these funds have been used to contract for a vendor to assist the Child Welfare Allocations Committee in meeting the statutory requirements under SB 16-201, a bill concerning revising the Child Welfare funding mechanism.

The funds held out for these programs are made available for the intended use and then any funds remaining at closeout are put back into the child welfare fund and made available for use during the closeout process to provide additional funds to counties with expenses in excess of their allocations. Table 3 shows the holdouts and actual expenditures for FY 2012-13 through 2015-16.

Table 3: Child Welfare Hold Outs vs. Actual Expenses FY 2012-13 through FY 2015-16			
	Hold Outs	*Actual Hold Out Expenditures*	*Amount of Unused Hold Out Funds Returned to Child Welfare Block for Redistribution During Close-Out*
FY 2012-13			
Legislative			
- Parental Fees	*$3,208,511*	*$1,770,312*	*$1,438,199*
- Tribal Child Welfare Services	*$950,000*	*$55,031*	*$894,969*
- Foster Care Insurance	*$346,500*	*$259,313*	*$87,187*
- Contractual Services	*$100,000*	*$37,185*	*$62,815*
Total	*$4,605,011*	*$2,121,841*	*$2,483,170*
FY 2013-14			
Legislative			
- Parental Fees	*$3,208,511*	*$1,379,016*	*$1,829,495*
- Tribal Child Welfare Services	*$950,000*	*$254,842*	*$695,158*
- Foster Care Insurance	*$346,500*	*$235,378*	*$111,122*
- Contractual Services	*$100,000*	*$0*	*$100,000*
IV-E Waiver Demonstration	*$6,686,861*	*$2,056,035*	*$4,630,826*
Total	*$11,291,872*	*$3,925,271*	*$7,366,601*
FY 2014-15			
Legislative			
- Parental Fees	*$3,208,511*	*$1,301,763*	*$1,906,748*
- Tribal Child Welfare Services	*$950,000*	*$244,506*	*$705,494*
- Foster Care Insurance	*$346,500*	*$223,721*	*$122,779*
- Contractual Services	*$100,000*	*$128,101*	*-$28,101*
IV-E Waiver Demonstration	*$8,000,000*	*$3,387,974*	*$4,612,026*

DD Transition Funding	*$2,829,586*	*$2,810,151*	*$19,435*
Total	*$15,434,597*	*$8,096,216*	*$7,338,381*
FY 2015-16			
Legislative			
- Parental Fees	*$3,208,511*	*$1,172,919*	*$2,035,592*
- Tribal Child Welfare Services	*$950,000*	*$32,312*	*$917,688*
- Foster Care Insurance	*$346,500*	*$211,121*	*$135,379*
- Contractual Services	*$100,000*	*$76,523*	*$23,477*
IV-E Waiver Demonstration	*$6,000,000*	*$5,063,634*	*$936,366*
Total	*$10,605,011*	*$6,556,509*	*$4,048,502*

33 **For the past four fiscal years, please provide the amounts, by the following purposes the Department used to pay for indirect costs:**

a. Year-end accounting adjustments;

Accounting adjustments involving Medicaid are described in part "b" below. Other adjustments were as follows:

FY 2012-13: $45,072 in POTS was reallocated to the Executive Director's Office personal services line and $4 in POTS was reallocated to the Operations personal services line.

FY 2013-14: $51,200 in POTS was reallocated to the Executive Director's Office personal services line and $2,278,466 in POTS was reallocated to the Operations personal services line.

FY 2014-15: $485,000 in POTS was reallocated to the Executive Director's Office personal services line and $1,102,476 in POTS was reallocated to the Operations personal services line.

FY 2015-16: $35,986 in POTS was reallocated to the Executive Director's Office personal services line.

b. Conversion of Medicaid Funds to General Fund;

FY 2012-13: The Department did not make any Medicaid transfers to cover indirect revenue shortages.

FY 2013-14: $3,450,000 of Medicaid spending authority was transferred to HCPF to receive $1,725,000 that allowed the Department to transfer the same amount in POTS to the Executive Director's Office and Office of Operations' personal services lines.

FY 2014-15: Medicaid spending authority was transferred to HCPF in order to receive $4,012,862 that aided the Department in collecting the full amount of Title XX indirect revenues.

FY 2015-16: Medicaid spending authority was transferred to HCPF in order to receive $4,293,242 that aided the Department in collecting the full amount of Title XX indirect revenues.

c. Transfer of funds appropriated for POTS line items to indirect cost pool line items; and

The indirect cost pool is not one specific line in the long bill, but rather the Department's indirect cost pool is comprised of expenses in long bill groups (1) Executive Director's Office, (2) Office of Information Technology Services, and (3) Office of Operations. The indirect cost pool includes both personal services and operating costs not directly attributable to the activities in any single program/division.

POTS is centrally appropriated in one of the Department's indirect cost pool line items, long bill line (1)(A) (Executive Director's Office, General Administration), to cover expenses associated with health, life, dental, PERA, and short-term disability; expenses that are incurred in the Department's other line items that have personal services expenses. The Department transfers POTS from this centrally appropriated line to the other personal services lines, including the personal services lines included in the indirect cost pools.

The line items that comprise the indirect cost pool are no different than the other long bill lines in that there are personal services expenses in the indirect cost pool that require allocations of POTS to cover health, life, dental, PERA, and short-term disability.

Table 4 shows the amount of POTS allocated to the indirect cost pool lines from the centrally appropriated line during FY 2012-13 through FY 2015-16.

Table 4: POTS Allocations to Indirect Cost Pool Lines
FY 2012-13 through FY 2015-16

Indirect Appropriation	Fiscal Year 2011-12	Fiscal Year 2012-13	Fiscal Year 2013-14	Fiscal Year 2014-15	Fiscal Year 2015-16
EDO Personal Services	$ 654,104	$ 844,534	$ 1,388,898	$ 1,823,969	$ 1,984,077
Office of Operations	$ 3,598,859	$ 4,116,695	$ 6,677,094	$ 5,959,557	$ 5,799,017
Total POTS Allocated to Indirect Lines	$ 4,252,963	$ 4,961,229	$ 8,065,992	$ 7,783,526	$ 7,783,094

d. Federal Child Welfare Funds transfer.

Over the past four years, the Department recovered indirect costs from the Child Welfare Block grant federal funds (Title XX and Title IV-B) as follows:

FY 2012-13: $0

FY 2013-14: $0

FY 2014-15: $5,025,984 ($4,298,319 from Title XX and $727,665 from Title IV-B)

FY 2015-16: $5,548,167 ($5,125,347 from Title XX and $422,820 from Title IV-B)

34 **Please provide the impact, by county and fund source, of the Department's proposed change to the Child Welfare funding to pay for Department indirect costs.**

The Department is required to prepare a cost allocation plan, called the Public Assistance Cost Allocation Plan (PACAP). The PACAP is reviewed and approved by seven different federal oversight agencies each year. The approval process takes approximately 9 months. PACAP is prepared in accordance with 2 CFR Part 200 - Uniform Administration Requirements, Cost Principles, and Audit Requirements for Federal Awards.

In FY 2014-15, the Department identified that it had not been recovering indirect costs from the Child Welfare Services program (Title XX and IV-B) going back to at least 2003. The Department also found that it had been under-recovering from several other programs, based on the Department's indirect cost recovery plan.

- The Department corrected the error in Child Welfare Services error in FY 2014-15 by recovering indirect costs from the Child Welfare block grants at year-end closeout, and recovered the amount again in FY 2015-16 in the same manner. Counties were not negatively impacted by these recoveries in these years, and incurred no additional expenses due to the Department's recovery of indirect costs. (See additional information in the response to question #35).

- The Department's budget request for indirect costs identifies the budget actions needed to correct the under-recovery from the other programs.

The Department's decision to hold out the indirect costs from the Child Welfare Services appropriation at the beginning of the Fiscal Year (similar to other holdouts) is necessary for the Department to comply with its federally approved cost allocation plan.

Table 5 shows the impact to counties of recovering indirect cost share to counties for FY 2017-18, based on the current allocation formula and the actual indirect costs held out for FY 2015-16. If the CWAC changes the funding formula, the impact to each county could also change.

Table 5: Impact of Indirect Cost Hold Out on County Child Welfare Allocations Estimated FY 2017-18				
County	Current FY 2017-18 Net Child Welfare Block Allocation with Incentives	Proposed County Match Reduction as a Result of the Indirect Hold Out	Proposed Indirect Recovery Hold Out by County (Federal Funds)	Revised FY 2017-18 Allocation after Indirect Hold Out
ADAMS	$ 36,377,708	$ (149,248)	$ (596,992)	$ 35,631,468
ALAMOSA	2,630,351	(10,910)	(43,641)	2,575,800
ARAPAHOE	32,751,255	(134,694)	(538,773)	32,077,788
ARCHULETA	854,510	(3,619)	(14,476)	836,415
BACA	356,393	(1,512)	(6,046)	348,835
BENT	601,388	(2,561)	(10,244)	588,583
BOULDER	15,820,651	(64,545)	(258,179)	15,497,927
BROOMFIELD	2,510,424	(10,160)	(40,642)	2,459,622
CHAFFEE	960,906	(3,905)	(15,620)	941,381
CHEYENNE	237,590	(1,012)	(4,049)	232,529
CLEAR CREEK	842,280	(3,451)	(13,803)	825,026
CONEJOS	769,595	(3,268)	(13,070)	753,257
COSTILLA	425,544	(1,747)	(6,990)	416,807
CROWLEY	445,575	(1,850)	(7,400)	436,325
CUSTER	237,213	(1,012)	(4,049)	232,152
DELTA	2,285,073	(9,253)	(37,011)	2,238,809
DENVER	51,936,793	(219,155)	(876,614)	50,841,024
DOLORES	236,612	(1,012)	(4,049)	231,551
DOUGLAS	8,584,724	(34,532)	(138,130)	8,412,062
EAGLE	2,019,861	(8,116)	(32,464)	1,979,281
EL PASO	45,134,670	(184,287)	(737,145)	44,213,238
ELBERT	1,369,705	(5,717)	(22,868)	1,341,120
FREMONT	4,297,787	(17,899)	(71,594)	4,208,294
GARFIELD	3,349,200	(13,787)	(55,150)	3,280,263
GILPIN	584,015	(2,364)	(9,456)	572,195
GRAND	648,362	(2,615)	(10,459)	635,288
GUNNISON	787,596	(3,298)	(13,191)	771,107
HINSDALE	32,983	(137)	(547)	32,299
HUERFANO	761,270	(3,139)	(12,554)	745,577
JACKSON	235,501	(1,012)	(4,049)	230,440
JEFFERSON	28,998,827	(120,493)	(481,974)	28,396,360

KIOWA	236,043	(1,012)	(4,049)	230,982
KIT CARSON	385,329	(1,644)	(6,574)	377,111
LA PLATA	2,413,207	(9,822)	(39,288)	2,364,097
LAKE	617,467	(2,601)	(10,402)	604,464
LARIMER	16,383,962	(66,863)	(267,451)	16,049,648
LAS ANIMAS	1,419,411	(5,768)	(23,071)	1,390,572
LINCOLN	944,536	(4,042)	(16,170)	924,324
LOGAN	2,451,347	(10,213)	(40,854)	2,400,280
MESA	15,178,980	(62,112)	(248,450)	14,868,418
MINERAL	30,000	(129)	(517)	29,354
MOFFAT	1,196,183	(5,013)	(20,051)	1,171,119
MONTEZUMA	1,835,891	(7,673)	(30,693)	1,797,525
MONTROSE	3,315,938	(13,675)	(54,700)	3,247,563
MORGAN	3,238,240	(13,756)	(55,025)	3,169,459
OTERO	1,838,006	(7,461)	(29,846)	1,800,699
OURAY	237,718	(1,012)	(4,049)	232,657
PARK	728,172	(2,953)	(11,811)	713,408
PHILLIPS	288,006	(1,189)	(4,758)	282,059
PITKIN	474,161	(1,854)	(7,415)	464,892
PROWERS	1,125,035	(4,719)	(18,878)	1,101,438
PUEBLO	13,859,497	(56,955)	(227,821)	13,574,721
RIO BLANCO	617,432	(2,627)	(10,507)	604,298
RIO GRANDE	1,206,867	(4,919)	(19,678)	1,182,270
ROUTT	793,644	(3,164)	(12,656)	777,824
SAGUACHE	656,075	(2,800)	(11,200)	642,075
SAN JUAN	30,235	(129)	(517)	29,589
SAN MIGUEL	331,520	(1,318)	(5,273)	324,929
SEDGWICK	238,160	(1,012)	(4,049)	233,099
SUMMIT	873,635	(3,501)	(14,002)	856,132
TELLER	1,822,539	(7,745)	(30,981)	1,783,813
WASHINGTON	509,158	(2,177)	(8,708)	498,273
WELD	18,960,269	(77,643)	(310,573)	18,572,053
YUMA	741,284	(3,019)	(12,076)	726,189
TOTALS	$ 342,062,309	$ (1,410,830)	$ (5,643,322)	$335,008,157

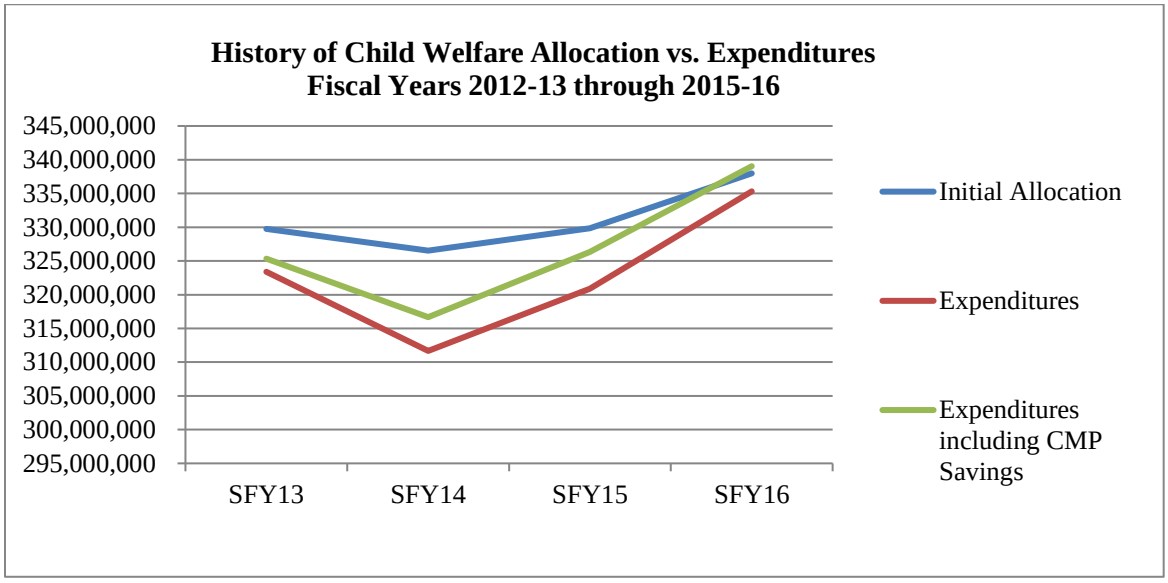
Source: Department analysis of Human Services analysis of indirect cost hold out impact on county Child Welfare Services allocations for Title XX and IV-B.

Note: The amounts included in this analysis are based on actual indirect costs recovered in FY 2015-16 and the current Child Welfare allocation formula. Should the amount of indirect costs or the allocation formula change, the resulting allocations would change also. This analysis is slightly different from earlier analysis presented to the CWAC.

35 **Please discuss which counties will be able to absorb the reduction of child welfare funding based on the Department's request.**

Based upon historical county expenditures following the year-end county settlement process, holding out the Title XX and Title IV-B funds from the Child Welfare Services appropriation for indirect costs should not negatively affect the counties.

As shown in the following graph, counties have underspent their Child Welfare allocations in each of the past 4 years.



The Department recovered indirect costs from the Child Welfare allocation (under Title XX and Title IV-B) in each of the last two years (FY 2014-15 and FY 2015-16) and no county has owed additional dollars as a result. However, past results are not necessarily indicative of future outcomes. Total Child Welfare expenditures have increased in each of the past two years. Thus, Child Welfare expenditures could rise to the level that would result in the Department not being able to cover over spent counties in total.

It is important to note that the counties who participate in the Collaborative Management Program (CMP) receive "CMP" payments that are funds paid back to counties from the Child Welfare grant that have underspent their Child Welfare allocation. As a result, while the green line for FY 2015-16 shows total expenses in excess of the allocation, that line includes $3.7 million in CMP payments that went back to counties.

36 **Please discuss the federal guidelines for calculating indirect costs for Regional Centers and whether the Department has followed these guidelines. Please discuss why the Department has under collected indirect costs from the Regional Centers and under what authority the Department has been allowed to convert Medicaid Funds to General Fund.**

The Department's cost allocation plan indicates that it should be recovering $6,452,103 from the Regional Centers for indirect costs. However, letternote 'b' in the Office of

Operations (A) Administration Long Bill Line caps the amount of indirects that the Department can recover from the Regional Centers at $5,150,923, resulting in an under-collection of $1,301,180.

Finally, the authority to convert Medicaid Funds to General Funds is outlined in Section 24-75-106, C.R.S. (2016)

37 **Please discuss why the Department did not identify these issues in last year's request for General Fund and why there is a growth in the need for General Fund from the FY 2016-17 request to the FY 2017-18 request.**

The Department identified the lack of General Fund relative to the transfer of DVR in both FYs 2015-16 and 2016-17. Specifically:

- A Departmental Difference is noted in the Fiscal Note for SB 15-239, and stated that the indirect cost impact would best be handled during the typical budget process. When DVR was proposed to be moved in SB 15-239, the Department provided a fiscal note impact statement indicating the fiscal impact to the Department of the DVR move, to include an identified need for $837,948 in General Fund that had previously been covered by the DVR program's enhanced federal matching rate.

- The Department submitted a FY 2016-17 budget request (R-09) to request an additional $1,094,283 General Fund to cover the indirect costs no longer covered by DVR after its transfer to CDLE. This request was not funded.

- The impact of DVR's move in FY 2016-17 was further exacerbated by an error in the related budget request R-09 that resulted in a reduction of $680,123 federal funds and a reduction of 10.3 FTE related to the transfer of 3.4 FTE for administrative support to the Department of Labor and Employment. The request contained an error in the funds transferred to CDLE to support DVR.

Table 6: FY 2016-17 Error Resulting in a Reduction to the Office of Operations that follows illustrates what was in the request, what should have been in the request and the action taken during figure setting. The result of the figure setting action was an additional reduction of 6.9 FTE and $680,123 federal funds from the DHS Office of Operations.

Table 6: FY 2016-17 Error Resulting in a Reduction to the Office of Operations

Action	Total Funds	General Fund	Federal Fund	FTE	Notes
FY 2016-17 Budget Request Indirect Cost Recovery Offset for DVR Transfer to CDLE	($184,074)	($184,074)	$ -	(3.4)	The request reflected a reduction of General Fund only
Revised Request	($184,074)	($39,208)	($144,866)	(3.4)	Request should have reflected 21.3%

					General Fund and 78.7% federal funds
Figure setting Action	($864,197)	($184,074)	($680,123)	(10.3)	The $184,074 General Fund was used as a match for the federal funds
Difference between the Revised Request and Action	$680,123	($144,866)	($535,257)	(6.9)	Calculation: Revised Request minus Figure setting Action

4:15-4:25 COMMISSION FOR THE DEAF AND HARD OF HEARING

38 **Please discuss the results of the Department conversations regarding services for children who are deaf and hard of hearing with the Special Education Unit in the Department of Education. If the Department has not yet had these conversations, please provide a timeframe when the Committee will be notified of the results/findings of these conversations.**

The Department contacted the Special Education Unit in the Department of Education to schedule a meeting in January 2017. Upon request, the Department can provide a summary of these conversations to the JBC when it is available.

39 **Please discuss the responsibilities of the following Departments for ensuring that services are available to children who are deaf and hard of hearing: Department of Human Services, Department of Labor and Employment, and Department of Education.**

As condition of receiving federal funding, the Department must comply with Title II of the Americans with Disabilities Act, Title VI of the Civil Rights Act of 1964, and Section 504 of the Rehabilitation Act to ensure that individuals who are deaf and hard of hearing have equal access to government services. These laws require that the Department be able to communicate effectively with individuals with communication disabilities. There are multiple programs within the Department that provide services to those in the deaf-blind community, including children, as discussed below.

<u>Colorado Commission for the Deaf and Hard of Hearing (Commission)</u>
The Commission advocates for public policies, regulations and programs to provide full and equal opportunity for the deaf-blind community. The Commission also serves as the central repository for information and as a clearinghouse for Colorado community stakeholders and individuals. Finally, the Commission is also responsible for managing five programs designed to improve access to governmental services for the deaf-blind community:

- Telecommunications equipment distribution to citizens who qualify.
- Auxiliary services (i.e., sign language interpreting and Communication Access Real-time Translation) for the State court system, probation and court-ordered treatment (e.g., parenting and Alcoholics Anonymous classes).
- Referral agency to State agencies providing services for the deaf-blind community.
- Grants for governmental agencies and community organizations.
- Outreach and consultative services for community stakeholders and individuals.

Division of Early Care and Learning

The Colorado Child Care Assistance Program (CCCAP) allows counties the option to prioritize services to this population, and providers caring for these children can be paid at a higher rate. This agreement occurs between the counties and their childcare providers. As a result, the Department does not participate in these agreements and does not have a responsibility to ensure that they occur.

Division of Community and Family Support

The primary program in this division that serves children who are deaf or hard of hearing is the Early Intervention (EI) program. The EI program serves children birth through age two who have a diagnosis of hearing loss by connecting them to services supporting healthy development. Children with bilateral hearing loss are automatically eligible for EI. Children with unilateral hearing loss must complete the eligibility process and often receive services through EI.

The EI program collaborates with Community Centered Boards (CCBs) and the Colorado School for the Deaf and Blind (CSDB) to meet the needs of children who are deaf or hard of hearing. CSDB provides expertise in hearing loss for children and families receiving services in Early Intervention. Highly trained professionals work with families to connect them to medical supports, therapy services, and family support resources. CSDB oversees the following services for children with hearing loss:

- Colorado Hearing Resource (CO-Hear) Coordinators have expertise that includes early childhood specialization as well as Colorado Department of Education licensure as teachers of the deaf/hard of hearing, speech/language pathologists, and/or educational audiologists. The regionally based CO-Hear Coordinators have also participated in EI Colorado's Service Coordination Core Training.
- The Colorado Home Intervention Program (CHIP) serves infants and toddlers who are deaf or hard of hearing and their families, in their own homes, through a coordinated program involving assessments, facilitators, audiologists, adult deaf and hard of hearing role models, educators, parent consultants, sign language instructors, and other advisors and community members.

The systems managed by the Department and the Colorado School for the Deaf and Blind work together to ensure that families with children with hearing loss are supported, educated, and empowered.

All other programs in this division provide an interpreter for children and families participating in family support programs that are deaf or hard of hearing.

Juvenile Parole Board

For parole hearings, the Juvenile Parole Board utilizes certified translators in both American Sign Language and textile, depending on the need of the client. The services are obtained through the Colorado Commission on Deaf and Hard of Hearing (CCDHH).

Domestic Violence Program

The Domestic Violence Program (DVP) monitors the DVP funded programs to ensure they have a written Language Accessibility Plan, which must include assurances that they will make services available for deaf and hard of hearing adults and children through interpreters, teletypewriter (TTY), video relay, or other means.

Division of Child Welfare

The Division of Child Welfare (DCW) works with Deaf Overcoming Violence through Empowerment (DOVE) to provide training to caseworkers and supervisors regarding the deaf and hard of hearing community, and how best to serve this population. The Department also provides the resource of DOVE to county departments to use as a resource for guidance and assistance when serving families. In addition, DCW has released information to counties on how to connect to the CCDHH's Telecommunications Equipment Distribution Program.

Division of Youth Corrections

The Division of Youth Corrections (DYC) utilizes special education funding to ensure independent services are offered during school hours for children who are deaf and hard of hearing. These independent services continue during non-school hours, but are funded by DYC General Fund dollars.

40 **Please discuss why the Commission for the Deaf and Hard of Hearing is located in the Department of Human Services and whether a different department is better suited to house the Commission.**

The enabling legislation (SB 00-194) for the Commission for the Deaf and Hard of Hearing (Commission) placed the Commission in the Department of Human Services. SB 00-194 expected the Commission to serve as a liaison between the deaf and hard of hearing community and the General Assembly, the Governor, and Colorado's executive departments and agencies in order to improve access for the deaf and hard of hearing community to appropriate government services. As such, the decision to house the Commission at the Department of Human Services appears logical, as the Department oversees many small commissions, boards, and programs designed to improve access to needed services. These include the Colorado Commission on Aging, the Development Disabilities Council, Early Childhood Leadership Councils, the Colorado Long-Term Care Ombudsman, and the Traumatic Brain Injury Trust Fund.

41 **Please discuss why the Department has not begun providing services to individuals who are deaf blind and when services will be available.**

There are many services currently available to individuals who are deaf-blind. Among these services are:

- Telecommunications distribution program and arranging for auxiliary services (sign language interpreting and captioning).
- Aids to allow deaf-blind individuals to participate effectively in court proceedings or programs.

SB 16-1414 created two positions within the Commission for the Deaf and Hard of Hearing (Commission), a Deaf-Blind Services Coordinator and an Outreach Consultant – Deaf-Blind Specialty. Funding for these positions was available as of July 1, 2016. Below is the hiring timeline for these positions:

- August 2016 - Finalized job descriptions for both positions.
- September 2016 - Posted both positions for four weeks to maximize recruitment of qualified candidates given the scarcity of professionals with expertise in deaf-blindness.
- October-November 2016 - Conducted multiple interviews for both positions. Commission members, Commission staff, and members of the deaf-blind community participated in the interviews.
- December 2016 - Selected candidate for the Deaf-Blind Services Coordinator position, who will start work on January 9, 2017. Re-posted the Outreach Consultant position because the previous search did not yield a qualified candidate with the unique skill-set required for the position. Plan to complete second search by February 2017.

The Deaf-Blind Services Coordinator will allow the Commission to serve more individuals itself, provide more connections to the deaf-blind community to non-Commission services, and increase awareness of Commission programs. The Outreach Consultant will focus on the educating part and making resources available to this population.

4:25-4:30 VETERANS COMMUNITY LIVING CENTERS

42 **Please provide an update on the implementation of H.B. 16-1397 regarding the Fitzsimons Veterans Community Living Center.**

Implementation of HB 16-1397 is progressing according to schedule. Below is a summary of current progress and next steps that will occur. The Advisory Group has submitted its report and included recommendations and a timeline of next steps of development. The Advisory Group recommends completion of two distinct portions of the Fitzsimon Veterans Community Living Center including a North portion and a South portion. A summary of the recommendations are below.

Recommendations:
Northern Portion/Complementary Service Lines to existing veteran services: The northern portion should be developed as an integrated facility (or cohort of facilities) that provide a continuum of care for veterans seeking an increased level of care as they age.

Southern Portion/Permanent Supportive Housing Program: The southern portion of the site should be developed as Permanent Supportive Housing through a competitive Request For Proposal (RFP) that stipulates conditions on the development while also seeking to benefit from the experience and creativity of the successful applicant. The Department should exercise further oversight over the project by including requirements in a ground lease. Timing is important for the prospective developer to obtain the favorable tax credits that would make the project more viable. This project should move forward as quickly as possible with the project developer selected through a competitive RFP in early 2017.

Overview and Background
Project Management: Singleton Strategies will continue in the role of project manager by assisting the Department in developing a Request for Proposal (RFP) for the southern portion and identifying the optimal mix of services to be offered on the northern portion, including the development of a financing strategy.

Site Assessment: The Office of the State Architect assisted the Department in engaging RNL Design to conduct an assessment of the Fitzsimons site. The site assessment found that there are no significant impediments to development of either portion of the site. The site assessment also confirmed physical capacity will not be a limiting factor for development.

Financing: The Department engaged SB Clark Associates to provide information on financing options for developing various types of services on the site. The report highlighted a number of different financing options, including the potential of the Department to use enterprise funds to invest in the facilities, recovering the funding over a set period of time and to utilize its role as owner of the site to ensure the sustained quality of services.

Service Needs Assessment: The Public Consulting Group (PCG) built upon its previous consultancy with the Department to evaluate the fiscal and programmatic sustainability of various types of services and facilities to meet the needs of Colorado's current and future

veteran population. The study found that a mixture of Green House Model skilled nursing and dementia care is a potentially financially and programmatically sustainable mix of services.

Timeline of Next Steps

December 2016:	Release a general Request for Proposal (RFP) to a list of eligible profit and nonprofit providers and host a briefing session to orient potential respondents to the project and the elements of a successful proposal. Clarify that the RFP will be updated and refined based on possible feedback from the December submittal of the plan to the Legislature.
December:	Include the general RFP in the report to the legislature.
2017	
January:	Revise the RFP with more specific refinements. Deadline for submittal of proposals in late January.
February:	Before the end of the second week, award the RFP to the successful bidder.
March – April:	Negotiation of contract with developer. Draft lease with clear stipulations that allow the Department to have control over key quality aspects on the site.
March – December:	Design process and partnerships for supportive services ensure a successful development.
June:	Developer submits proposal for the LIHTC.
August:	Execute southern portion site lease.
2018	
January	Ceremonial groundbreaking
December	Permanent Supportive Housing facility opens

Attachment C - Cover Letter

Attachment D - Fitzsimons Quarterly Report 12/2016

Attachment E - Fitzsimons Advisory Group Report

Colorado Home and Community Based Services (HCBS) Statewide Transition Plan (STP)

EXECUTIVE SUMMARY

Federal HCBS Settings Rule

In January 2014, the Centers for Medicare & Medicaid Services (CMS) published a rule to ensure that the provision of Home and Community Based Services (HCBS) occurs pursuant to a person-centered planning process and in settings that meet certain criteria. 79 Fed. Reg. 2948 (Jan. 16, 2014). The rule went into effect in March 2014, and states have five years—until March 2019—to ensure that their HCBS settings are compliant with the rule. The new regulations ensure that participants in HCBS programs have access to the benefits of community living, and that services are true alternatives to services provided in an institutional setting and are delivered in the most integrated setting possible.

The final rule requires that all HCBS settings meet specific criteria, including that they:

- Be integrated in and support full access to the greater community,
- Be selected by the participant from among setting options,
- Ensure individual rights of privacy, dignity, and respect, and freedom from coercion and restraint,
- Optimize autonomy and independence in making life choices, and
- Facilitate choice regarding services and who provides them.

In addition, provider-owned or -controlled residential settings must meet additional criteria, including that they:

- Have a lease or other written agreement providing similar protections for the client that address eviction and appeals processes,
- Ensure privacy in the client's unit including lockable doors, choice of roommates, and freedom to furnish and decorate the unit,
- Ensure that individuals have freedom and support to control their own schedules and activities, and have access to food at any time,
- Protect individuals' ability to have visitors of their choosing at any time, and
- Be physically accessible.

Affected Colorado Waivers and Settings

The HCBS Settings Rule affects the following Colorado HCBS waivers:

- Elderly, Blind, and Disabled (EBD)
- Persons with Brain Injury (BI)
- Persons with Spinal Cord Injury (SCI)
- Community Mental Health Services (CMHS) for Persons with Major Mental Illnesses
- Persons with Developmental Disabilities (DD)
- Supported Living Services (SLS)
- Children's Habilitation Residential Program (CHRP)
- Children's Extensive Support (CES)
- As well as the following waivers, under which services are provided in children's homes, professional provider offices, and clinics, which are presumed to be compliant with the federal settings requirements:
    - Children's HCBS (CHCBS)
    - Children with Autism (CWA)
    - Children with Life Limiting Illness (CLLI)

Under the waivers identified above, the following settings are affected:

- Adult day services centers, including basic and specialized adult day services centers, under the BI, EBD, SCI, and CMHS Waivers
- Alternative care facilities (ACFs) under the EBD and CMHS Waivers. The Department plans to delete references to ACFs in the BI Waiver (with ACFs being replaced by SLPs and TLPs, listed below).
- Child Residential Habilitation settings under the CHRP Waiver, including

    - Foster Care Homes
    - Kinship Foster Care
    - Non-certified Kinship Care
    - Specialized Group Facilities (SGFs), including group homes and group centers
    - Residential Child Care Facilities (RCCFs)
- Day Habilitation settings for individuals with Intellectual and Developmental Disabilities (IDD), including
    - Specialized Habilitation under the SLS and DD Waivers
    - Supported Community Connections (SCC)/Community Connector under the SLS, DD, CHRP, and CES Waivers
    - Prevocational Services facilities under the SLS and DD Waivers
- Day treatment facilities under the BI waiver
- Group Residential Services and Supports (GRSS) Community Residential Homes for four to eight people under the DD Waiver
- Individual Residential Services and Supports (IRSS) settings for up to 3 people under the DD Waiver, including
    - Host Homes
    - Homes owned or leased by agency
    - Family homes
    - Own homes
- Private homes belonging to clients or their families, professional provider offices, and clinics, which are presumed to be compliant with the federal settings requirements, for any waiver
- Supported Employment locations, including group and individual program locations, under the SLS and DD Waivers; individual employment settings are presumed to be compliant with the federal settings requirements
- Supported Living Program (SLP) facilities under the BI waiver
- Transitional Living Program (TLP) facilities under the BI waiver
- Youth Day Service settings under the CES waiver, including the child's home, the provider's home, and other settings in the community

Overview of Statewide Transition Plan (STP)

The Colorado Department of Health Care Policy & Financing (HCPF or "the Department") has developed a Statewide Transition Plan (STP) for bringing Colorado's HCBS services into compliance with the HCBS Settings Rule. The STP is a detailed project plan of Colorado's road to compliance, and it is required by CMS to be subject to public input, be regularly updated, and be submitted for CMS approval and guidance.

The STP is organized *left to right* with: Action Steps that identify the steps necessary for the State of Colorado to come into compliance with the HCBS Settings Rule; projected dates for beginning and ending Action Steps; Key Stakeholders involved with or affected by Action Steps; Progress/Status thus far of Action Steps; and Findings/Results/Outcomes of Action Steps. *Top to bottom*, the STP is organized into three overall Program Components. The first is Stakeholder Engagement and Oversight; this component describes the Action Steps that the Department will take to get input from and provide information to HCBS participants, providers, and other members of the public. The second Program Component is Infrastructure, or ensuring that all the key parts are in place to comply with the HCBS Settings Rule. Within this framework, there are five major endeavors: (1) site-specific assessments of existing HCBS residential and non-residential settings; (2) site-specific remediation for these settings, including creation and implementation of Provider Transition Plans; (3) systemic assessment of existing Colorado statutes, regulations, waivers, and other authorities; (4) systemic updating of these authorities as needed; and (5) enhancing training and technical assistance. The third Program Component is Inclusion of Requirements within the HCBS Quality Framework; this component describes Action Steps to ensure that compliance is measured and monitored in the future.

Completed Work

Since the implementation of the HCBS Settings Rule, the Department has been working with stakeholders to ensure that Colorado is fully compliant by March 17, 2019. The Department created and has been updating the STP. The Department has convened an interagency group, which includes the Colorado Department of Human Services (CDHS) and the Colorado Department of Public Health and Environment (CDPHE), to assist in preparing and taking Action Steps. The Department has solicited waiver participants, providers, and other stakeholders to assist with onsite technical assistance, participation in web-based trainings, and stakeholder workgroups, as well as presentations at various committees and boards to educate and engage in conversation regarding the HCBS Settings Rule. The Department maintains a website for educational materials, Department communications, and CMS communications. The Department will continue to provide trainings to stakeholders regarding the HCBS Final Settings Rule to ensure that participants, providers and other stakeholders understand the HCBS Final Setting Rule and its implementation. The Department has completed a crosswalk that systemically assesses current state statutes, regulations, and waivers and identifies where changes may be necessary; this crosswalk is incorporated by reference into the STP. The Department has begun conducting site visits and collecting provider transition plans (PTPs). Other projects completed by the Department are described below.

For more information on the HCBS Settings Rule, you may visit: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/home-and-community-based-services.html.

For more information on Colorado's path to compliance with the HCBS Settings Rule, you may visit: https://www.colorado.gov/pacific/hcpf/hcbs-waiver-transition and https://www.colorado.gov/pacific/hcpf/home-and-community-based-services-settings-final-rule.

Please send questions/comments to:

Phone: Sarah Hoerle, LCSW—Community First Choice
Long Term Services and Supports Division
303-866-6113

Lori Thompson—HCBS Specialist
Division of Intellectual and Developmental Disabilities
303-866-5142

E-mail: STP.PublicComment@state.co.us

Mail: Statewide Transition Plan Team
1570 Grant St.
Denver, CO 80203

STATEWIDE TRANSITION PLAN (STP)

	Action Item	Start Date	Projected End Date	Key Stakeholders	Progress/Status	Findings/Results/Outcomes
Program Component: Stakeholder Engagement and Oversight						
1.	Convene an interagency group to manage the transition planning process.	5/21/2014	Completed 6/1/2014	Colorado Department of Health Care Policy and Financing ("the Department"), the Colorado Department of Public Health and Environment (CDPHE), the Colorado Department of Human Services (CDHS), the Lewin Group	An interagency team has been convened and meets weekly. The team will continue to meet to monitor and problem-solve issues that may arise throughout the planning process.	A timeline of prioritized tasks for the Department and key stakeholders was developed as a result of an in-person meeting where the interagency group discussed managing the transition process. This timeline will be included on weekly meeting agendas and leveraged as a guide for next steps. Weekly meetings provide a forum for Department staff, leaders, and other key stakeholders to discuss and work on mapping out processes and how to best support the state's providers and waiver participants.
2.	Develop a communication strategy to manage the public input required by the rule as well as ongoing communication on the implementation of the transition plan. Adapt the strategy to different audiences (*e.g.*, case management agencies (CMAs), including Single Entry Point (SEPs) and Community Center Boards (CCBs); providers).	7/10/2014	Completed 7/30/2014; Update to be completed by 3/16/17	The Department	Ongoing communication occurs with stakeholders, state agencies, and other community partners. The Department's written strategy for managing formal public notice is described in Row 6 below. The Department's written strategy for managing other forms of notice to different audiences is described in Rows 4, 5, 7, and 8 below. The Department carefully considers all the input it receives. The Department's responses to the comments it has received during formal public notice periods are summarized and made available to the public, as stated in Row 6. The Department considers all input it receives, formal and informal, in developing trainings and in presenting information at meetings. The Department has been presenting and will continue to present updates about the STP and implementation status at regular stakeholder, provider, and case manager meetings. The Department will include updates on its website (https://www.colorado.gov/hcpf/home-and-community-based-services-settings-final-rule). The Department has conducted a number of webinar based trainings for service providers and stakeholders, to discuss how to support individuals receiving services be integrated into their community, including discussions on employment and volunteer opportunities that will allow individuals to engage with their community. The topics of these webinars were chosen from the feedback the Department received from service providers about their highest concerns. The Department convened a stakeholder workgroup, which met five times, comprised of service providers, family members, and advocates to work collaborative to create best practices that providers can start to implement to support their work of coming into compliance with the HCBS Settings Rule. The Department has met with numerous providers on an individual basis to provide technical assistance concerning the HCBS Setting Final Rule and has discussed employment and volunteer opportunities that can support individuals receiving services to engage with their community. The Department will develop a more formal and effective communication plan by March 16, 2017.	The Department has received and continues to receive valuable input from the public. From November 2015 through March 2016, the Department hosted several in-person and webinar-based stakeholder workgroups to discuss concerns, best practices, and other issues for implementing the HCBS Settings Rule. The workgroups discussed both residential and non-residential settings. The workgroups focused in particular on expanding community integration opportunities, informed choice, and participant rights. The workgroups prepared drafts of best practices that can be shared with other providers. The Department is currently finalizing these drafts.

	Action Item	Start Date	Projected End Date	Key Stakeholders	Progress/Status	Findings/Results/Outcomes
3.	Develop a provider scorecard for assessing the level of support providers need to come into compliance.	10/1/2014	Completed 7/1/2015	The Department, HCBS providers, CDPHE, Communication Department	Completed. A set of provider scorecards is available for review at https://www.colorado.gov/hcpf/home-and-community-based-services-settings-final-rule.	Provider Scorecards available and posted to website at https://www.colorado.gov/hcpf/home-and-community-based-services-settings-final-rule.
4.	Contact providers and provider associations to increase understanding of the rule and maintain open lines of communication.	6/30/2014	Ongoing through 3/15/2019	The Department, CDPHE, CMAs, including SEPs and CCBs, Program Approved Service Agencies and other providers, disability specific organizations, private case management agencies, Alliance, Assisted Living Residences, Parents of Adults with Disabilities Colorado (PADCO), Self-Advocacy Network, Advocacy Communication Group, Participant Directed Programs Policy Collaborative, Waiver Simplification Workgroup, Brain Injury Stakeholder Workgroup, Mental Health Centers, Behavioral Health Organizations (BHOs), County Directors/CHRP Liaison, Guardian at Litem (GAL), Residential Care Collaborative, Arc of Colorado, Arc's, 24 hour Monitoring Unit, Residential Child Care Facility, Permanency Round Table, Foster Home Placements, Policy Advisory Committee (PAC), Sub PAC Family Voices, Parent to Parent, Colorado Cross-Disability Coalition (CCDC), Independent Living Centers, Rooster Ranch, Tall Tales Ranch,	During provider meetings, advisory committees, stakeholder meetings, etc., Department staff have been discussing the rule and how the Department is working to support all providers to become compliant. Communications coming from the Department include information about the requirements with additional information on how to take steps towards compliance. These communications will become more robust as the Department learns more about provider status, needs, and progress in the implementation of the STP.	The Department has actively contacted 580 providers and the organizations listed at left.

	Action Item	Start Date	Projected End Date	Key Stakeholders	Progress/Status	Findings/Results/Outcomes
				Colorado Legal Services, Leading Age, Alliance, Department of Human Services Division for Regional Center Operations, Ombudsman, Colorado Gerontological Society, and other organizations as identified		
5.	Create a space on an existing Department website to post materials related to settings and person-centered planning.	7/10/2014	Completed 7/10/2014; Update to be completed by 3/16/17	The Department	Completed. Currently, the HCBS Waiver-Specific Draft Transition Plans and Amendments are posted at https://www.colorado.gov/pacific/hcpf/hcbs-waiver-transition. The Department has posted training webinars and other education and outreach materials, as well as Provider Transition Plan (PTP) Templates, at https://www.colorado.gov/hcpf/home-and-community-based-services-settings-final-rule. The Department plans to enhance stakeholder involvement by improving the organization and availability of STP-related materials on its website.	https://www.colorado.gov/hcpf/home-and-community-based-services-settings-final-rule : In August 2015: 106/Sept2015: 22 ("hits")
6.	Develop and issue required public notices. Collect comments and summarize for consideration and, where applicable, incorporate changes in the transition plan and within communication tools (*e.g.*, FAQs).	7/30/2014	Ongoing	See Row 4	The Department will provide public notice of the current version of the STP (STP.4) through the following means: • Emailing a Communication Brief to the Long Term Services and Supports Stakeholder list; the Division for Intellectual and Developmental Disabilities Stakeholder list; and providers, advising the recipients of the availability of the full STP, the comment period, and the ways to comment. • Publishing a notice on the Department's website at https://www.colorado.gov/pacific/hcpf/hcbs-waiver-transition, advising the public of the availability of the full STP, the comment period, and the ways to comment. • Emailing a notice to Tribal Consultation recipients advising them of the availability of the full STP, the comment period, and the ways to comment. • Publishing notices in the newspapers of widest circulation in each city in Colorado with a population of 50,000 or more advising the public of the availability of the full STP, the comment period, and the ways to comment. • Publishing a notice in the Colorado Register, which is available at http://www.sos.state.co.us/CCR/RegisterHome.do, advising the public of the availability of the full STP, the comment period, and the ways to comment. The full STP is available on the Department's website at www.colorado.gov/hcpf/hcbs-waiver-transition, and individuals may request the full STP in electronic or hard copy format via email at STP.PublicComment@state.co.us or Lori.Thompson@state.co.us or Sarah.Hoerle@state.co.us, via phone at 303-866-6113 (Sarah Hoerle, LCSW—Community First Choice, Long Term Services and Supports Division) or 303-866-5142 (Lori Thompson—HCBS Specialist, Division for Intellectual and Developmental Disabilities), via fax at 303-866-3991 (Attention: Statewide Transition Plan Team), or in person or via U.S. mail at ATTN: Lori Thompson, Statewide Transition Plan Team, 1570 Grant Street, Denver, CO 80203. The comment period will be the 30-day period following public notice. The public may provide comments via email at STP.PublicComment@state.co.us or Lori.Thompson@state.co.us or Sarah.Hoerle@state.co.us, via phone at 303-866-6113 (Sarah Hoerle, LCSW—Community First Choice, Long Term Services and Supports Division) or 303-866-5142 (Lori Thompson—HCBS Specialist, Division for Intellectual and Developmental Disabilities), via fax at 303-866-3991 (Attention: Statewide Transition Plan Team), or in person or via U.S. mail at ATTN: Lori Thompson, Statewide Transition Plan Team, 1570 Grant Street, Denver, CO 80203.	During the public comment period on the initial STP (STP.1), the Department received 106 questions from eleven different community stakeholders. The questions were clarifying questions that did not require the Department to change the STP. The only changes the Department made were to ensure that all of the community stakeholder groups were listed in the STP. Since the initial public notice period, the Department has implemented a more thorough public notice procedure. The Department has prepared a separate summary, dated November 16, 2015, of the public notice process employed with the second version of the STP (STP.2), as well as a summary of the comment(s) received and the Department's responses to such comment(s). This summary is available at https://www.colorado.gov/pacific/hcpf/hcbs-waiver-transition. The Department has prepared a separate summary, dated June 30, 2016, of the public notice process employed with the third version of the STP (STP.3), as well as a summary of the comments received and the Department's response to such comments. A more comprehensive summary will be available online by March 16, 2017.
7.	Continue ongoing stakeholder engagement for Supported Employment Services and similar programs for non-DIDD waivers.	5/22/2014	3/15/2019	See Row 4	Ongoing discussions regarding Supported Employment occur with the Department and stakeholders. Currently identifying possibilities and areas of concern. The Department has conducted a number of webinar based trainings for service providers and stakeholders, to discuss how to support individuals receiving services be integrated into their community, including discussions on employment and volunteer opportunities that will allow individuals to engage with their community. The topics of these webinars were chosen from the feedback the Department received from service providers about their highest concerns.	The Department has met with many residential and non-residential providers and expressed the importance of community integration and meaningful community roles for individuals. This has included individuals seeking competitive employment, volunteer opportunities, and other activities of their choosing. The Department is currently reviewing regulations to identify and eliminate barriers to meaningful community

	Action Item	Start Date	Projected End Date	Key Stakeholders	Progress/Status	Findings/Results/Outcomes
					The Department convened a stakeholder workgroup, which met five times, comprised of service providers, family members, and advocates to work collaboratively to create best practices that providers can start to implement to support their work of coming into compliance with the HCBS Settings Rule. The Department has met with 30 providers on an individual basis to provide technical assistance concerning the HCBS Settings Final Rule and has discussed employment and volunteer opportunities that can support individuals receiving services to engage with their community.	integration; as an example, the Department is reviewing a possible disincentive to work when in an Alternative Care Facility, given that payments to the facility increase as income increases.
8.	Provide quarterly updates to CMS on status of systemic assessment and site-specific assessment projects.	9/31/2016	Ongoing until projects are completed or 3/15/2019	CMS	The Department has begun providing quarterly updates by email to CMS Regional Office and Central Office staff.	
Program Component: Infrastructure						
1. Site-specific assessments of existing HCBS residential and non-residential settings						
9.	Create a two-stage provider survey process to assess settings where HCBS participants live and/or receive services.	5/21/2014	Completed 6/30/2014	The Department, the Lewin Group	Completed.	See below.
10.	Conduct Stage 1 macro review of provider settings (initial survey of existing providers).	6/30/2014	Completed 1/21/2016	See Row 9	Completed. The Stage 1 provider self-assessment survey is closed as of January 2016.	See below.
11.	Conduct Stage 2 micro review of provider settings based on the results of Stage 1 (secondary survey).	7/20/2014	Completed 1/21/2016	See Row 9	Completed. The Stage 2 provider self-assessment survey is closed as of January 2016. As of January 21, 2016, 613 unique providers completed the Initial and/or Secondary Provider Self-Assessment Surveys. Some providers offer multiple services and/or participate in multiple waivers, and hence completed multiple surveys, yielding 1,602 completed surveys. 145 providers did not complete the self-assessment survey, or their response submissions could not be linked to a provider. Providers that did not complete the self-assessment survey, like all other providers, will have to complete Provider Transition Plans (PTPs) and may be selected for site visits. See Rows 14 and 15 below.	As of January 21, 2016, 211 residential providers scored a Support Level 1, meaning that their responses to the Initial and/or Secondary Provider Self-Assessment Surveys yielded an indicators of isolation score less than 25% and a score less than 50% on concerns relating to "Rights, Autonomy, and Choice." 146 residential providers scored a Support Level 2 or higher, meaning that their responses to the Initial and/or Secondary Provider Self-Assessment Surveys fell within one of the following categories: Support Level 4 (any indication of a setting located on the grounds of or immediately adjacent to a public institution or an indicators of isolation score greater than 50%), Support Level 3 (indicators of isolation score less than 50% and greater than 25%), or Support Level 2 (indicators of isolation score less than 25% and a score greater than 50% on concerns relating to "Rights, Autonomy, and Choice"). Residential providers' self-assessment survey responses indicate that they have practices that promote empowerment and community inclusion, and that they tend to ensure that residents have access to food at all times. Key areas for improvement include promoting residents' interactions with people who are not disabled, Medicaid-only residents, and/or paid staff; increasing individuals' control over their finances; and protecting residents' ability to leave the property. As of January 21, 2016, the majority of nonresidential providers appear to need support in complying with the rule. 142 nonresidential providers scored a Support Level 2 or higher, and 58 scored a Support Level 1. (Some providers may

	Action Item	Start Date	Projected End Date	Key Stakeholders	Progress/Status	Findings/Results/Outcomes
						appear in both the residential and nonresidential categories.) Nonresidential providers' self-assessment survey responses indicate that they respect individuals' ability to choose to engage or not in various activities based on their own interests and preferences. The main area for improvement for nonresidential providers is to address the prevalence of segregated settings where the majority of individuals do not work in integrated competitive employment and/or do not engage in activities with the general community. Updated scorecards summarizing the survey data for providers serving particular waiver populations were posted on the Department's website.
12.	Develop and conduct survey for individuals and families to provide input on settings by type and location.	10/1/2014	Development completed 6/30/2014. Survey data collection is ongoing.	See Row 9	Completed the development of the survey. Click here for links to the English (https://www.research.net/r/ColoradoHCBS?sm=siM2g6TQhRelxbnaIcDL%2b0R1oNDQQAE%2bE8GvzAQHv1s%3d) and Spanish (https://www.research.net/r/Z2N3TQM) versions of the survey for online completion. A hard copy version of the survey is available at https://www.colorado.gov/pacific/sites/default/files/Colorado%20HCBS%20Survey-Individual%20Family%20Advocates-Paper%20version-2015.pdf. Individuals may request that a hard copy version of the survey be sent to them by sending an email to Lori.Thompson@state.co.us or Sarah.Hoerle@state.co.us, by calling 303-866-6113 (Sarah Hoerle, LCSW—Community First Choice, Long Term Services and Supports Division) or 303-866-5142 (Lori Thompson—HCBS Specialist, Division for Intellectual and Developmental Disabilities), by faxing 303-866-3991 (Attention: Statewide Transition Plan Team), or by visiting in person or sending U.S. mail to ATTN: Lori Thompson, Statewide Transition Plan Team, 1570 Grant Street, Denver, CO 80203. Individuals may return their completed hard copy surveys by emailing, faxing, or mailing the same recipients. Data from survey responses is currently being analyzed.	The Department will keep the IFA Survey open for individuals and their families/advocates to take as often as they like, through at least the end of the five-year transition period. Results will inform processes and providers and/or locations that need additional support. Results will also inform stakeholder engagement agenda items, as well as training topics. As of April 22, 2016, 389 individual surveys have been completed. Many survey respondents have elected to identify the particular setting at which they or their family member receive services, which allows their responses to be used in the site-specific assessment process. The Department is asking providers to circulate the IFA Survey to their clients and family members when they begin working on the PTP for a given setting. The completed survey is submitted to the Department directly by the person who completes the survey. Site visit teams will confirm that providers circulated the survey and will directly interview individuals and their family members at settings selected for a site visit. The Department will continue to periodically remind stakeholders of the IFA Survey by issuing quarterly reminders to stakeholders at stakeholder meetings and in notices sent to the DIDD Communication Brief recipient list, the LTSS notice recipient list, and the list of stakeholders that have been participating in the conflict-free case management project. The Department will also ask case managers to inform their clients about how to take the IFA Survey.
13.	Prepare for on-site surveys.	3/1/2015	Completed 4/8/2016	The Department, the Lewin Group, Telligen, CDPHE, CMAs, including SEPs and CCBs, providers that own or operate affected settings,	The Department has created a Provider Transition Plan (PTP) Excel file; the PTP User Manual; the Protocol for Site Visits and Heightened Scrutiny; and a Checklist for site visitors. These materials are being used to support providers in coming into compliance with the HCBS Settings Rule and to guide the site visit process. The Department's prior contractor, Telligen, emailed PTP Excel files and PTP User Manuals to the initial set of providers whose settings received an on-site survey. Telligen conducted site visits with these providers.	The **Provider Transition Plan (PTP)** is an Excel document that the provider completes in order to assess its compliance with the HCBS Settings Rule, assess the potential application of heightened scrutiny, and set out a remedial action plan and timeline. When submitting its PTP, the provider attaches relevant evidence (*e.g.*, leases,

<table>
<tr><th></th><th>Action Item</th><th>Start Date</th><th>Projected End Date</th><th>Key Stakeholders</th><th>Progress/Status</th><th>Findings/Results/Outcomes</th></tr>
<tr><td></td><td></td><td></td><td></td><td>clients that receive services at or reside in affected settings, and other community stakeholders</td><td>The Department's current partner, CDPHE, is emailing PTPs and User Manuals to more providers and conducting site visits with these providers.

PTP templates are available on the Department's website at https://www.colorado.gov/pacific/hcpf/home-and-community-based-services-settings-final-rule.

The Department is currently working with CDPHE to update the PTP templates, the PTP User Manual, and the Protocol for Site Visits and Heightened Scrutiny. The Department plans to post these materials online once the updates are completed.</td><td>photographs). The completed PTP and attached evidentiary materials are subject to review and approval by the Department.

The PTP User Manual is a Word document that guides providers in completing the PTP.

The Protocol for Site Visits and Heightened Scrutiny (Protocol) is a Word document that guides site visitors in conducting site visits and determining whether a setting may be subject to heightened scrutiny. The Protocol includes a Checklist for site visitors to use when assessing particular settings.

Under the HCBS Settings Rule, CMS will apply heightened scrutiny where a setting

• is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment;

• is in a building located on the grounds of, or immediately adjacent to, a public institution; or

• has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving HCBS.</td></tr>
<tr><td>14.</td><td>Conduct on-site surveys.</td><td>4/13/2016</td><td>6/30/2017</td><td>See Row 13</td><td>As noted above, the Department's prior contractor, Telligen, conducted site visits with the initial set of providers to receive an on-site survey. The Department's current partner, CDPHE, is continuing to conduct site visits.

The Department is conducting site visits to verify survey responses and to further assess particular settings. A statistically significant number of randomly selected site visits will be completed. During site visits, PTPs will be updated and completed for providers that are being visited.

After the preparation of STP.3, the Department created an updated, comprehensive registry of settings at which HCBS services were provided and for which Medicaid reimbursement was paid in Fiscal Year 2015-2016. This list is more accurate than the one than the one used in preparing STP.3 in that it (a) contains more current information, and (b) identifies all settings where services are rendered rather than all providers who are offering services. Using this updated registry, the Department used a probability proportional to size sampling strategy to randomly select settings, stratified by setting type, for site visits.

The overall setting universe, based on the number of settings in the updated registry, is N = 3811 settings. In order to select settings for site visits, the Department did not de-duplicate this figure by consolidating settings at which agencies provide more than one service, as doing so would interfere with the proportional allocation of site visits across setting types.

The Department used a validated sample size calculator (https://www.surveymonkey.com/mp/sample-size-calculator/) to select a statistically significant sample size (n=350) of the population (N=3811), using a 95% confidence level, 5% margin of error, and 50% response distribution.

The sample of 350 sites to be surveyed was determined using a probability proportional to size sampling methodology (see Table 1). Under this methodology, the Department allocated the 350 site visits proportionately across setting types, and then randomly within setting type. For example, ACFs comprise 8.9% (n=340) of the setting universe (N=3811), and so they receive 8.9% (n=31) of the total site visits (350). The sample sites, stratified by setting type, were then randomly selected from the updated registry of settings using the random number generator function in Microsoft Excel.

Table 1. Sample Setting Sites Stratified by Setting Type

<table><tr><th>Setting Type</th><th>Setting Population (N)</th><th>Proportion of Population (%)</th><th>Settings in Sample (n)</th></tr></table></td><td>• The selected approach most closely follows available guidance, which states that "[s]tates may . . . perform on-site assessments of a statistically significant sample of settings"; "[s]tatistically valid sampling means the number of providers selected for review is proportionally representative of the total number of settings OF THAT TYPE in the state"; "the sampling should be stratified – a statistically representative number of settings FOR EACH type of setting should be visited"; and "[s]tratified sample means X% of adult foster homes, X% of group homes, X% of sheltered work facilities, X% Adult Day services, etc." Slide Deck on Assessment of State Systems (presented by Sharon Lewis, Senior Advisor to the Secretary on Disability Policy and Principal Deputy Administrator for the Administration on Community Living (ACL), on CMS-hosted Sept. 23, 2015 SOTA call).

• The selected approach ensures that "the number of providers selected for review is proportionally representative of the total number of settings OF THAT TYPE in the state." Id.

• While an approach the Department considered in the prior STP is also generally consistent with CMS's guidance, it may go too far: by providing for a 95% confidence level within each setting type, it yields a disproportionately high number of site visits—as many as 100% of providers—within setting types that have relatively few providers (e.g., Adult Day; Supported Living Program). Visiting</td></tr>
</table>

	Action Item	Start Date	Projected End Date	Key Stakeholders	Progress/Status	Findings/Results/Outcomes

Adult Day Services Centers (basic & specialized—now combined into a single category for sampling purposes)	105	2.8	10
Alternative Care Facilities (ACFs)	340	8.9	31
CHRP settings	33	0.9	3
Day Habilitation - Specialized Day Habilitation settings	194	5.1	18
Day Habilitation - Supported Community Connections (SCC)	181	4.7	17
Prevocational Services centers	43	1.1	4
Day Treatment facilities under BI waiver	4	0.1	0
Residential Habilitation (GRSS) - Group Homes	150	3.9	14
Residential Habilitation (IRSS) - Host Homes	1971	51.7	181
Residential Habilitation (IRSS) - Other	540	14.2	50
Supported Employment - Group settings	177	4.6	16
Supported Living Program (SLP) Facilities	10	0.3	1
Transitional Living Program (TLP) Facilities	4	0.1	0
CES Youth Day Service settings	59	1.5	5
TOTAL	**3811**		**350**
Figures in this table are subject to change as providers open and close settings in particular categories, and as the Department receives additional information from providers.			

Where this process did not lead to at least two settings within a setting type being selected for a site visit, the Department randomly selected additional settings to yield at least two site visits per setting type. Specifically, the Department randomly selected two Day Treatment facilities, one Supported Living Program (SLP) facility, and two Transitional Living Program (TLP) facilities under BI waiver. These additional selections increased the sample size from 350 to 355 setting sites.

After proportionately allocating site visits across setting types and randomly selecting specific sites for visits, the Department de-duplicated nonresidential settings (*e.g.*, settings that provide both Specialized Habilitation and SCC) and adult residential settings (*e.g.*, settings that provide both IRSS-HH and IRSS-Other). This process yields a de-duplicated total of over 3,000 PTPs and approximately 314 site visits to be completed.

For adult day service centers and ACFs, the Department is counting site visits already selected and conducted under its prior sampling methodology toward the total site visits called for under the new methodology, because the prior sampling was random within a similarly sized population (n), and the site visits for these setting types were conducted in random order.

For purposes of site-specific assessments (*e.g.*, Provider Transition Plans and site visits), Colorado plans to draw on its understanding of the way most private homes, professional provider offices, clinics, and Supported Employment – Individual settings operate in presuming that they are compliant with the applicable federal requirements. Anyone may seek to rebut this presumption by providing information about a particular setting to the Department. For situations where a family caregiver is a provider and owns the home in which he or she provides services to a family member, Colorado plans to test its presumption by conducting site visits at a random selection of family-caregiver-owned homes; assuming the presumption holds, Provider Transition Plans will not be required for all family-caregiver-owned homes. Supported Employment – Group settings will be subject to the same PTP and site visit process as other settings.

Providers that did not complete the self-assessment survey, like all other providers, may be selected for site visits.

100% of any setting type defeats the purpose of sampling, and is probably not what CMS has in mind.

- The Department reserves the right—but not the obligation—to add site visits if it believes a particular provider may be out of compliance. For example, if the Department develops concerns based on the provider self-assessment survey responses, any client or family responses to the Individual and Family Survey that are identifiable to a particular setting, or public input, it could decide that it would be worthwhile to visit the setting in question (even if the setting is not part of the randomly selected settings).

- Compared to the other approaches considered, the selected approach makes the most efficient use of state time and resources by providing for the smallest total number of site visits. The smaller the number of site visits, the more likely it is that Colorado will be able to complete them within its proposed timeframe (aiming to complete all initial site visits by June 30, 2017) and within budget. The other approaches would generate a far greater—and probably unrealistic—burden in terms of time and effort.

- Even though it provides for a smaller number of site visits, the selected approach still provides for a very significant number of site visits. Because such a large number of settings will receive direct, in-person contact with site visitors, it is questionable whether the other, more burdensome, approaches provide any appreciable value to CMS, the Department, and stakeholders.

The outcomes of the site visits will inform providers' next steps and will be acted upon as described below.

	Action Item	Start Date	Projected End Date	Key Stakeholders	Progress/Status	Findings/Results/Outcomes
2. Site-specific remediation for existing HCBS residential and non-residential settings						
15.	Provider Transition Plans (PTPs) will be completed by all HCBS providers for all settings at which they provide HCB Services, except for private homes belonging to clients or their families, professional provider offices, clinics, and Supported Employment – Individual settings (unless anyone seeks to rebut the presumption of compliance as to a particular setting). PTPs will include determinations of whether providers are potentially subject to heightened scrutiny and whether they need to make any changes to attain compliance and/or to be put forward to CMS for heightened scrutiny.	4/13/2016	6/30/2017	See Row 13	As noted above, the Department has created a Provider Transition Plan (PTP) Excel file; the PTP User Manual; the Protocol for Site Visits and Heightened Scrutiny; and a Checklist for site visitors. These materials are being used to support providers in coming into compliance with the HCBS Settings Rule and to guide the site visit process. The Department's prior contractor, Telligen, emailed PTP Excel files and PTP User Manuals to the initial set of providers to receive an on-site survey. The Department's current partner, CDPHE, is emailing PTPs and User Manuals to the remaining providers. Providers need not complete PTPs for their settings until they are contacted by the Department or CDPHE with information on how to complete their PTPs. In addition to the guidance contained within the PTP, Department assistance with remedial actions may include: conducting an additional site visit; meeting with the provider to identify potential solutions for compliance; sharing information from stakeholder action groups to identify innovations and problem-solve challenges; and providing in-person training, webinar training, fact sheets, frequently asked questions documents, slide decks, and a website with an innovation corner for provider feedback and comments. Providers that did not complete the prior self-assessment surveys, like all other providers, will have to complete PTPs. The PTP requirement applies regardless of whether a setting has been selected for a site visit.	
16.	Updated PTPs will be submitted, along with evidence supporting changes made by the provider to come into compliance.	10/13/2016	12/31/2017	See Row 13	Providers must submit an update to their PTP within three months of their site visit or initial submission of their PTP without a site visit (if the provider was only asked to complete a PTP), with evidence of any changes made (*e.g.*, new leases or resident agreements). Providers must continue to update their PTP every three months, demonstrating the remedial actions they have taken, until they are notified by the Department that they are in compliance with the federal rule or the Department determines that they cannot meet the federal requirements, in which case they must prepare to transition their HCBS participants to other settings. The Department may conduct additional site visits as necessary, including to better understand how individuals are experiencing any changes made by the provider.	
17.	Determine whether each provider has made any required changes (including any necessary to be put forward to CMS for heightened scrutiny) or whether the provider needs to begin the process of transitioning clients from the impacted setting to another setting.	10/13/2016	12/31/2017	See Row 13	The Department will use the data from the two Provider Self-Assessment Surveys, the on-site surveys, the PTPs, and any updates to PTPs (with evidence of any changes made by the provider) to sort settings into the following categories: • Setting is not subject to heightened scrutiny and is compliant with the HCBS Settings Rule; no further action needed. • Setting is not subject to heightened scrutiny and will become compliant with remediation that it will complete in a reasonable timeframe. • Setting is not subject to heightened scrutiny, cannot meet the federal requirements, and will be removed from HCBS program; setting must prepare to transition clients elsewhere. • Setting is presumptively non-HCBS, and state will submit evidence to CMS to overcome the presumption of institutional or isolating qualities. This category includes: o (a) Setting is subject to heightened scrutiny and is able to overcome institutional presumption, and evidence will be put forward to CMS; and o (b) Setting is subject to heightened scrutiny and is not yet able to overcome institutional presumption, but will be able to do so in a reasonable timeframe. • Setting is institutional or is subject to heightened scrutiny and not timely able to overcome institutional presumption; setting must prepare to transition clients elsewhere.	
18.	Publicly notice final outcomes of site-specific assessments (including which providers will be put forward to CMS for heightened scrutiny).	12/31/2017	1/31/2018	See Row 13		
19.	Submit updated STP with site-specific assessments to CMS	1/31/2018	3/5/2018	See Row 13		

	Action Item	Start Date	Projected End Date	Key Stakeholders	Progress/Status	Findings/Results/Outcomes
	(including which providers are being put forward for heightened scrutiny).					
20.	Develop a process to support a stable transition for individuals to new settings as appropriate.	10/13/2016	1/31/2018	See Row 4	Key elements of this process are described in the next several rows. The Department will develop a framework similar to that currently used by the Colorado Choice Transitions (CCT)/Community Transition Services (CTS) program. While this program focuses on transitioning from institutional to community settings, the lessons and processes can be adapted for what is needed to comply with the HCBS Settings Rule. The Department will require the use of an Individual Transition Plan (ITP) to support the individual(s) being served in the transition.	**Individual Transition Plan (ITP)** is a plan developed with an individual to identify the services and supports needed if their current setting is not going to timely come into compliance and the individual needs to transition to a new setting. The ITP will include assurances that the beneficiary received reasonable notice and due process in their transition; that the beneficiaries are given the opportunity, information, and supports to make informed choice of an alternate setting; and that critical services/supports are in place in advance of the individual's transition. The number of affected beneficiaries has not yet been determined. The ITP will be documented in the individual's existing person-centered service plan and log notes; it will not be a separate document.
The Department expects the individual transition process to include the following steps:						
21.	Reach out to providers that need to begin the process of transitioning clients from the impacted setting to another setting.	1/31/2018	2/28/2018	See Row 4	As stated above (see Row 18), the Department will publicly notice its determinations of which providers cannot meet the federal requirements or cannot timely overcome the institutional presumption and must prepare to transition clients elsewhere by 1/31/2018.	
22.	Providers that believe their settings are compliant or will timely comply with the HCBS Settings Rule may submit relevant evidence to the Department.	3/1/2018	3/31/2018	See Row 4	The Department will use an informal process by which individuals and providers can submit their objections, with relevant evidence, by email or other appropriate means.	
23.	The Department will complete its reassessment of any settings as to which providers have submitted evidence of compliance.	4/1/2018	4/30/2018	See Row 4		
24.	The Department will publicly notice any revisions to its site-specific determinations.	5/1/2018	5/31/2018	See Row 4		
25.	The Department will submit any revised site-specific determinations to CMS.	6/1/2018	6/30/2018	See Row 4		
26.	Case managers will prepare an ITP with each individual that resides or receives services at a setting that has been finally determined noncompliant/not able to timely comply.	7/1/2018	7/30/2018	See Row 4	Individuals who do not object to a determination of noncompliance can begin this process with their case managers as early as 1/31/2018. If necessary, funding for individual transition assistance should be available by July 1, 2018. See Row 42, below.	
27.	ITPs will be implemented, such that clients no longer receive services from noncompliant settings.	8/1/2018	12/31/2018	See Row 4		

	Action Item	Start Date	Projected End Date	Key Stakeholders	Progress/Status	Findings/Results/Outcomes
28.	Transition assistance and weekly check-ins by case manager continue for 30 days after individual's transition to ensure a stable relocation.	9/1/2018	1/31/2019	See Row 4		
3. Systemic assessment of existing Colorado statutes, regulations, waivers, and other authorities						
29.	Review Colorado statutes, regulations, and waivers to determine whether these authorities are compliant with, silent on, or in conflict with the HCBS Settings requirements; prepare crosswalk summarizing this analysis and recommending any changes necessary to achieve compliance.	5/21/2014	Completed 4/15/2016; Updated 12/16/16	The Department, CDPHE, CDHS, the Lewin Group	The systemic assessment crosswalk is being submitted to CMS with, and is incorporated by reference in, the current version of the STP.	The Lewin Group provided the Department with an initial set of recommended redlines to relevant statutes, regulations, waivers, and other authorities. The Department has since conducted a more detailed and comprehensive review of potentially relevant statutes, regulations, and waivers, and it has prepared a more detailed crosswalk as described at left. The crosswalk will be used as a roadmap for preparing a more detailed and comprehensive set of recommended redlines to relevant statutes, regulations, and waivers. The Department is collecting best practices relevant to potential rule changes as part of the Stakeholder Engagement Workgroups (November 2015-March 2016).
30.	Publicly notice crosswalk.	4/15/2016	Completed 5/5/2016; update 12/30/16	See Row 4, plus CDHS	The Department has revised the crosswalk in light of CMS's August 30, 2016 feedback and the public comments it has received.	
31.	Submit amended STP with crosswalk to CMS.	5/5/2016	Completed 6/30/2016; Updated 12/16/16	See Row 29	As noted above, the updated systemic assessment crosswalk is being submitted to CMS with, and is incorporated by reference in, the current version of the STP.	
32.	Update crosswalk to account for any revisions to and renumbering of cited authorities.	6/1/2017	12/31/2017 and 12/31/2018	See Row 29	Because Colorado's statutes, regulations, and waivers are always being revised and renumbered to some extent, the Department plans to update the crosswalk by the end of 2017 and the end of 2018 to ensure that it cites and analyzes the current versions of the relevant authorities. As part of this annual update process, the Department plans to ask CDPHE and CDHS whether these agencies have made any changes to their regulations that should be reflected in the crosswalk. The Department will make the updated crosswalk available on its website but does not plan to employ the full public notice process in Row 6.	
33.	To the extent not already addressed in Row 29, work with other agencies as appropriate to analyze existing provider enrollment/re-enrollment, validation, survey, quality assurance, licensure, and certification standards, processes, and frequency; and to determine where changes could be made to promote and monitor ongoing compliance with HCBS Settings requirements, both for current providers and new/potential providers.	4/1/2015	12/30/2017	See Row 29	The Department is working with CDPHE to modify survey requirements and to review survey cycles. The Department is gathering data, evaluating, and discussing with other stakeholders potential changes to existing provider enrollment/re-enrollment, validation, survey, quality assurance, licensure, and certification standards, processes, and frequency. The Department has developed a list of modifications to quality assurance documents. This action step will include deleting references to "non-integrated work services programs [that] provide paid work in sheltered/segregated settings."	
34.	To the extent not already addressed in Row 29, work with	4/1/2015	12/30/2017	The Department, CDHS, County	The Department is working with the Colorado Department of Human Services (CDHS), which administers the CHRP waiver, to review setting and setting requirements. This work includes analysis of the interface between the HCBS Settings Rule and	

	Action Item	Start Date	Projected End Date	Key Stakeholders	Progress/Status	Findings/Results/Outcomes
	CDHS to analyze existing policies for CHRP settings and to determine where changes could be made to promote compliance with HCBS Settings requirements, potentially including: • Strengthening the person-centered planning processes in group homes, group centers, and RCCFs • Expanding financial and dietary rights in group homes, group centers, and RCCFs when appropriate by age or court order • Ensuring informed choice of settings, including providers available within waiver (and not just choice between waiver and institutional/other options), and choice of roommates, when consistent with court orders • Expanding Individual Choice Statement described in the waiver to include additional flexibility in choosing persons who attend team meetings, roommates when applicable, and setting type when such an option is available through a court order. • Identifying where educational supports are provided within the residential setting and moving toward integration within the public school system.			Departments of Social Services (DSS), County Directors/CHRP Liaison, Educational settings, GAL, Residential Care Collaborative, Arc of Colorado, 24 hour Monitoring Unit, Residential Child Care Facility, Permanency Round Table, Foster Home Placements, PAC, Sub PAC	current CHRP operations and the restrictions in place due to the statutes that govern the Colorado Foster Care system, along with the legal authorities that restrict choices youth can make.	
Determining and responding to cost impacts						
35.	Provide sample PTPs to CMS	5/15/2016	1/1/2017	See Row 13, plus CMS	The Department has sent sample PTPs to CMS, and may send additional samples in the future, to ensure the plans are compliant with the federal rule. CMS has stated that it will review providers' proposed remedial action plans to ensure that they are compliant with the federal rule. The Department will use this process to ensure that remedial action plans without cost impacts can be sufficient in some cases, and to better understand the need in CMS's mind for any changes that have significant cost impacts.	

	Action Item	Start Date	Projected End Date	Key Stakeholders	Progress/Status	Findings/Results/Outcomes
36.	Calculate the potential cost impacts of provider remediation strategies, individual transition planning, and potential Interchange programming to prevent payments for HCBS services rendered at noncompliant settings; determine (a) whether a budget action is necessary and (b) whether any waiver amendments are necessary.	1/1/2017	2/29/2017	See Row 29, plus Governor's Office and General Assembly	The Department has received and will continue to seek relevant information from the site-visit process, public comments on the STP and crosswalk, CMS's expected feedback on PTPs, and stakeholder/provider/case manager meetings.	
4. Systemic updating of existing Colorado statutes, regulations, waivers, and other authorities						
If a budget change request or a change to state statute is necessary:						
37.	Internal departmental preparation of budget request and/or state statute change	1/1/2017	10/31/2017	See Row 36		
38.	Governor's Office includes request in budget provided to Joint Budget Committee (JBC) and/or approves Department Bills	11/1/2017	11/1/2017	See Row 36		
39.	JBC staff and Department explain request to JBC during briefings and hearings; Legislative Team secures legislative sponsors for non-budget bills	11/2/2017	1/31/2018	See Row 36		
40.	JBC staff makes recommendations on the request to the JBC during figure setting	3/1/2018	3/31/2018	See Row 36		
41.	Bills proceed through and are passed by General Assembly, then signed by Governor	1/16/2018	5/30/2018	See Row 36	Once Long Bill (budget) is passed, see Rows 51-58 below for process of amending rate methodology in waiver(s), if necessary.	
42.	Funding is available; enacted bills become effective	7/1/2018	Ongoing	See Row 36	If necessary, funding should be available by July 1, 2018 so that providers can make changes to come into compliance by March 2019.	
If any substantive amendments to waivers are necessary and can proceed prior to legislative approval of budget/statutory changes (see Rows 51-58 below for changes to rate methodology in waivers):						
43.	Using crosswalk as a roadmap, draft substantive waiver amendments and public notice, and submit same for internal clearance	3/1/2017	7/1/2017	See Row 36		
44.	Email cleared public notice to Medical Services Board (MSB) Coordinator	7/2/2017	7/20/2017	See Row 36		
45.	MSB Coordinator submits public notice to Colorado Register (1st and 15th of each month); Department staff submit notice to newspapers (unless Department's website meets CMS's criteria for web-only	7/21/2017	8/1/2017	See Row 36		

	Action Item	Start Date	Projected End Date	Key Stakeholders	Progress/Status	Findings/Results/Outcomes
	notice); Department staff post notice on Department website and email it to various stakeholder lists					
46.	Colorado Register publishes notice (posts on the 10th and 25th of each month); newspapers publish notice	8/2/2017	8/10/2017	See Row 36		
47.	Tribal Consultation process and public comment period	8/10/2017	9/10/2017	See Row 36		
48.	Review public and tribal comments; revise waiver amendment(s) as appropriate	9/11/2017	10/11/2017	See Row 36		
49.	Submit proposed waiver amendment(s) to CMS	10/12/2017	10/15/2017	See Row 36		
50.	Waiver amendment(s) effective with CMS approval	10/16/2017	1/15/2018	See Row 36	Effective date may be delayed in the event of CMS Requests for Additional Information (RAIs).	
If any changes to rate methodology in waivers (or other changes that are contingent on legislative approval) are necessary:						
51.	Draft public notice and waiver rate methodology amendment(s) and submit for internal clearance	5/1/2018	7/1/2018	See Row 36	This process begins as soon as the General Assembly and Governor have authorized any necessary appropriations increases; see Rows 37-42 above.	
52.	Email cleared public notice to MSB Coordinator	7/2/2018	7/20/2018	See Row 36		
53.	MSB Coordinator submits public notice to Colorado Register (1st and 15th of each month); Department staff submit notice to newspapers (unless Department's website meets CMS's criteria for web-only notice); Department staff post notice on Department website and email it to various stakeholder lists	7/21/2018	8/1/2018	See Row 36		
54.	Colorado Register publishes notice (posts on the 10th and 25th of each month); newspapers publish notice	8/2/2018	8/10/2018	See Row 36		
55.	Tribal Consultation process and public comment period	8/10/2018	9/10/2018	See Row 36		
56.	Review public and tribal comments; revise rate methodology amendment(s) as appropriate	9/11/2018	10/11/2018	See Row 36		
57.	Submit proposed rate methodology amendment(s) to CMS	10/12/2018	10/15/2018	See Row 36		
58.	Rate methodology change(s) effective with CMS approval	10/16/2018	1/15/2019	See Row 36	Effective date may be delayed in the event of CMS Requests for Additional Information (RAIs).	

	Action Item	Start Date	Projected End Date	Key Stakeholders	Progress/Status	Findings/Results/Outcomes
For changes to Department/Medical Services Board (MSB) regulations: This schedule sets out the approximate last date(s) by which rule changes must be moved forward. In reality, some rule changes (such as those being developed by the ACF workgroup) are already in progress or may begin in advance of the schedule below. To the extent that changes to other agencies' regulations are necessary, the timeline will be similar to that described below.						
59.	Complete and clear Rule Revision Timeline and Rule Initiation Form (RIF)	3/1/2018	4/1/2018	See Row 36	The Rule Revision Timeline and Rule Initiation Form (RIF) are internal documents used to initiate an informal stakeholder engagement process.	
60.	Prepare and clear initial draft of new/amended rules	4/2/2018	7/1/2018	See Row 36	The Department will prepare its initial draft of new/amended rules using the crosswalk as a roadmap, and drawing on feedback received to date from CMS and the public.	
61.	Release draft rules for informal public comment period	7/2/2018	9/1/2018	See Row 36	The Department will initiate an informal stakeholder engagement period by emailing a Communication Brief to the Long Term Services and Supports Stakeholder list; the Division for Intellectual and Developmental Disabilities Stakeholder list; and providers. The Communication Brief will explain to stakeholders how they can comment on the draft rules. The Department will also make announcements about the draft rules on its website and at stakeholder meetings.	
62.	Submit Rule Work Order and Executive Order 05 Worksheet (regarding impact on local government) to MSB Coordinator	9/2/2018	9/12/2018	See Row 36	MSB Coordinator will provide correctly formatted Word version of the current official rule text and make available the remaining rule packet documents (*e.g.*, notice of proposed rulemaking). The Word version is to be edited in Track Changes. MSB Coordinator's office will consult with local governments about impact on local governments and get written notice of compliance from OSPB.	
63.	Prepare and clear final rules, MSB Rule Packet, and response to public comments; submit cleared materials to MSB Coordinator	9/13/2018	11/12/2018	See Row 36	Once the packet has been cleared through Office Director, it is sent to Budget and Program Integrity for their review and approval. After all appropriate reviewers have approved, a rule packet is sent to the Office Director for final approval, then forwarded to the MSB Coordinator.	
64.	MSB Preview	11/9/2018	11/9/2018	See Row 36	MSB hearings are held on the second Friday of the month. The Department will provide the MSB with an overview of its new/amended regulations and the crosswalk used to draft them in order to allow the MSB to more efficiently review the actual proposals down the road.	
65.	Notice of proposed rulemaking issued to public; draft of proposed rules/amendments submitted to Department of Regulatory Agencies (DORA)	11/14/2018	11/25/2018	See Row 36	Notice of proposed rulemaking will be published in Colorado Register (if submitted by 1st of month, will post on the 10th of the month; if submitted by 15th of month, will post on the 25th of month), circulated to Department's list of people who have requested notification of proposed rulemakings, and emailed to LTSS and DIDD stakeholder lists. The Department will also engage in a Tribal Consultation process.	
66.	Public Rule Review Meeting (PRRM)	11/19/2018	11/19/2018	See Row 36	The Department will seek feedback from interested members of the public and update its list of interested stakeholders.	
67.	Final version of rule prior to Medical Services Board (MSB) hearing made available	11/27/2018	12/3/2018	See Row 36	The Department will make available to the MSB the actual proposed rule, together with a proposed statement of basis, specific statutory authority, purpose, and any requested regulatory analysis. The MSB Coordinator will obtain the Attorney General's confirmation of the constitutionality and legality of the rule and will submit the rule with this feedback to the Office of Legislative Counsel.	
68.	MSB Initial Approval	12/14/2018	12/14/2018	See Row 36	MSB hearings are held on the second Friday of the month.	
69.	MSB Final Adoption	1/11/2019	1/11/2019	See Row 36	MSB hearings are held on the second Friday of the month.	
70.	Rule filed with Secretary of State	1/12/2019	1/31/2019	See Row 36	The MSB Coordinator will file the rule and Attorney General's opinion with Secretary of State.	
71.	Rule published in Colorado Register	2/1/2019	2/10/2019	See Row 36		
72.	Rule becomes effective	3/2/2019	3/2/2019	See Row 36		

	Action Item	Start Date	Projected End Date	Key Stakeholders	Progress/Status	Findings/Results/Outcomes
Systemic updating of authorities, policies, and procedures other than statutes, regulations, and waivers						
73.	Issue Q&A on HCBS settings requirements relating to leases and landlord/tenant law	12/1/2016	5/1/2017	See Row 4	The Department is drafting a Q&A to explain its interpretation of the federal requirement of an agreement that provides the individual with at least the same eviction and appeals rights that tenants have under the landlord/tenant law of the jurisdiction. The Q&A will specify what must be included in a lease/residency agreement, and will also go further by addressing questions that have arisen about the application of the federal requirement to various scenarios. The Q&A will be more useful than a draft lease (which the Department had initially planned to provide), by itself, would be.	
74.	Publish/implement revisions to Departmental manuals, provider agreements, and other materials to promote compliance with HCBS Settings requirements.	6/30/2016	12/31/2017	See Row 4		
75.	To the extent not already addressed in Row 29, work with other agencies as appropriate to implement changes to provider enrollment/re-enrollment, validation, survey, quality assurance, licensure, and certification standards, processes, and frequency to promote and monitor ongoing compliance with HCBS Settings requirements, both for current providers and new/potential providers.	1/1/2017	3/15/2019	See Row 34		
76.	To the extent not already addressed in Row 29, work with CDHS to implement changes to CHRP policies to promote compliance with HCBS Settings requirements, potentially including: • Strengthening the person-centered planning processes in group homes, group centers, and RCCFs • Expanding financial and dietary rights in group homes, group centers, and RCCFs when appropriate by age or court order • Ensuring informed choice of settings, including providers available within waiver (and not just choice between waiver and institutional/other options), and choice of roommates, when consistent with court orders	1/1/2017	3/15/2019	See Row 34		

	Action Item	Start Date	Projected End Date	Key Stakeholders	Progress/Status	Findings/Results/Outcomes
	• Expanding Individual Choice Statement described in the waiver to include additional flexibility in choosing persons who attend team meetings, roommates when applicable, and setting type when such an option is available through a court order • Identifying where educational supports are provided within the residential setting and moving toward integration within the public school system.					
77.	Design and implement procedures so that the Department does not pay for HCBS services rendered at noncompliant settings	1/1/2017	3/15/2019		The Department will consider possible changes to Interchange (the new Medicaid Management Information Systems (MMIS)) as well as other avenues of ensuring that payments are not made for services at noncompliant settings.	
5. Enhancing training and technical assistance						
78.	Require provider and CMA (including SEP and CCB) staff training on person centered planning (PCP) philosophy and practice.	3/1/2015	3/15/2019	The Department, the Lewin Group, CMAs, including SEPs and CCBs	Webinar trainings regarding PCP requirements have been conducted. Training slide decks are published on the Colorado State Transition website (https://www.colorado.gov/hcpf/home-and-community-based-services-settings-final-rule) so this information can be utilized by stakeholders when it is needed. Trainings will be ongoing. In addition, the Department worked with a contractor to conduct statewide trainings for approximately 500 people regarding person-centered planning.	Webinars have been well-attended. The Department has conducted seven webinars since September of 2015, with the average attendance being 221: September 28, 2015-CO HCBS Settings Rule Overview-228 participants October 20, 2015-Person Centered Planning and HCBS Settings Final Rule-178 participants January 29, 2016-The HCBS Settings Rule effect on Residential Services-261 participants February 23, 2016-The HCBS Settings Rule effect on Non-Residential Services-217 participants March 31, 2016-Guardianship and the HCBS Final Rule-200 participants (approx.) April 28, 2016-Balancing Individual Rights and Provider Liability-200 participants (approx.) May 18, 2016-Residency Agreements and the HCBS Final Rule
79.	Provide clarity on the need for all settings to comply with home and community based settings requirements, and conduct a webinar series to highlight the settings requirements (residential, non-residential, adults, children), principles of	3/1/2015	12/1/2015 and ongoing thereafter	See Row 4 and the Lewin Group	Webinar trainings have been conducted for all stakeholders focusing on an overview of the final rule, person centered planning, details of the rule as applicable to residential and non-residential settings, guardianship, balancing individual rights and provider liability, and residency agreements. Trainings will be ongoing. Slides will be posted online at https://www.colorado.gov/hcpf/home-and-community-based-services-settings-final-rule.	See Row 78.

	Action Item	Start Date	Projected End Date	Key Stakeholders	Progress/Status	Findings/Results/Outcomes
	person-centered planning, and implementation.					
80.	Provide strategic technical assistance to all key stakeholders by issuing fact sheets and FAQs and responding to questions related to the implementation of the transition plan (action steps, timelines, and available technical assistance).	8/1/2014	Ongoing	See Row 4	The Department has posted guidance documents on its website at https://www.colorado.gov/hcpf/home-and-community-based-services-settings-final-rule. The Department will continue to update these documents. Additional FAQs and other messaging documents are expected over the course of the next year to further inform and update providers, individuals, and other stakeholders on ongoing rule compliance. Department staff are also meeting regularly with providers around the state to provide technical assistance.	
81.	Provide training to licensure/certification staff on new settings requirements.	1/1/2016	11/1/2018	The Department, the Lewin Group, CDPHE	Webinar trainings have been administered for all stakeholders, as described in Rows 33 and 34. More targeted training and support to licensure/certification staff is expected over the course of the next year. Although there has not yet been formal training specifically for licensing and certification staff, representatives from licensure and certification staff have been in attendance for many of the trainings held to date, and a representative was present at an in-person event in June 2015 held by the Department.	
82.	Provide training to quality improvement staff on new settings outcomes measures.	1/1/2017	11/1/2018	See Row 29		
83.	Provide training to enrollment staff regarding review and potential heightened scrutiny of new providers/facilities.	1/1/2016	11/1/2018	See Row 29		
84.	Provide training to case managers through CMAs, including SEPs & CCBs, & County Departments of Social Services to support informed choice of setting, identify areas of non-compliance, and support implementation of STP	31/2015	3/1/2017	The Department, CDPHE, CDHS, County DSS, CMAs, including SEPs and CCBs	Webinar trainings have been administered for all stakeholders involving person centered planning and clarification regarding the final rule for residential and non-residential settings. More targeted training and support to case managers is expected over the course of the next year.	See Row 78.
Program Component: Inclusion of Requirements within the HCBS Quality Framework						
85.	Include setting-related outcomes measures within the current 1915(c) waiver quality improvement system.	6/1/2017	1/1/2018	The Department, CDPHE, CDHS		
86.	Develop process(es) for case managers to confirm with individuals that the settings at which they receive services are compliant	6/1/2017	1/1/2018	See Row 84		
87.	Identify and publicize process(es) for waiver participants, case managers, and others to report potential violations of settings criteria	6/1/2017	1/1/2018	See Rows 4 and 86		
88.	Monitor data from Quality of Life and National Core Indicators (NCI) related to outcomes (*e.g.*, opportunities for informed choice, choice of roommate and setting, freedom from coercion).	1/1/2016	3/15/2019	The Department		

Systemic Assessment Crosswalk on Settings

In January 2014, the Centers for Medicare & Medicaid Services (CMS) published a rule to ensure that Home and Community Based Services (HCBS) are provided in settings that meet certain criteria. 79 Fed. Reg. 2948 (Jan. 16, 2014). The rule went into effect in March 2014, and states have five years—until March 2019—to ensure that their HCBS settings are compliant with the rule.

The Colorado Department of Health Care Policy & Financing (HCPF or "the Department") has developed a Statewide Transition Plan (STP) for bringing Colorado's HCBS settings into compliance with the HCBS Settings Rule. Under the STP, the Department has conducted a comprehensive review of the kinds of settings in which HCBS services are provided in Colorado and the state statutes, regulations, and waivers that govern the provision of HCBS services in these settings. The results of this systemic review are set forth below. Summaries and paraphrases of state legal authorities are for convenience only and are not intended to be complete or authoritative for any purpose outside of this crosswalk.

In addition to the Department, other state agencies, such as the Colorado Department of Public Health and Environment (CDPHE) and the Colorado Department of Human Services (CDHS), are involved in ensuring compliance with the HCBS Settings Rule. The Department plans to work with these agencies to ensure that their relevant statutes and regulations promote compliance. Although the Department has begun coordinating with CDPHE and CDHS on this endeavor, this crosswalk is issued only by the Department and is not a joint publication with CDPHE or CDHS.

The following notes are intended to make it easier to review and comment on the crosswalk:

1. Certain criteria in the HCBS Settings Rule apply to all HCBS settings. These criteria are set out below in red font above Table 1. Within Table 1, all affected HCBS settings are listed alphabetically from top to bottom. From left to right, the crosswalk summarizes existing state statutes, regulations, and waivers, stating whether they are consistent with, silent with respect to, or in conflict with each federal criterion.

2. Additional criteria in the HCBS Settings Rule apply only to provider-owned or –controlled residential HCBS settings. These criteria are set out below in orange font above Table 2. Within Table 2, all affected provider-owned or –controlled residential HCBS settings are listed alphabetically from top to bottom. From left to right, the crosswalk summarizes existing state statutes, regulations, and waivers, stating whether they are consistent with, silent with respect to, or in conflict with each federal criterion.

3. The Department is proposing to take a "belt and suspenders" approach to ensuring that all HCBS settings conform to the federal requirements.

    a. Pursuant to this approach, the Department plans to propose two new regulations: 10 CCR 2505-10 AAA, requiring all HCBS settings to comply with set 1 of the federal criteria (see red text above Table 1), and 10 CCR 2505-10 BBB, requiring all provider-owned or –operated residential HCBS settings to comply with set 2 of the federal criteria (see orange text above Table 2). "AAA" and "BBB" are placeholders for numbers to be assigned later.

    b. In addition, the Department plans to propose piecemeal edits to its regulations governing particular HCBS settings, and to work with other agencies that are involved with such settings, as set out in the two tables below. These edits are described below as "redlines." The Department hopes that these redlines will be relatively uniform across different kinds of settings, but it invites comment on whether different language or considerations should apply to particular settings.

4. For the sake of efficiency and uniformity, the Department expects the bulk of the redlines to affect its own regulations and those of other agencies. The Department plans to seek changes to statutes and waivers only where necessary to mitigate possible conflicts with federal requirements, and not to address mere silence in a statute or waiver vis-à-vis federal requirements (which will be addressed via regulatory amendments). Working with CMS, the Department may eventually seek to amend its waivers so that similar requirements are addressed with similar language, and so that services that are provided under multiple waivers are described in a consistent way.

5. Where a statute, regulation, or waiver is silent with respect to two or more federal requirements, the silence is noted in the first column in the table; subsequent columns in the table that direct the reader to "see Column X" (prior column) mean that the authority is also silent with respect to the additional federal requirements.

6. Where the crosswalk indicates that the Department plans to propose redlines or work with another agency to do so, the public will have an opportunity down the road to review and comment on the actual proposed redlines (*e.g.*, during a rulemaking proceeding or the notice-and-comment period for waiver amendments). Therefore, while you may comment on all aspects of this crosswalk, you may find it most efficient to focus now on big-picture issues, and to save particular wording preferences for the comment periods to come.

7. To review the authorities identified in this crosswalk, please visit:

    a. For state statutes: http://leg.colorado.gov/colorado-revised-statutes.

    b. For regulations: https://www.sos.state.co.us/CCR/Welcome.do.

    c. For waivers: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/waivers_faceted.html.

Set 1 of federal criteria: standards applicable to all HCBS settings (42 C.F.R. § 441.301(c)(4))

Home and community-based settings must have all of the following qualities, and such other qualities as [CMS] determines to be appropriate, based on the needs of the individual as indicated in their person-centered service plan:

(i) 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.

(ii) 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.

(iii) Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.

(iv) 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.

(v) Facilitates individual choice regarding services and supports, and who provides them.

New Rule AAA will provide that the above standards apply to all settings in which HCB services are provided, except where HCB services are otherwise permitted to be delivered in a setting that is institutional or does not meet the HCBS settings standards, such as respite services available under certain waivers. *See* 79 Fed. Reg. at 3011. Palliative/Supportive Care services provided outside the child's home (under the Children with Life-Limiting Illness waiver) are similar to respite, and new Rule AAA will not apply to such services. In addition to protecting the federally prescribed rights as set forth above, new Rule AAA will also

- protect some of the rights currently set forth in 10 CCR 2505-10 8.515.80(C) (rights of participants in the Waiver for People with Brain Injury);
- require that if restraints are used with an individual, the use be based on an assessed need after all less restrictive interventions have been exhausted; be documented in the individual's person-centered plan as a modification of the generally applicable settings criteria, consistent with the standards in Rule BBB; be compliant with any applicable waiver; and be reassessed over time;
- provide that any restrictive or controlled egress measures must be consistent with the following criteria:
    - the measures are implemented on an individualized (not setting-wide) basis;
    - the measures make accommodations for individuals who are not at risk of wandering or exit-seeking behaviors;
    - the measures are documented in the individual's person-centered plan as a modification of the generally applicable settings criteria, consistent with the standards in Rule BBB;
    - the plan documents an assessment of the individual's wandering or exit-seeking behaviors (and the underlying conditions, diseases, or disorders relating to such behaviors) and the need for safety measures; options that were explored before any modifications occurred to the person-centered plan; the individual's understanding of the setting's safety features, including any controlled-egress; the individual's choices for prevention of unsafe wandering or exit-seeking; the individual's and their caregivers'/representatives' consent to controlled-egress goals for care; the individual's preferences for engagement within the setting's community and within the broader community; and the opportunities, services, supports, and environmental design that will enable the individual to participate in desired activities and support their mobility; and
    - the measures are not developed or used for non-person-centered purposes, such as punishment or staff convenience;
- provide that if an individual requests that a provider hold his/her funds, their signed person-centered plan must document this request, the reasons for the request, and the parties' agreement on how the provider should handle the funds (including acknowledgement of the provider's obligations under C.R.S. 25.5-10-227 and the Social Security Administration's (SSA's) requirements for representative payees, if applicable or if the parties so elect) and what they define as "reasonable amounts" under C.R.S. 25.5-10-227 (if applicable or if the parties so elect).

Table 1: standards applicable to all HCBS settings

Type of setting	A.Integrated	B.Selected by individual	C.Ensures individual's rights	D.Optimizes autonomy in life choices	E.Facilitates choice regarding services and supports
1. **Adult day services centers** (alternatives to nursing facilities)—includes basic and specialized adult day services centers *The Department has convened a stakeholder workgroup comprised of providers, clients, advocates, and representatives from CDPHE.*	**Statute**: C.R.S. 25.5-6-303(1) generally requires that all federal requirements be met, but does not specifically list integration, etc. C.R.S. 25.5-6-313(1.5) requires the MSB to regulate restricted environments and restrictive egress alert devices at adult day care centers.	**Statute**: See Column A. **Regs**: See Column A; as stated at left, the Department plans to add a reference to new Rule AAA within the two adult day services regulations.	**Statute**: C.R.S. 26-20-103 limits the use of restraints by state agencies as well as public or private entities that contract with or are licensed/certified by state agencies. Otherwise, see Column A.	**Statute**: See Column A. **Regs**: 10 CCR 2505-10 8.491.14(F) provides that clients have the right to choose not to participate in social and recreational activities. 8.515.70 is silent on autonomy. As stated at left, the Department plans to	**Statute**: See Column A. **Regs**: See Column A; as stated at left, the Department plans to add a reference to new Rule AAA within the two adult day services regulations. **Waiver**: See Column A.

Type of setting	A.Integrated	B.Selected by individual	C.Ensures individual's rights	D.Optimizes autonomy in life choices	E.Facilitates choice regarding services and supports
The workgroup is reviewing current Department regulations for compliance with the HCBS Settings Rule and to make any other necessary updates. **Summary of cited authorities:** C.R.S. 25.5-6-301 *et seq.* provides statutory authority for HCBS services for people who are elderly, blind, or physically disabled (EBD). Section 303 sets out definitions, including one for adult day care facilities. Section 313 requires the Medical Services Board (MSB) to adopt certain rules for the administration of the EBD waiver, including adult day care services. C.R.S. 26-20-101 *et seq.* is the Protection of Individuals from Restraint and Seclusion Act. CDPHE's general licensure standards are set forth in 6 CCR 1011-1 Chapter 02, and its regulations protecting people from involuntary restraints in licensed heath care facilities are set forth in Chapter 02 Part 8. 10 CCR 2505-10 8.491 regulates adult day services for purposes of the EBD Waiver, the Waiver for Persons with Spinal Cord Injury (SCI) (see 8.517.1), and the Waiver for Community Mental Health Services (CMHS) for Persons with Major Mental Illnesses (see 8.509.13). Section 8.515 *et seq.* regulates services under the Waiver for Persons with Brain Injury (BI), with Section 8.515.70 defining adult day services for purposes of that waiver. The cited waivers provide for adult day services.	**Regs**: 10 CCR 2505-10 8.491 and 8.515.70 do not specifically require integration, etc. The Department plans to require integration by adding a reference to new Rule AAA within these two regs. For this particular setting and federal requirement (integration), the Department also plans to propose redlines that specify concrete, desired outcomes. The Department will implement C.R.S. 25.5-6-313(1.5) by adding the reference to Rule AAA—which will specify that any restrictive egress measures must meet the criteria set out above—and any additional appropriate language to the adult day services regulations. **Waiver**: BI Waiver, EBD Waiver, SCI Waiver, and CMHS Waiver are silent with respect to integration, etc.	**Waiver**: BI Waiver, EBD Waiver, SCI Waiver, and CMHS Waiver at App. B-7 and App. D-1, items b & c confirm that people are informed of feasible service alternatives provided by the waiver and the choices of either institutional or home and community-based services, and that the case manager provides a choice of providers.	**Regs**: 6 CCR 1011-1 Chapter 02 Part 8 limits the use of restraints in all licensed health care facilities. 10 CCR 2505-10 8.491.20(B)(11) requires a restraint-free environment. To preserve this requirement, the Department will propose to modify this rule to require a restraint-free environment "notwithstanding" anything in Rule AAA that might otherwise appear to allow a restraint. 8.515.70 is silent on this issue; see Column A; as stated at left, the Department plans to add a reference to new Rule AAA. **Waiver**: BI Waiver, EBD Waiver, SCI Waiver, and CMHS Waiver at App. G-2 describe statutory and regulatory protections for certain rights, including freedom from restraint.	add a reference to new Rule AAA within the two adult day services regulations. **Waiver**: See Column A.	
2. **Alternative care facilities (ACFs)** *The Department has convened a stakeholder workgroup comprised of providers, clients, advocates, and representatives from CDPHE. The workgroup is reviewing current Department regulations for compliance with the HCBS Settings Rule and to make any other necessary updates. The Department is working closely with CDPHE to ensure that any revisions to the HCPF regulations not only address the HCBS Settings Rule, but do not conflict with the assisted living residence (ALR) regulations with which ACFs must comply. At the same time, CDPHE is currently working with stakeholders, including representatives from the Department, to update its ALR regulations.* **Summary of cited authorities:** The Department's regulations require an ACF to be licensed by CDPHE as an assisted living residence (ALR) and to meet other criteria, as set forth in 10 CCR 2505-10 8.495. C.R.S. 25-27-101 *et seq.* provides statutory authority for CDPHE to regulate ALRs, including by implementing the minimum standards in Section 104. C.R.S. 25.5-6-301 *et seq.* provides	**Statute**: C.R.S. 25-27-104 is silent with respect to integration, etc. C.R.S. 25.5-6-303(3) generally requires that all federal requirements be met, but does not specifically list integration, etc. **Regs**: For ALRs generally: 6 CCR 1011-1 Chap 07 1.104(5)(m) requires ALR to have a policy on restrictive egress alert devices, and 1.108 regulates secured environments. 1.106(1)(l) protects resident's right to make visits outside the facility. 1.107(2) requires ALR to provide opportunities for social and recreational activities within and outside the facility. For ACFs specifically: under 10 CCR 2505-10 8.495.1, protective oversight includes resident choice and ability to travel and engage independently in the wider community. 8.495.2.B requires an assessment of whether the ACF meets the person's need for independence and community integration. 8.495.6.F requires ACF to encourage and assist client's participation in activities within the wider community, when appropriate. The Department plans to add a reference to	**Statute**: See Column A. **Regs**: Client chooses to live in an ACF, per 10 CCR 2505-10 8.495.2.B and 8.495.4.A(1). Otherwise silent; as stated at left, the Department plans to add a reference to new Rule AAA within 10 CCR 2505-10 8.495. **Waiver**: EBD Waiver and CMHS Waiver at App. B-7 and App. D-1, items b & c confirm that people are informed of feasible service alternatives provided by the waiver and the choices of either institutional or home and community-based services, and that the case manager provides a choice of providers.	**Statute**: C.R.S. 25-27-104(e) requires promulgation of regs to protect individual rights but does not specify which rights. C.R.S. 26-20-103 limits the use of restraints by state agencies as well as public or private entities that contract with or are licensed/certified by state agencies. **Regs**: No redlines needed beyond adding a reference to new Rule AAA within 10 CCR 2505-10 8.495. Under 6 CCR 1011-1 Chap 07 1.104(5)(g), ALRs must have written policies on resident rights that incorporate the provisions of Section 1.106(1), which address privacy, dignity, respect, and freedom from restraint; *see also* 6 CCR 1011-1 Chapter 02 Part 8 and Chap 07 1.106(3) (limiting use of restraints); 10 CCR 2505-10 8.495.6.E. (protecting privacy during phone calls and visits and in bedroom). Also, 6 CCR 1011-1 Chap 07 1.102(3)(b)(iv), 1.104(5)(j), 1.105(3), and 1.106(1)(m) protect residents' control of their money and property. And under 10 CCR 2505-10 8.495.4.B, clients shall be informed of their rights.	**Statute**: See Column A. **Regs**: No redlines needed beyond adding a reference to new Rule AAA within 10 CCR 2505-10 8.495. Under 10 CCR 2505-10 8.495.4.A, ACF must foster client independence, promote individuality and lifestyle, and avoid reducing personal choice and initiative. **Waiver**: EBD Waiver at App. G-2, item a requires ACF to be homelike and provide choice about care and lifestyle. CMHS Waiver at App. G-2, item a-ii, requires ACF to "comply with the home-like and person centered environment requirements."	**Statute**: See Column A. **Regs**: No redlines needed beyond adding a reference to new Rule AAA within 10 CCR 2505-10 8.495. Under 10 CCR 2505-10 8.495.4.A, ACF must promote choice of care. **Waiver**: See Column D.

Type of setting	A.Integrated	B.Selected by individual	C.Ensures individual's rights	D.Optimizes autonomy in life choices	E.Facilitates choice regarding services and supports
statutory authority for HCBS services for people who are elderly, blind, or physically disabled (EBD). Section 303 sets out definitions, including one for ACFs. C.R.S. 26-20-101 *et seq.* is the Protection of Individuals from Restraint and Seclusion Act. CDPHE's general licensure standards are set forth in 6 CCR 1011-1 Chapter 02, and its regulations protecting people from involuntary restraints in licensed heath care facilities are set forth in Chapter 02 Part 8. CDPHE's regulations for ALRs are set forth in 6 CCR 1011-1 Chap 07. The cited waivers provide for ACF services.	new Rule AAA within 10 CCR 2505-10 8.495. As stated above, Rule AAA will require integration and will specify that any restrictive egress measures must meet the criteria set forth above. **Waiver**: EBD Waiver, App. G-2, item a requires ACF to facilitate community integration. CMHS Waiver at App. G-2, item a-ii, states that a survey tool administered by CDPHE ensures that ACFs "comply with the home-like and person centered environment requirements and support community integration." CMHS Waiver at App. G-2, item c, states that ACF "must facilitate community integration; protect the health, welfare and safety of the client; and be home-like and person-centered." The Department plans to delete references to ACFs in the BI Waiver (with ACFs being replaced by 10.Supported Living Program (SLP) and Transitional Living Program (TLP) facilities).		**Waiver**: EBD Waiver and CMHS Waiver at App. G-2 describe statutory and regulatory protections for certain rights, including freedom from restraint.		
3. **Child Residential Habilitation settings** • Foster Care Homes (no more than 3 foster care children) • Kinship Foster Care • Non-certified Kinship Care • Specialized Group Facilities (SGFs) o Group Homes (up to 6 children if three are in CHRP program) o Group Centers (up to 7 children if two are in CHRP program or 9 children if one is in CHRP program) • Residential Child Care Facilities (RCCFs) *The rules relating to this type of setting are currently being revised.* *The Department plans to work with CDHS on regulatory and/or waiver edits that will have minimal impact on the numerous foster care homes, SGFs, and RCCFs that serve children who are not enrolled in the Children's Habilitation Residential Program (CHRP) Waiver.* **Summary of cited authorities:** C.R.S. 25.5-10-201 *et seq.* sets forth statutory standards and procedures for providing services to individuals with IDD. C.R.S. 26-6-101 *et seq.* is the Child Care Licensing Act. C.R.S. 26-20-101 *et seq.* is the Protection of Individuals from Restraint and Seclusion Act.	**Statute**: C.R.S. 25.5-10-201 declares the General Assembly's intent that individuals with IDD be included in community life, but does not specify integration as a requirement for particular settings. C.R.S. 25.5-10-227 provides that "[u]pon the request of a person receiving services, a service agency may hold [in trust] money or funds belonging to the person receiving services," and that "[u]pon request, a person receiving services is entitled to receive reasonable amounts of such person's money or funds held in trust" by the agency. In conjunction with the part of new Rule AAA relating to agreements on the provider's handling of funds, this statutory provision is consistent with the HCBS Settings Final Rule. **Regs**: The Department plans add a reference to new Rule AAA in the Department's CHRP-specific regulations (10 CCR 2505-10 8.508). 10 CCR 2505-10 8.608 and the service plan require providers serving people with IDD to promote community inclusion. Under 12 CCR 2509-8 7.701.200, children in foster care are entitled to participate in appropriate cultural and social activities. Facilities providing residential care must use a "reasonable and prudent parent standard" in deciding whether to allow participation. *Id.* 7.708.38 and -.39 specify educational and community participation rights for children in foster	**Statute**: Statutes do not address whether the child chooses the residential habilitation setting. **Regs**: No redlines needed beyond adding references to new Rule AAA in the Department's CHRP-specific regulations (10 CCR 2505-10 8.508). 12 CCR 2509-8 7.708.61 (for children in foster care), 7.714.2 (for children in SGFs and RCCFs), and the service plan require placement agreement to be developed with the involvement of the child and parent(s) or guardian(s). **Waiver**: CHRP Waiver, App. B-7, provides that "[w]hen an individual is determined to be likely to require a level of care as indicated in the waiver, the individual or his/her legal representative will be: a. informed of any feasible alternatives under the waiver; and b. given the choice of either institutional or home and community-based services." In some circumstances, the legal guardian or custodian making this choice may be the county.	**Statute**: C.R.S. 25.5-10-216 through -240 protect the rights of individuals with IDD in general (-218), and in particular with respect to privacy (-223) and freedom from coercion and restraint (-221). Dignity and respect are protected through C.R.S. 25.5-10-201 and -216 through -240 as a whole. C.R.S. 26-6-106(2)(g) authorizes child care facility licensing rules to "safeguard the legal rights of children served," but does not specify which rights. C.R.S. 26-6-106(2)(k) authorizes rules to set standards for short-term confinement of children. C.R.S. 26-20-103 limits the use of restraints by state agencies as well as public or private entities that contract with or are licensed/certified by state agencies. **Regs**: As stated at left, the Department plans add a reference to new Rule AAA, which will explicitly protect an individual's rights of privacy, dignity, respect, and freedom from coercion and restraint, to the Department's CHRP-specific regulations (10 CCR 2505-10 8.508). In addition, the Department plans to propose redlines to 10 CCR 2505-10 8.508.180 to more explicitly ensure children's rights of privacy, dignity and respect, and freedom from coercion and restraint, and to ensure that any use of restraints is based on an assessed need after all less restrictive interventions have been exhausted; be documented in the child's person-centered plan as a modification of the generally applicable	**Statute**: See Column B. **Regs**: No redlines needed beyond adding references to new Rule AAA in the Department's CHRP-specific regulations (10 CCR 2505-10 8.508). 10 CCR 2505-10 8.608 requires providers serving people with IDD to work to help these clients make increasingly sophisticated and responsible choices, exert greater control over their life, and develop and exercise their competencies and talents. 12 CCR 2509-8 7.708.61 (for children in foster care) and 7.714.2 (for children in SGFs and RCCFs) require care to be provided in the least restrictive, most appropriate setting in order to meet the child's needs. **Waiver**: CHRP waiver is silent with respect to autonomy.	**Statute**: See Column B. **Regs**: No redlines needed beyond adding references to new Rule AAA in the Department's CHRP-specific regulations (10 CCR 2505-10 8.508). **Waiver**: See Column D.

Type of setting	A.Integrated	B.Selected by individual	C.Ensures individual's rights	D.Optimizes autonomy in life choices	E.Facilitates choice regarding services and supports
The Department's regulations for CHRP services are set forth in 10 CCR 2505-10 8.508, and its general regulations for the provision of services to individuals with IDD are set forth in 10 CCR 2505-10 8.600 *et seq.* CDHS's regulations for child welfare services and facilities are set forth in 12 CCR 2509 *et seq.*, also known as Staff Manual Volume 7. Within Volume 7, Part 5 (Section 7.401 *et seq.*) addresses reimbursement and provider requirements, and Part 8 (Section 7.700 *et seq.*) addresses child care facility licensing. Several of CDHS's regulations require counties and child welfare providers serving children enrolled in the CHRP waiver to follow the Department's CHRP-specific regulations. See 12 CCR 2509-5 7.406.2(O) as well as 2509-8 7.708.1(A)(3) for foster care, 7.701.2 for SGFs, and 7.705.21(C) for RCCFs). The cited waiver provides for CHRP services.	care; work must be approved by foster parent(s) and the county designee. 12 CCR 2509-8 7.708.33, 7.708.67, and 7.708.68 (for foster care) and 7.714.31 and 7.714.7 (for SGFs and RCCFs) protect children's right to keep and use their possessions, subject to certain limits, and be allowed to spend a "reasonable sum" of their own money. 12 CCR 2509-8 7.714.2, 7.714.6, & 7.714.7, applicable to SGFs and RCCFs, require facilities to have policies on participation in recreational & religious activities & community life; to provide for educational & vocational programs in the most appropriate & least restrictive setting; & to encourage participation in community activities. 7.709.25 provides for children in SGFs to participate in school & community activities. **Waiver**: CHRP waiver does not expressly address integration, although it states in App. C-2 that "[a] group home is located within a community and provides an environment that is similar to a foster or familial home. The children [like those in a foster home] [have] access to activities in the community."		settings criteria, consistent with the standards in Rule BBB; be compliant with the CHRP waiver; and be reassessed over time. The Department will also propose to update this regulation's reference to "Children's Rights as defined in CDHS Social Services Staff Manual" from the outdated "Section 7.714.50, 'CHILDREN'S RIGHTS' (12 CCR 2509-8)" to the current relevant provisions. 10 CCR 2505-10 8.604.1 (relating to people with IDD) reiterates that people receiving services have the same rights as others; 8.604.2 requires providers to protect rights in C.R.S. 25.5-10-218 through -231 (the Department plans to change this to C.R.S. 25.5-10-216 through -240); and 8.608.3 thru 8.608.5 limit the use of restraints. The Department plans to propose redlines to some or all of these regulations to more explicitly state that individuals have rights of privacy, dignity, respect, and freedom from coercion and restraint, and to require that any use of restraints be based on an assessed need after all less restrictive interventions have been exhausted; be documented in the child's person-centered plan as a modification of the generally applicable settings criteria, consistent with the standards in Rule BBB; be compliant with the CHRP; and be reassessed over time. In 10 CCR 2505-10 8.500.15, 8.500.105, and 8.503.150, the Department plans to update references from the outdated C.R.S. 27-10.5-101 *et seq.* or 112 *et seq.* to the current C.R.S. 25.5-10-216 through -240. 12 CCR 2509-8 7.708.33 thru -.37 (for foster care) and 7.714.31 thru 7.714.4 & 7.714.52 (for SGFs and RCCFs) explicitly protect privacy, implicitly protect dignity and respect, and limit coercion & restraint. 12 CCR 2509-8 7.714.53 *et seq.* sets out conditions under which restraints are allowed in foster care, SGFs, and RCCFs. **Waiver**: CHRP waiver, App. C-2, refers to CDHS's rules for group homes, including rights protections as described above. CHRP waiver Appendix G-2 describes safeguards concerning restraints and restrictive intentions.		
4. **Day Habilitation/treatment locations for individuals with IDD**—includes 3 subcategories, below	**Statute**: C.R.S. 25.5-10-206(1)(D) and 27-10.5-104(1)(c) require day services and supports to support community integration. Also, C.R.S. 25.5-6-409.3 requires redesigned adult IDD waiver to support	**Statute**: C.R.S. 25.5-6-409.3 requires redesigned adult IDD waiver to incorporate freedom of choice over living arrangements and social, community, and recreational opportunities; individual authority over	**Statute**: C.R.S. 25.5-6-409.3 is silent with respect to individual rights. However, C.R.S. 25.5-10-216 through -240 protect the rights of individuals with IDD in general (-218), and in particular with respect to	**Statute**: C.R.S. 25.5-6-409.3 requires redesigned adult IDD waiver to incorporate freedom of choice over living arrangements and social, community, and recreational opportunities; individual authority over	**Statute**: C.R.S. 25.5-6-409.3 requires redesigned adult IDD waiver to provide support to organize resources and achieve

Type of setting	A.Integrated	B.Selected by individual	C.Ensures individual's rights	D.Optimizes autonomy in life choices	E.Facilitates choice regarding services and supports
Summary of cited authorities: C.R.S. 13-21-101 *et seq.* sets forth provisions on damages in court proceedings. C.R.S. 25.5-6-401 *et seq.* is the Home- and Community-based Services for Persons with Developmental Disabilities Act. C.R.S. 25.5-10-201 *et seq.* sets forth statutory standards and procedures for providing services to individuals with IDD. C.R.S. 26-20-101 *et seq.* is the Protection of Individuals from Restraint and Seclusion Act. C.R.S. 27-10.5-104 authorizes services and support for people with IDD. CDPHE's general licensure standards are set forth in 6 CCR 1011-1 Chapter 02, and its regulations protecting people from involuntary restraints in licensed heath care facilities are set forth in Chapter 02 Part 8. The Department's regulations for the Waiver for Persons with Developmental Disabilities (DD) are set forth at 10 CCR 2505-10 8.500 *et seq.* (see 8.500.5.a(2), defining Day Habilitation services for purposes of the DD waiver), and its regulations for the Supported Living Services (SLS) Waiver are set forth at 10 CCR 2505-10 8.500.90 *et seq.* (see 8.500.94.A(3), defining Day Hab for purposes of SLS waiver). The Department's general regulations for the provision of services to individuals with IDD are set forth in 10 CCR 2505-10 8.600 *et seq.* (see 8.609.9, defining Day Hab in general). The cited waivers provide for day habilitation services for individuals with IDD.	employment and community integration. (N/A to children.) *See also* C.R.S. 25.5-10-201 & -202(21) (General Assembly's intent that individuals with IDD be included in community life). In addition, C.R.S. 13-21-117.5 encourages community integration by limiting the liability of CCBs & providers serving individuals with IDD. C.R.S. 25.5-10-227 provides that "[u]pon the request of a person receiving services, a service agency may hold [in trust] money or funds belonging to the person receiving services," and that "[u]pon request, a person receiving services is entitled to receive reasonable amounts of such person's money or funds held in trust" by the agency. In conjunction with the part of new Rule AAA relating to agreements on the provider's handling of funds, this statutory provision is consistent with the HCBS Settings Final Rule. **Regs**: 10 CCR 2505-10 8.608 requires providers serving people with IDD to promote community inclusion. 8.500.5.A(2), 8.500.94.A(3), and 8.609.9(A)(1) require day habilitation services to be provided outside the home unless otherwise indicated by documented need. The Department plans to change the foregoing regs, as well as 8.609.4 and 8.609.9(A)(3), which provide for non-integrated, sheltered, and/or segregated settings for activities. The Department plans to propose redlines to eliminate non-integrated settings and require integration. In addition, the Department plans to add a reference to new Rule AAA to one or more of the foregoing regs. **Waiver**: SLS Waiver, App. C, provides that day habilitation "takes place in a non-residential setting, separate from the participant's private residence or other residential living arrangement, except when due to medical and/or safety needs." *See also* DD Waiver, App. C (similar).	supports and services; and maximum personal control. (N/A to children.) **Regs**: Day habilitation regs are silent with respect to selection by individual. No redlines needed beyond adding references to new Rule AAA to the Department's regs for day habilitation. **Waiver**: SLS Waiver, App. D-1, items c, d, and f, confirm that the CCB must provide information to participants about the potential services, supports, and resources that are available, and that the participant or his/her guardian are offered free choice from among qualified providers. *See also* DD Waiver, App. D-1, items c, d, and f (same).	privacy (-223) and freedom from coercion and restraint (-221). Dignity and respect are protected through C.R.S. 25.5-10-201 and -216 through -240 as a whole. In addition, C.R.S. 26-20-103 limits the use of restraints by state agencies as well as public or private entities that contract with or are licensed/certified by state agencies. **Regs**: As stated at left, the Department plans add a reference to new Rule AAA, which will explicitly protect an individual's rights of privacy, dignity, respect, and freedom from coercion and restraint, to the Department's regs for day habilitation. 10 CCR 2505-10 8.604.1 (relating to people with IDD) reiterates that people receiving services have the same rights as others; 8.604.2 requires providers to protect rights in C.R.S. 25.5-10-218 through -231 (the Department plans to change this to C.R.S. 25.5-10-216 through -240); and 8.608.3 thru 8.608.5 limit the use of restraints. The Department plans to propose redlines to some or all of these regulations to more explicitly state that individuals have rights of privacy, dignity, respect, and freedom from coercion and restraint, and to require that any use of restraints be based on an assessed need after all less restrictive interventions have been exhausted; be documented in the individual's person-centered plan as a modification of the generally applicable settings criteria, consistent with the standards in Rule BBB; be compliant with any applicable waiver; and be reassessed over time. 10 CCR 2505-10 8.609.5(B)(6) presumes that people can manage their own funds and possessions unless their plan documents limitations and a plan to increase this skill. In 10 CCR 2505-10 8.500.15, 8.500.105, and 8.503.150, the Department plans to update references from the outdated C.R.S. 27-10.5-101 *et seq.* or 112 *et seq.* to the current C.R.S. 25.5-10-216 through -240. 6 CCR 1011-1 Chapter 02 Part 8 limits the use of restraints in all licensed health care facilities. **Waiver**: SLS Waiver, App. G-2, describes statutory protections for certain rights, including freedom from restraint. *See also* DD Waiver, App. G-2 (same).	supports and services; and maximum personal control. (N/A to children.) **Regs**: No redlines needed beyond adding a reference to new Rule AAA to the Department's regs for day habilitation. 10 CCR 2505-10 8.500.5.A(2) and 8.500.94.A(3) require day habilitation environments to foster independence and personal choice. Also, 10 CCR 2505-10 8.608 requires providers serving people with IDD to work to help these clients make increasingly sophisticated and responsible choices, exert greater control over their life, and develop and exercise their competencies and talents. **Waiver**: SLS Waiver, App. C, provides that day habilitation "[a]ctivities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice." *See also* DD Waiver, App. C (same).	"key service outcomes." (N/A to children.) **Regs**: See Column B; no redlines needed beyond adding a reference to new Rule AAA to the Department's regs for day habilitation **Waiver**: SLS Waiver and DD Waiver are silent with respect to obligation on provider's part to facilitate choice regarding services and supports.

Type of setting	A.Integrated	B.Selected by individual	C.Ensures individual's rights	D.Optimizes autonomy in life choices	E.Facilitates choice regarding services and supports
• **(a) Specialized Habilitation centers** **Summary of cited authorities:** See Row 4, above.	See Row 4, above, with the following additional points: **Regs**: As stated above, the Department plans to add a reference to new Rule AAA to its day habilitation regulations. Also, under 10 CCR 2505-10 8.500.5.A(2) and 8.500.94.A(3), specialized habilitation is provided in a non-integrated setting where a majority of the clients have a disability; the Department plans to change this to eliminate non-integrated settings and require integration. **Waiver**: SLS Waiver, App. C, provides that specialized habilitation is "generally provided in non-integrated settings where a majority of the persons have a disability, such as program sites." The Department plans to change this to eliminate non-integrated settings and require integration. *See also* DD Waiver, App. C (same).				
• **(b) Supported Community Connections (SCC) (adults)/Community Connector (children) locations** **Summary of cited authorities:** See Row 4, above. In addition, the Department's regulations for the Children's Extensive Support (CES) Waiver are set forth in 10 CCR 2505-10 8.503 (see 8.503.40.a(4), defining Community Connector Services), and its regulations for the Children's Habilitation Residential Program (CHRP) Waiver are set forth in 10 CCR 2505-10 8.508 (see 8.508.100(h), defining Community Connections Service for purposes of CHRP Waiver).	See Row 4, above, with the following additional points: **Regs**: As stated above, the Department plans to add references to new Rule AAA to its day habilitation regulations and to its CHRP-specific regulations (10 CCR 2505-10 8.508); in addition, the Department plans to add a reference to new Rule AAA to its CES-specific regulations (10 CCR 2505-10 8.503). Under 10 CCR 2505-10 8.500.5.A(2) and 8.500.94.A(3), SCC services help the client access typical activities and functions of community life, such as those chosen by the general population, including community education or training, retirement, and volunteer activities. The services are conducted in a variety of settings in which the client interacts with persons without disabilities. Under 10 CCR 2505-10 8.508.100(H), community connections services under the CHRP Waiver "may explore community services available to the individual, and develop methods to access additional services/supports/activities desired by the individual. Community connection services can provide the individual with the resources to participate in the activities and functions of the community desired and chosen by the individual receiving the services. Typically, these will be the same type of activities available and desired by the general population." The CES Waiver regulations at 8.503.40.A(4) define Community Connector services similarly. **Waiver**: SLS Waiver, App. C, provides that SCC "supports the abilities and skills necessary to enable the participant to access typical activities and functions of community life such as those chosen by the general population, including community education or training, retirement and volunteer activities. [SCC] provides a wide variety of opportunities to facilitate and build relationships and natural supports in the community, while utilizing the community as a learning environment to provide services and supports as identified in a participant's Service Plan. These activities are conducted in a variety of settings in which participants interact with non-disabled individuals (other than those individuals who are providing services to the participant). These types of services may include socialization, adaptive skills and personnel to accompany and support the participant in community settings, resources necessary for participation in activities and supplies related to skill acquisition, retention or improvement." *See also* DD Waiver, App. C (similar); CHRP waiver, App. C (similar); CES waiver, App. C (similar).				
• **(c) Prevocational Services centers** **Summary of cited authorities:** See Row 4, above.	See Row 4, above, with the following additional points: **Statute**: Under C.R.S. 25.5-10-204(g)(I), as recently amended by the Employment First Act (S.B. 16-077), the Department will "[f]acilitate employment first policies and practices by . . . [d]eveloping practices that reflect a presumption that all persons with disabilities are capable of working in competitive integrated employment if they choose to do so, and ensuring that options for competitive integrated employment with appropriate supports are explored before consideration of segregated activities." **Regs**: Under 10 CCR 2505-10 8.500.5.A(2) and 8.500.94.A(3), prevocational services are provided in a variety of non-residential locations. **Waiver**: Under SLS Waiver, App. C., prevocational services "are provided in a variety of locations separate from the participant's private residence or other residential living arrangement." *See also* DD Waiver, App. C (same).				
5. **Day treatment facilities under BI waiver** *The Department has convened a stakeholder workgroup to ensure that the rules relating to this type of setting comply with the HCBS Settings Rule.* **Summary of cited authorities:** C.R.S. 25.5-6-701 *et seq.* provides statutory authority for HCBS services for people with brain injuries (BI). Section 703 sets out definitions, including one for structured day treatment. C.R.S. 26-20-101 *et seq.* is the Protection of Individuals from Restraint and Seclusion Act. CDPHE's general licensure standards are set forth in 6 CCR 1011-1 Chapter 02, and its regulations protecting people from involuntary restraints in licensed heath care facilities are set forth in Chapter 02 Part 8. 10 CCR 2505-10 8.515 *et seq.* regulates services under the Waiver for Persons with Brain Injury (BI), with Section 8.515.80 defining day treatment services for purposes of that waiver. The cited waiver provides for day treatment services.	**Statute**: C.R.S. 25.5-6-703(7) is silent with respect to integration, etc. **Regs**: 10 CCR 2505-10 8.515.80 is silent with respect to integration, etc. The Department plans to add a reference to new Rule AAA within this regulation. **Waiver**: BI waiver is silent with respect to integration, etc.	**Statute**: See Column A. **Regs**: See Column A; no redlines needed beyond adding a reference to new Rule AAA within the day treatment regulation. **Waiver**: BI Waiver at App. B-7 and App. D-1, items b & c confirms that people are informed of feasible service alternatives provided by the waiver and the choices of either institutional or home and community-based services, and that the case manager provides a choice of providers.	**Statute**: C.R.S. 26-20-103 limits the use of restraints by state agencies as well as public or private entities that contract with or are licensed/certified by state agencies. Otherwise, see Column A. **Regs**: No redlines needed beyond adding a reference to new Rule AAA within the day treatment regulation. 10 CCR 2505-10 8.515.80(C) enumerates individual rights, including privacy and freedom from restraint; dignity and respect are protected though not explicitly listed. As stated above and below, new Rules AAA and BBB will incorporate some or all of the rights in 8.515.80(C); to avoid duplication, the Department will eliminate from 8.515.80(C) any rights that are made generally applicable through Rules AAA or BBB. In addition, 6 CCR 1011-1 Chapter 02 Part 8 limits the use of restraints in all licensed health care facilities. **Waiver**: BI Waiver at App. G-2 describes statutory and regulatory protections for certain rights, including freedom from restraint.	**Statute**: See Column A. **Regs**: See Column A; no redlines needed beyond adding a reference to new Rule AAA within the day treatment regulation. **Waiver**: See Column A.	**Statute**: See Column A. **Regs**: See Column A; no redlines needed beyond adding a reference to new Rule AAA within the day treatment regulation. **Waiver**: See Column A.

Type of setting	A.Integrated	B.Selected by individual	C.Ensures individual's rights	D.Optimizes autonomy in life choices	E.Facilitates choice regarding services and supports
6. **Group Residential Services and Supports (GRSS) community residential homes for four to eight people** **Summary of cited authorities:** C.R.S. 13-21-101 *et seq.* sets forth provisions on damages in court proceedings. C.R.S. 25.5-6-401 *et seq.* is the Home- and Community-based Services for Persons with Developmental Disabilities Act. C.R.S. 25.5-10-201 *et seq.* sets forth statutory standards and procedures for providing services to individuals with IDD. C.R.S. 26-20-101 *et seq.* is the Protection of Individuals from Restraint and Seclusion Act. C.R.S. 27-10.5-104 authorizes services and support for people with IDD. CDPHE's general licensure standards are set forth in 6 CCR 1011-1 Chapter 02, and its regulations protecting people from involuntary restraints in licensed heath care facilities are set forth in Chapter 02 Part 8. CDPHE's regulations for facilities for individuals with IDD, including group homes, are set forth in 6 CCR 1011-1 Chapter 08. The Department's regulations for the Waiver for Persons with Developmental Disabilities (DD) are set forth at 10 CCR 2505-10 8.500 *et seq.* (see 8.500.1 on GRSS and 8.500.5.A(5) on Residential Habilitation Services and Supports (RHSS)). The Department's general regulations for the provision of services to individuals with IDD are set forth in 10 CCR 2505-10 8.600 *et seq.* (see 8.609.5 on comprehensive services and 8.609.8 on GRSS). The cited waiver provides for GRSS services for individuals with IDD.	**Statute**: C.R.S. 25.5-6-409.3 requires redesigned adult IDD waiver to support employment and community integration. (N/A to children.) *See also* C.R.S. 25.5-10-201 & -202(21) (General Assembly's intent that individuals with IDD be included in community life). Also, C.R.S. 25.5-10-214(5)(a) requires regulation of the distance between such homes. In addition, C.R.S. 13-21-117.5 encourages community integration by limiting the liability of CCBs & providers serving individuals with IDD. C.R.S. 25.5-10-227 provides that "[u]pon the request of a person receiving services, a service agency may hold [in trust] money or funds belonging to the person receiving services," and that "[u]pon request, a person receiving services is entitled to receive reasonable amounts of such person's money or funds held in trust" by the agency. In conjunction with the part of new Rule AAA relating to agreements on the provider's handling of funds, this statutory provision is consistent with the HCBS Settings Final Rule. **Regs**: 10 CCR 2505-10 8.608 requires providers serving people with IDD to promote community inclusion. 8.609.8(B) also prevents conspicuous grouping of GRSS homes near other DIDD settings. The Department plans to add a reference to new Rule AAA to one or more of its regulations regarding GRSS settings (10 CCR 2505-10 8.500.1, 8.500.5.A(5), 8.609.5, and 8.609.8). The Department also plans to update 8.600.4 (definition of Regional Center), which should say that CDHS, not HCPF, operates Regional Centers. 6 CCR 1011-1 Chap 08 Section 10 requires policy on resident funds but does not explicitly provide for resident control of personal resources. **Waiver**: DD Waiver, App. C-2, item c-ii, cites rule above regarding community inclusion. Also, under App. C, residential habilitation services, which include GRSS, "are designed to assist participants to reside as independently as possible in the community" and include community access services to "explore community services available to all people, natural supports available to the participant, and develop methods to access additional services/supports/activities needed by the participant."	**Statute**: C.R.S. 25.5-6-409.3 requires redesigned adult IDD waiver to incorporate freedom of choice over living arrangements and social, community, and recreational opportunities, and individual authority over supports and services. (N/A to children.) Under C.R.S. 25.5-10-216(7) and 27-10.5-110(2), a person shall not be admitted to a Regional Center without a court order. **Regs**: No redlines needed beyond adding reference(s) to new Rule AAA within the Department's GRSS regulations. **Waiver**: DD Waiver, App. D-1, items c, d, and f, confirm that the CCB must provide information to participants about the potential services, supports, and resources that are available, and that the participant or his/her guardian are offered free choice from among qualified providers.	**Statute**: C.R.S. 25.5-6-409.3 is silent with respect to individual rights. However, C.R.S. 25.5-10-216 through -240 protect the rights of individuals with IDD in general (-218), and in particular with respect to privacy (-223) and freedom from coercion and restraint (-221). Dignity and respect are protected through C.R.S. C.R.S. 25.5-10-201 and -216 through -240 as a whole. C.R.S. 26-20-103 limits the use of restraints by state agencies as well as public or private entities that contract with or are licensed/certified by state agencies. **Regs**: As stated at left, the Department plans to add reference(s) to new Rule AAA within the Department's GRSS regulations. 10 CCR 2505-10 8.604.1 (relating to people with IDD) reiterates that people receiving services have the same rights as others; 8.604.2 requires providers to protect rights in C.R.S. 25.5-10-218 through -231 (the Department plans to change this to C.R.S. 25.5-10-216 through -240); and 8.608.3 thru 8.608.5 limit the use of restraints. The Department plans to propose redlines to some or all of these regulations to more explicitly state that individuals have rights of privacy, dignity, respect, and freedom from coercion and restraint, and to require that any use of restraints be based on an assessed need after all less restrictive interventions have been exhausted; be documented in the individual's person-centered plan as a modification of the generally applicable settings criteria, consistent with the standards in Rule BBB; be compliant with any applicable waiver; and be reassessed over time. In 10 CCR 2505-10 8.500.15, 8.500.105, and 8.503.150, the Department plans to update references from the outdated C.R.S. 27-10.5-101 *et seq.* or 112 *et seq.* to the current C.R.S. 25.5-10-216 through -240. 10 CCR 2505-10 8.609.5(B)(6) presumes that people can manage their own funds and possessions unless their plan documents limitations and a plan to increase this skill. 6 CCR 1011-1 Chap 08 Section 9 protects resident rights set forth 6 CCR 1011-1, Chapter II, Part 6 (includes dignity, privacy, & freedom from inappropriate restraint), and C.R.S. 25.5-10-218 through 225 (the Department plans to change this to C.R.S. 25.5-10-216 through -240). Also, 6 CCR 1011-1 Chapter 02 Part 8 limits the	**Statute**: C.R.S. 25.5-6-409.3 requires redesigned adult IDD waiver to incorporate freedom of choice over living arrangements and social, community, and recreational opportunities; individual authority over supports and services; and maximum personal control. (N/A to children.) **Regs**: No redlines needed beyond adding reference(s) to new Rule AAA within the Department's GRSS regulations. Under 10 CCR 2505-10 8.500.5.A(5), residential habilitation services assist clients to reside as independently as possible in the community, including through self-advocacy training and community access services. Also, 10 CCR 2505-10 8.608 requires providers serving people with IDD to work to help these clients make increasingly sophisticated and responsible choices, exert greater control over their life, and develop and exercise their competencies and talents. **Waiver**: Under DD Waiver, App. C, residential habilitation services, which include GRSS, "are designed to assist participants to reside as independently as possible in the community" and include self-advocacy training (which may include training "to make increasingly responsible choices") and cognitive services (which may include training in "planning and decision making").	**Statute**: C.R.S. 25.5-6-409.3 requires redesigned adult IDD waiver to provide support to organize resources and achieve "key service outcomes." (N/A to children.) **Regs**: Regs for GRSS community residential homes are silent with respect to facilitating choice regarding services and supports. The regs for case planning cover this, but the Department plans to add this point to the regs for this setting as well by adding reference(s) to new Rule AAA within the Department's GRSS regulations. **Waiver**: DD Waiver is silent with respect to obligation on provider's part to facilitate choice regarding services and supports.

Type of setting	A.Integrated	B.Selected by individual	C.Ensures individual's rights	D.Optimizes autonomy in life choices	E.Facilitates choice regarding services and supports
			use of restraints in all licensed health care facilities. **Waiver**: DD Waiver, App. G-2, describes statutory protections for certain rights, including freedom from restraint.		
7. **Individual Residential Services and Supports (IRSS) homes for up to 3 people** • Host homes • Homes owned or leased by agency • Family homes (see Row 8) • Own homes (see Row 8) **Summary of cited authorities:** C.R.S. 13-21-101 *et seq.* sets forth provisions on damages in court proceedings. C.R.S. 25.5-6-401 *et seq.* is the Home- and Community-based Services for Persons with Developmental Disabilities Act. C.R.S. 25.5-10-201 *et seq.* sets forth statutory standards and procedures for providing services to individuals with IDD. C.R.S. 26-20-101 *et seq.* is the Protection of Individuals from Restraint and Seclusion Act. The Department's regulations for the Waiver for Persons with Developmental Disabilities (DD) are set forth at 10 CCR 2505-10 8.500 *et seq.* (see 8.500.1 on IRSS and 8.500.5.A(5) on Residential Habilitation Services and Supports (RHSS)). The Department's general regulations for the provision of services to individuals with IDD are set forth in 10 CCR 2505-10 8.600 *et seq.* (see 8.609.5 on comprehensive services and 8.609.7 on IRSS). The cited waiver provides for IRSS services for individuals with IDD.	**Statute**: C.R.S. 25.5-6-409.3 requires redesigned adult IDD waiver to support employment and community integration. (N/A to children.) *See also* C.R.S. 25.5-10-201 & -202(21) (General Assembly's intent that individuals with IDD be included in community life). In addition, C.R.S. 13-21-117.5 encourages community integration by limiting the liability of CCBs & providers serving individuals with IDD. C.R.S. 25.5-10-227 provides that "[u]pon the request of a person receiving services, a service agency may hold [in trust] money or funds belonging to the person receiving services," and that "[u]pon request, a person receiving services is entitled to receive reasonable amounts of such person's money or funds held in trust" by the agency. In conjunction with the part of new Rule AAA relating to agreements on the provider's handling of funds, this statutory provision is consistent with the HCBS Settings Final Rule. **Regs**: The Department plans to add a reference to new Rule AAA to one or more of its regulations regarding IRSS settings (10 CCR 2505-10 8.500.1, 8.500.5.A(5), 8.609.5, and 8.609.7). 10 CCR 2505-10 8.608 requires providers serving people with IDD to promote community inclusion; 8.609.7(B) requires the same for IRSS providers. Also, 8.609.7(A)(3) makes community inclusion and distance from other settings (to avoid conspicuous grouping) considerations in selecting a setting. **Waiver**: DD Waiver, App. C-2, item c-ii, cites rule above regarding community inclusion. Also, under DD Waiver, App. C, residential habilitation services, which include IRSS, "are designed to assist participants to reside as independently as possible in the community" and include community access services to "explore community services available to all people, natural supports available to the participant, and develop methods to access additional services/supports/activities needed by the participant."	**Statute**: C.R.S. 25.5-6-409.3 requires redesigned adult IDD waiver to incorporate freedom of choice over living arrangements and social, community, and recreational opportunities, and individual authority over supports and services. (N/A to children.) **Regs**: No redlines needed beyond adding reference(s) to new Rule AAA within the Department's IRSS regulations. **Waiver**: DD Waiver, App. D-1, items c, d, and f, confirm that the CCB must provide information to participants about the potential services, supports, and resources that are available, and that the participant or his/her guardian are offered free choice from among qualified providers.	**Statute**: C.R.S. 25.5-6-409.3 is silent with respect to individual rights. However, C.R.S. 25.5-10-216 through -240 protect the rights of individuals with IDD in general (-218), and in particular with respect to privacy (-223) and freedom from coercion and restraint (-221). Dignity and respect are protected through C.R.S. 25.5-10-201 and -216 through -240 as a whole. C.R.S. 26-20-103 limits the use of restraints by state agencies as well as public or private entities that contract with or are licensed/certified by state agencies. **Regs**: As stated at left, the Department plans to add reference(s) to new Rule AAA within the Department's IRSS regulations. 10 CCR 2505-10 8.604.1 (relating to people with IDD) reiterates that people receiving services have the same rights as others; 8.604.2 requires providers to protect rights in C.R.S. 25.5-10-218 through -231 (the Department plans to change this to C.R.S. 25.5-10-216 through -240); and 8.608.3 thru 8.608.5 limit the use of restraints. The Department plans to propose redlines to some or all of these regulations to more explicitly state that individuals have rights of privacy, dignity, respect, and freedom from coercion and restraint, and to require that any use of restraints be based on an assessed need after all less restrictive interventions have been exhausted; be documented in the individual's person-centered plan as a modification of the generally applicable settings criteria, consistent with the standards in Rule BBB; be compliant with any applicable waiver; and be reassessed over time. In 10 CCR 2505-10 8.500.15, 8.500.105, and 8.503.150, the Department plans to update references from the outdated C.R.S. 27-10.5-101 *et seq.* or 112 *et seq.* to the current C.R.S. 25.5-10-216 through -240. 10 CCR 2505-10 8.609.5(B)(6) presumes that people can manage their own funds and possessions unless their plan documents limitations and a plan to increase this skill.	**Statute**: C.R.S. 25.5-6-409.3 requires redesigned adult IDD waiver to incorporate freedom of choice over living arrangements and social, community, and recreational opportunities; individual authority over supports and services; and maximum personal control. (N/A to children.) **Regs**: No redlines needed beyond adding reference(s) to new Rule AAA within the Department's IRSS regulations. Under 10 CCR 2505-10 8.500.5.A(5), residential habilitation services assist clients to reside as independently as possible in the community, including through self-advocacy training and community access services. Also, 10 CCR 2505-10 8.608 requires providers serving people with IDD to work to help these clients make increasingly sophisticated and responsible choices, exert greater control over their life, and develop and exercise their competencies and talents. **Waiver**: Under DD Waiver, App. C, residential habilitation services, which include IRSS, "are designed to assist participants to reside as independently as possible in the community" and include self-advocacy training (which may include training "to make increasingly responsible choices") and cognitive services (which may include training in "planning and decision making").	**Statute**: C.R.S. 25.5-6-409.3 requires redesigned adult IDD waiver to provide support to organize resources and achieve "key service outcomes." (N/A to children.) **Regs**: IRSS regs are silent with respect to facilitating choice regarding services and supports. The regs for case planning cover this, but the Department plans to add this point to the regs for this setting as well by adding reference(s) to new Rule AAA within the Department's IRSS regulations. **Waiver**: See Column B.

Type of setting	A.Integrated	B.Selected by individual	C.Ensures individual's rights	D.Optimizes autonomy in life choices	E.Facilitates choice regarding services and supports
			Waiver: DD Waiver, App. G-2, describes statutory protections for certain rights, including freedom from restraint.		
8. **Private homes belonging to clients or their families, professional provider offices, and clinics**	Colorado's statutes, regulations, and waivers do not expressly require that private homes, professional provider offices, and clinics be integrated, selected by the individual, etc. Colorado understands CMS's position to be that if HCBS services are provided in a private home, professional provider office, or clinic, the setting must meet the HCBS settings requirements set forth in 42 C.F.R. § 441.301(c)(4). Colorado plans to promulgate new Rule AAA making these requirements applicable to all settings in which HCBS services are provided. For purposes of site-specific assessments (*e.g.*, Provider Transition Plans and site visits), Colorado plans to draw on its understanding of the way most private homes, professional provider offices, and clinics operate in presuming that they are compliant with these requirements. Anyone may seek to rebut this presumption by providing information about a particular setting to the Department. For situations where a family caregiver is a provider and owns the home in which he or she provides services to a family member, Colorado plans to test its presumption by conducting site visits at a random selection of family-caregiver-owned homes; assuming the presumption holds, Provider Transition Plans will not be required for all family-caregiver-owned homes.				
9. **Supported Employment/vocational services locations** • Group • Individual **Summary of cited authorities:** C.R.S. 13-21-101 *et seq.* sets forth provisions on damages in court proceedings. C.R.S. 25.5-6-401 *et seq.* is the Home- and Community-based Services for Persons with Developmental Disabilities Act. C.R.S. 25.5-10-201 *et seq.* sets forth statutory standards and procedures for providing services to individuals with IDD. C.R.S. 26-20-101 *et seq.* is the Protection of Individuals from Restraint and Seclusion Act. The Department's regulations for the Waiver for Persons with Developmental Disabilities (DD) are set forth at 10 CCR 2505-10 8.500 *et seq.* (see 8.500.5.A(7) on Supported Employment for purposes of DD Waiver), and its regulations for the Supported Living Services (SLS) Waiver are set forth at 10 CCR 2505-10 8.500.90 *et seq.* (see 8.500.94.A(14) on Supported Employment for purposes of SLS Waiver). The Department's general regulations for the provision of services to individuals with IDD are set forth in 10 CCR 2505-10 8.600 *et seq.* (see 8.609.9(A) on Supported Employment). The cited waivers provide for Supported Employment services for individuals with IDD.	**Statute**: C.R.S. 25.5-6-409.3 requires redesigned adult IDD waiver to support employment and community integration. (N/A to children.) *See also* C.R.S. 25.5-10-201 & -202(21) (General Assembly's intent that individuals with IDD be included in community life). In addition, C.R.S. 13-21-117.5 encourages community integration by limiting the liability of CCBs & providers serving individuals with IDD. Under C.R.S. 25.5-10-204(g)(I), as recently amended by the Employment First Act (S.B. 16-077), the Department will "[f]acilitate employment first policies and practices by . . . [d]eveloping practices that reflect a presumption that all persons with disabilities are capable of working in competitive integrated employment if they choose to do so, and ensuring that options for competitive integrated employment with appropriate supports are explored before consideration of segregated activities." C.R.S. 25.5-10-227 provides that "[u]pon the request of a person receiving services, a service agency may hold [in trust] money or funds belonging to the person receiving services," and that "[u]pon request, a person receiving services is entitled to receive reasonable amounts of such person's money or funds held in trust" by the agency. In conjunction with the part of new Rule AAA relating to agreements on the provider's handling of funds, this statutory provision is consistent with the HCBS Settings Final Rule. **Regs**: 10 CCR 2505-10 8.608 requires providers serving people with IDD to promote community inclusion. Under 10 CCR 2505-10 8.500.5.A(7) and 8.500.94.A(14), supported employment may be delivered in a variety of settings in which clients interact with individuals without disabilities to the same extent that individuals without disabilities employed in comparable positions would interact;	**Statute**: C.R.S. 25.5-6-409.3 requires redesigned adult IDD waiver to incorporate freedom of choice over living arrangements and social, community, and recreational opportunities, and individual authority over supports and services. (N/A to children.) **Regs**: Regs are silent with respect to supported employment setting being selected by individual; no redlines needed beyond adding reference(s) to new Rule AAA within the Department's Supported Employment regulations. **Waiver**: SLS Waiver, App. D-1, items c, d, and f, confirm that the CCB must provide information to participants about the potential services, supports, and resources that are available, and that the participant or his/her guardian are offered free choice from among qualified providers. *See also* DD Waiver, App. D-1, items c, d, and f (same).	**Statute**: C.R.S. 25.5-6-409.3 is silent with respect to individual rights. However, C.R.S. 25.5-10-216 through -240 protect the rights of individuals with IDD in general (-218), and in particular with respect to privacy (-223) and freedom from coercion and restraint (-221). Dignity and respect are protected through C.R.S. 25.5-10-201 and -216 through -240 as a whole. Also, C.R.S. 26-20-103 limits the use of restraints by state agencies as well as public or private entities that contract with or are licensed/certified by state agencies. **Regs**: As stated at left, the Department plans to add reference(s) to new Rule AAA within the Department's Supported Employment regulations. 10 CCR 2505-10 8.604.1 (relating to people with IDD) reiterates that people receiving services have the same rights as others; 8.604.2 requires providers to protect rights in C.R.S. 25.5-10-218 through -231 (the Department plans to change this to C.R.S. 25.5-10-216 through -240); and 8.608.3 thru 8.608.5 limit the use of restraints. The Department plans to propose redlines to some or all of these regulations to more explicitly state that individuals have rights of privacy, dignity, respect, and freedom from coercion and restraint, and to require that any use of restraints be based on an assessed need after all less restrictive interventions have been exhausted; be documented in the individual's person-centered plan as a modification of the generally applicable settings criteria, consistent with the standards in Rule BBB; be compliant with any applicable waiver; and be reassessed over time. In 10 CCR 2505-10 8.500.15, 8.500.105, and 8.503.150, the Department plans to update references from the outdated C.R.S. 27-10.5-101 *et seq.* or 112 *et seq.* to the current C.R.S. 25.5-10-216 through -240.	**Statute**: C.R.S. 25.5-6-409.3 requires redesigned adult IDD waiver to incorporate freedom of choice over living arrangements and social, community, and recreational opportunities; individual authority over supports and services; and maximum personal control. (N/A to children) **Regs**: No redlines needed beyond adding reference(s) to new Rule AAA within the Department's Supported Employment regulations. 10 CCR 2505-10 8.608 requires providers serving people with IDD to work to help these clients make increasingly sophisticated and responsible choices, exert greater control over their life, and develop and exercise their competencies and talents. **Waiver**: SLS Waiver, App. C, and DD Waiver, App. C, are silent with respect to autonomy in connection with supported employment.	**Statute**: C.R.S. 25.5-6-409.3 requires redesigned adult IDD waiver to provide support to organize resources and achieve "key service outcomes." (N/A to children.) **Regs**: See Column B; no redlines needed beyond adding reference(s) to new Rule AAA within the Department's Supported Employment regulations. **Waiver**: See Column B.

Type of setting	A.Integrated	B.Selected by individual	C.Ensures individual's rights	D.Optimizes autonomy in life choices	E.Facilitates choice regarding services and supports
	occurs outside of a provider facility; and is provided in community jobs, enclaves, or mobile crews. The Department plans to change 8.609.4 and 8.609.9(A), which provide for non-integrated, sheltered, and/or segregated work services, to eliminate non-integrated settings and require integration. The Department also plans to eliminate "enclaves" from 8.500.5.A(7) and 8.500.94.A(14). In addition, the Department plans to add a reference to new Rule AAA to one or more of the foregoing regs. **Waiver**: SLS Waiver, App. C, describes supported employment as established in the above-cited regulations. The Department plans to eliminate "enclaves" from the waiver. *See also* DD Waiver, App. C (same).		10 CCR 2505-10 8.609.5(B)(6) presumes that people can manage their own funds and possessions unless their plan documents limitations and a plan to increase this skill. **Waiver**: SLS Waiver, App. G-2, describes statutory protections for certain rights, including freedom from restraint. *See also* DD Waiver, App. G-2 (same).		
	For purposes of site-specific assessments (*e.g.*, Provider Transition Plans and site visits), Colorado plans to draw on its understanding of the way most Supported Employment – Individual settings operate in presuming that they are compliant with these requirements. Anyone may seek to rebut this presumption by providing information about a particular setting to the Department. Supported Employment – Group settings will be subject to the same PTP and site visit process as other settings.				
10. **Supported Living Program (SLP) facilities under BI waiver** (note that SLP providers must be licensed as an ALR (see Row 2 above)) *The rules relating to this type of setting are currently being revised.* **Summary of cited authorities:** C.R.S. 25.5-6-701 *et seq.* provides statutory authority for HCBS services for people with brain injuries (BI). Section 703 sets out definitions, including one for supportive care campuses. C.R.S. 26-20-101 *et seq.* is the Protection of Individuals from Restraint and Seclusion Act. CDPHE's general licensure standards are set forth in 6 CCR 1011-1 Chapter 02, and its regulations protecting people from involuntary restraints in licensed heath care facilities are set forth in Chapter 02 Part 8. 10 CCR 2505-10 8.515 *et seq.* regulates services under the Waiver for Persons with Brain Injury (BI), with Section 8.515.85 setting out criteria for the SLP. The cited waiver provides for SLP services.	**Statute**: C.R.S. 25.5-6-703(9) is silent with respect to integration, etc. of supportive care campus. **Regs**: The Department plans to add a reference to new Rule AAA within 10 CCR 2505-10 8.515.85. Under 10 CCR 2505-10 8.515.85.F, the SLP must be integrated in and support full access to the greater community. Under 8.515.85.H, it must have certain policies on management of client funds and property. Also, under 8.515.85.A, protective oversight includes the client's choice and ability to travel and engage independently in the wider community; and under 8.515.85.C, SLP services include community participation. The SLP regs currently include a paraphrased restatement of the federal settings criteria (at 8.515.85.F(1)), F(2), and H(1)) and the process for modifying these criteria in particular cases (at F(3)). When it promulgates Rules AAA and BBB, the Department will eliminate this restatement in order to avoid duplication and potential inconsistency. **Waiver**: BI Waiver at App. C-2, item c(ii) requires SLP facility to facilitate community integration.	**Statute**: See Column A. **Regs**: No redlines needed beyond adding a reference to new Rule AAA to the SLP reg. Under 10 CCR 2505-10 8.515.85.F, SLP must be selected by the client from among setting options. **Waiver**: BI Waiver at App. B-7 and App. D-1, items b & c confirms that people are informed of feasible service alternatives provided by the waiver and the choices of either institutional or home and community-based services, and that the case manager provides a choice of providers.	**Statute**: C.R.S. 26-20-103 limits the use of restraints by state agencies as well as public or private entities that contract with or are licensed/certified by state agencies. Otherwise, see Column A. **Regs**: As stated at left, the Department plans to add a reference to new Rule AAA to the SLP reg. Under 10 CCR 2505-10 8.515.85.F, SLP must ensure client rights of privacy, dignity, respect, and freedom from coercion and restraint. The Department plans to propose redlines to 8.515.85.F(3)(c) to clarify that SLP providers may not use restraints or seclusion (as stated in the waiver). Also, 6 CCR 1011-1 Chapter 02 Part 8 limits the use of restraints in all licensed health care facilities. **Waiver**: Per BI waiver App. G-2, SLP is prohibited from the use of restraints and seclusion.	**Statute**: See Column A. **Regs**: No redlines needed beyond adding a reference to new Rule AAA to the SLP reg. Under 10 CCR 2505-10 8.515.85.F, SLP must optimize individual initiative, autonomy, and independence; also, under 8.515.85.C, SLP services include independent living skills training. **Waiver**: BI Waiver at App. C-2, item c(ii) requires SLP facility to be homelike and provide choice about care and lifestyle.	**Statute**: See Column A. **Regs**: No redlines needed beyond adding a reference to new Rule AAA to the SLP reg. Under 10 CCR 2505-10 8.515.85.F, SLP must facilitate client choice regarding services and supports. **Waiver**: BI Waiver at App. C-2, item c(ii) requires SLP facility to be homelike and provide choice about care and lifestyle.
11. **Transitional Living Program (TLP) facilities under BI waiver** (note that TLP providers must be licensed as an ALR (see Row 2 above))	**Statute**: C.R.S. 25.5-6-703(10) is silent with respect to integration, etc. of transitional living facility.	**Statute**: See Column A. **Regs**: 10 CCR 2505-10 8.516.30 is silent with respect to being selected by individual; as stated at left, the	**Statute**: C.R.S. 26-20-103 limits the use of restraints by state agencies as well as public or private entities that contract with or are licensed/certified by state agencies. Otherwise, see Column A.	**Statute**: See Column A. **Regs**: No redlines needed beyond adding a reference to new Rule AAA within the TLP reg. Per 10 CCR 2505-10 8.516.30(G)(3),	**Statute**: See Column A. **Regs**: See Column B; as stated at left, the Department plans add a reference to new Rule AAA within the TLP reg.

Type of setting	A.Integrated	B.Selected by individual	C.Ensures individual's rights	D.Optimizes autonomy in life choices	E.Facilitates choice regarding services and supports
The rules relating to this type of setting are currently being revised. **Summary of cited authorities:** C.R.S. 25.5-6-701 *et seq.* provides statutory authority for HCBS services for people with brain injuries (BI). Section 703 sets out definitions, including one for transitional living. C.R.S. 26-20-101 *et seq.* is the Protection of Individuals from Restraint and Seclusion Act. CDPHE's general licensure standards are set forth in 6 CCR 1011-1 Chapter 02, and its regulations protecting people from involuntary restraints in licensed heath care facilities are set forth in Chapter 02 Part 8. 10 CCR 2505-10 8.515 *et seq.* regulates services under the Waiver for Persons with Brain Injury (BI), with Section 8.516.30 setting out criteria for the TLP. The cited waiver provides for TLP services.	**Regs**: The Department plans to add a reference to new Rule AAA within 10 CCR 2505-10 8.516.30. Under 10 CCR 2505-10 8.516.30(E)(6), TLP services "will occur in the community or in natural settings and be non-institutional in nature." 8.516.30(C)(4) provides that "[i]tems of personal need or comfort shall be paid out of money set aside from client's[] income." As stated above, new Rule AAA will require that if an individual requests that a provider hold his/her funds, their person-centered plan must document this request as well as the parties' agreement on how the provider should handle the funds (including acknowledgement of the provider's obligations under the SSA's requirements for representative payees, if applicable or if the parties so elect). **Waiver**: BI Waiver at App. C-2, item c(ii) requires TLP facility to facilitate community integration.	Department plans add a reference to new Rule AAA within the TLP reg. **Waiver**: BI Waiver at App. B-7 and App. D-1, items b & c confirms that people are informed of feasible service alternatives provided by the waiver and the choices of either institutional or home and community-based services, and that the case manager provides a choice of providers.	**Regs**: As stated at left, the Department plans to add a reference to new Rule AAA within the TLP reg. 10 CCR 2505-10 8.516.30(H) makes rights in 8.515.80(C) (for day treatment facilities under BI waiver) applicable, and adds more privacy in correspondence. The Department plans to propose redlines to 8.516.30(E) to clarify that TLP providers may not use restraints or seclusion (as stated in the waiver). Also, 6 CCR 1011-1 Chapter 02 Part 8 limits the use of restraints in all licensed health care facilities. **Waiver**: Per BI waiver App. G-2, TLP is prohibited from the use of restraints and seclusion.	TLP helps client work toward goals that include personal and living independence. **Waiver**: BI Waiver at App. C-2, item c(ii) requires TLP facility to be homelike and provide choice about care and lifestyle.	**Waiver**: BI Waiver at App. C-2, item c(ii) requires TLP facility to be homelike and provide choice about care and lifestyle.
12. **Youth Day Service settings under the Children's Extensive Support (CES) Waiver** • Child's home (see Row 8) • Provider's home (see Row 8 and regulations at right regarding family child care homes) • Other settings in the community *The Department's rule relating to the Youth Day Service is currently being drafted for eventual public notice and codification at 10 CCR 2505-10 8.503.40.A.* **Summary of cited authorities:** C.R.S. 25.5-10-201 *et seq.* sets forth statutory standards and procedures for providing services to individuals with IDD. C.R.S. 26-6-101 *et seq.* is the Child Care Licensing Act. C.R.S. 26-20-101 *et seq.* is the Protection of Individuals from Restraint and Seclusion Act. The Department's regulations for the Children's Extensive Support (CES) Waiver are set forth in 10 CCR 2505-10 8.503, and its general regulations for the provision of services to individuals with IDD are set forth in 10 CCR 2505-10 8.600 *et seq.* CDHS's regulations for child welfare services and facilities are set forth in 12 CCR 2509 *et seq.*, also known as Staff Manual Volume 7. Within Volume 7, CDHS regulates child care centers at 12 CCR 2509-8 7.702 *et seq.*, family child care homes at 7.707 *et seq.*,	**Statute**: C.R.S. 25.5-10-201 declares the General Assembly's intent that individuals with IDD be included in community life, but does not specify integration as a requirement for particular settings. **Regs**: The Youth Day Service rule has not yet been promulgated. When it publishes this rule, the Department plans to include a reference to new Rule AAA. Under 12 CCR 2509-8 7.702.51(C), the child care center must make a reasonable effort to integrate children with IDD with other children. The Department plans to work with CDHS to provide in CDHS's regulations that child care centers (at 12 CCR 2509-8 7.702 *et seq.*), family child care homes (7.707 *et seq.*), and school-age child care centers (7.712 *et seq.*) that provide services under the CES Waiver must comply with the Department's criteria for such providers. **Waiver**: CES Waiver is silent w/r/t integration, etc.	**Statute**: Statutes do not address whether the child chooses the Youth Day Service setting. **Regs**: See Column A. CDHS's child care center regulations do not address whether the child chooses the setting. As stated at left, when it publishes its Youth Day Service rule, the Department plans to include a reference to new Rule AAA. **Waiver**: CES Waiver, App. B-7, provides that the child's parents, guardian, or representative are informed of any feasible alternatives under the waiver and given choice of either institutional or home and community based services. The case manager provides the child's parents, guardian, or representative with a choice of providers as well as choice of whether these services will be provided in the community or in an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID).	**Statute**: C.R.S. 25.5-10-216 through -240 protect the rights of individuals with IDD in general (-218), and in particular with respect to privacy (-223) and freedom from coercion and restraint (-221). Dignity and respect are protected through C.R.S. 25.5-10-201 and -216 through -240 as a whole. C.R.S. 26-6-106(2)(g) authorizes child care facility licensing rules to "safeguard the legal rights of children served," but does not specify which rights. C.R.S. 26-20-103 limits the use of restraints by state agencies as well as public or private entities that contract with or are licensed/certified by state agencies. **Regs**: See Column A. As stated at left, when it publishes its Youth Day Service rule, the Department plans to include a reference to new Rule AAA. 10 CCR 2505-10 8.604.1 (relating to people with IDD) reiterates that people receiving services have the same rights as others; 8.604.2 requires providers to protect rights in C.R.S. 25.5-10-218 through -231 (the Department plans to change this to C.R.S. 25.5-10-216 through -240); and 8.608.3 thru 8.608.5 limit the use of restraints. The Department plans to propose redlines to some or all of these regulations to more explicitly state that individuals have rights of privacy, dignity, respect, and freedom from coercion and restraint, and to require	**Statute**: See Column B. **Regs**: See Column A. **Waiver**: See Column A.	**Statute**: See Column B. **Regs**: See Column A. **Waiver**: See Column A.

Type of setting	A.Integrated	B.Selected by individual	C.Ensures individual's rights	D.Optimizes autonomy in life choices	E.Facilitates choice regarding services and supports
and school-age child care centers at 7.712 *et seq.* The cited waiver provides for Youth Day services.			that any use of restraints be based on an assessed need after all less restrictive interventions have been exhausted; be documented in the individual's person-centered plan as a modification of the generally applicable settings criteria, consistent with the standards in Rule BBB; be compliant with any applicable waiver; and be reassessed over time. In 10 CCR 2505-10 8.500.15, 8.500.105, and 8.503.150, the Department plans to update references from the outdated C.R.S. 27-10.5-101 *et seq.* or 112 *et seq.* to the current C.R.S. 25.5-10-216 through -240. 10 CCR 2505-10 8.609.5(B)(6) presumes that people can manage their own funds and possessions unless their plan documents limitations and a plan to increase this skill. Also, 12 CCR 2509-8 7.702.56, 7.707.8, and 7.712.55 forbid child care centers, family child care homes, and school-age child care centers from using harmful, humiliating, or frightening measures against a child. **Waiver**: CES Waiver, App. G-2, describes statutory and regulatory protections for rights. This description should be updated; for example, 2 CCR 503, Volume 16, has been repealed (with the transfer of DIDD (then DDS) from CDHS to the Department.		

Set 2 of federal criteria: standards applicable to provider-owned or controlled residential settings (42 C.F.R. § 441.301(c)(4))

Home and community-based settings must have all of the following qualities, and such other qualities as [CMS] determines to be appropriate, based on the needs of the individual as indicated in their person-centered service plan: . . .

(vi) In a provider-owned or controlled residential setting, in addition to the qualities at §441.301(c)(4)(i) through (v), the following additional conditions must be met:

(A) 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.

(B) Each individual has privacy in their sleeping or living unit:

(*1*) Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.

(*2*) Individuals sharing units have a choice of roommates in that setting.

(*3*) Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

(C) Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.

(D) Individuals are able to have visitors of their choosing at any time.

(E) The setting is physically accessible to the individual.

(F) Any modification of the additional conditions, 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. The following requirements must be documented in the person-centered service plan:

(*1*) Identify a specific and individualized assessed need.

(*2*) Document the positive interventions and supports used prior to any modifications to the person-centered service plan.

(*3*) Document less intrusive methods of meeting the need that have been tried but did not work.

(*4*) Include a clear description of the condition that is directly proportionate to the specific assessed need.

(*5*) Include regular collection and review of data to measure the ongoing effectiveness of the modification.

(*6*) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

(*7*) Include the informed consent of the individual.

(*8*) Include an assurance that interventions and supports will cause no harm to the individual.

New Rule BBB will provide that the above standards apply to all provider-owned or controlled residential settings in which HCB services are provided, except where HCB services are otherwise permitted to be delivered in a setting that is institutional or does not meet the HCBS settings standards, such as respite available under certain waivers. *See* 79 Fed. Reg. at 3011. Palliative/Supportive Care services provided outside the child's home (under the Children with Life-Limiting Illness waiver) are similar to respite, and new Rule BBB will not apply to such services. In addition to protecting the federally prescribed rights as set forth above, new Rule BBB will also protect some of the rights currently set forth in 10 CCR 2505-10 8.515.80(C) (rights of participants in the Waiver for People with Brain Injury).

Table 2: standards applicable to provider-owned or –controlled residential settings

Type of setting	A. Landlord/tenant rights	B. Privacy in sleeping/living unit	C. Freedom over schedule and access to food	D. Visitors at any time	E. Physically accessible	F. Documented justification for any modification to these conditions
1. **Adult day services centers**	N/A—this type of setting is not residential.					
2. **Alternative care facilities (ACFs)** *The Department has convened a stakeholder workgroup comprised of providers, clients, advocates, and representatives from CDPHE. The workgroup is reviewing current Department regulations for compliance with the HCBS Settings Rule and to make any other necessary updates. The Department is working closely with CDPHE to ensure that any revisions to the HCPF regulations not only address the HCBS Settings Rule, but do not conflict with the assisted living residence (ALR) regulations with which ACFs must comply. At the same time, CDPHE is currently working with stakeholders, including representatives from the Department, to update its ALR regulations.* **Summary of cited authorities:** The Department's regulations require an ACF to be licensed by CDPHE as an assisted living residence (ALR) and to meet other	**Statute**: 25-27-104.5 contemplates leases but does not require them or require that they provide protections comparable to landlord/tenant law. **Regs**: For ALRs generally: 6 CCR 1011-1 Chap 07 1.104(5)(i) requires ALR to have a policy for eviction, and 1.105(6) limits discharge of residents, but they do not say that the policy must comply with landlord/tenant rights; 1.105(2) requires a written resident agreement but does not require that it provide protections comparable to landlord/tenant law. For ACFs specifically: 10 CCR 2505-10 8.49 is silent with respect to landlord/tenant rights. The Department plans to add a reference to new Rule BBB within 10 CCR 2505-10 8.495. **Waiver**: EBD Waiver is silent with respect to landlord/tenant rights. CMHS Waiver, Attach. 2, notes plans to "support providers in documenting protections and appeals comparable to those provided	**Statute**: 25-27-104 and 25-27-104.5 are silent with respect to privacy in unit. **Regs**: As stated at left, the Department plans to add a reference to new Rule BBB within its ACF regulation. Regarding the three components of privacy in the federal rule: (1) The Department plans to change 10 CCR 2505-10 8.495.4.G ("Clients and their roommates determined capable to control access to private personal quarters, shall be allowed to lock their doors and control access to their quarters" and 8.495.6.H(3) ("Doors to bedrooms shall not be locked unless the resident is able to manage the key independently") to provide that "individuals shall have personal quarters with entrance doors lockable by the individual and shall control access to their quarters, unless otherwise specified in their	**Statute**: See Column B. **Regs**: Under 10 CCR 2505-10 8.495.6.E(1), ACFs must maintain a home-like quality and feel. 8.495.6.E(9) provides that "Facilities shall provide nutritious food and beverage that clients have access to at all times." 8.495.4.H provides that "Clients shall have unscheduled access to food and food preparation areas if determined capable to appropriately handle cooking activities." The Department plans to change this regulation to state that "Clients shall have access to food at all times. Clients shall have access to food preparation areas if they can appropriately handle any equipment in these areas." In addition, as stated at left, the Department plans to add a reference to new Rule BBB within its ACF regulation.	**Statute**: See Column B. **Regs**: 6 CCR 1011-1 Chap 07 1.106(1)(k) protects right to visitors, but not necessarily at any time. As stated at left, the Department plans to add a reference to new Rule BBB within its ACF regulation. **Waiver**: EBD Waiver and CMHS Waiver at App. G-2, item b, refer to visitors, but not necessarily at any time.	**Statute**: See Column B. **Regs**: No redlines needed beyond adding a reference to new Rule BBB within the Department's ACF regulation. 6 CCR 1011-1 Chap 07 1.106(1)(g) and 1.112(2) protect right to use of and access to dining room, other common areas, and building. **Waiver**: EBD Waiver, and CMHS Waiver are silent with respect to physical accessibility.	**Statute**: See Column B. **Regs**: 10 CCR 2505-10 8.495.6.E(10) provides for client's cooking capacity to be assessed and limited if necessary, and for the foregoing to be contained in care plan. Otherwise silent with respect to documenting modifications to the additional conditions; as stated at left, the Department plans to add a reference to new Rule BBB within its ACF regulation. **Waiver**: See Column E.

Type of setting	A.Landlord/tenant rights	B.Privacy in sleeping/living unit	C.Freedom over schedule and access to food	D.Visitors at any time	E.Physically accessible	F.Documented justification for any modification to these conditions
criteria, as set forth in 10 CCR 2505-10 8.495. C.R.S. 25-27-101 *et seq.* provides statutory authority for CDPHE to regulate ALRs, including by implementing the minimum standards in Section 104. C.R.S. 25.5-6-301 *et seq.* provides statutory authority for HCBS services for people who are elderly, blind, or physically disabled (EBD). Section 303 sets out definitions, including one for ACFs. CDPHE's general licensure standards are set forth in 6 CCR 1011-1 Chapter 02, and its regulations protecting people from involuntary restraints in licensed heath care facilities are set forth in Chapter 02 Part 8. CDPHE's regulations for ALRs are set forth in 6 CCR 1011-1 Chap 07. The cited waivers provide for ACF services.	under Colorado landlord tenant law." The Department plans to delete references to ACFs in the BI Waiver (with ACFs being replaced by SLPs and TLPs).	person-centered care plan. Only appropriate staff shall have keys to private quarter doors, as specified in the person's plan." (2) 8.495.4.F. provides that "the provider will accommodate roommate choices within reason." The Department plans to strike "within reason" to prevent providers from interfering with roommate choices outside of the person-centered planning process. (3) 8.495.4.E is compliant with the federal rule ("Clients shall be allowed to decorate and use personal furnishings in their bedrooms in accordance with house rules while maintaining a safe and sanitary environment at all times."). **Waiver**: EBD Waiver at App. G-2, item b requires ACF to be homelike and provide privacy. CMHS Waiver at App. G-2, item b-i refers to regulatory protections for privacy in general (see Table 1, cell C-2 above).	**Waiver**: EBD Waiver and CMHS Waiver do not address freedom over schedule (except in CDASS context) or access to food.			
3. **Child Residential Habilitation settings** • Foster Care Homes (no more than 3 foster care children) • Kinship Foster Care • Non-certified Kinship Care • Specialized group facilities o Group Homes (up to 6 children if three are in CHRP program) o Group Centers (up to 7 children if two are in CHRP program or 9 children if one is in CHRP program) • Residential Child Care Facilities (RCCFs) *The rules relating to this type of setting are currently being revised.* *The Department plans to work with CDHS on regulatory and/or waiver edits that will have minimal impact on the numerous foster care homes, SGFs, and RCCFs that*	**Statute**: Statutes are silent with respect to landlord/tenant rights, etc. for child residential habilitation settings. **Regs**: CDHS child welfare regulations are silent with respect to landlord/tenant rights, etc. for child residential habilitation settings. The Department plans add a reference to new Rule BBB in the Department's CHRP-specific regulations (10 CCR 2505-10 8.508). In Colorado, the age of majority for purposes of entering into a binding contract is 18. Hence, the Department plans to require that the child's parent, guardian, or other legal representative sign a lease on the child's behalf. Under 8.604.3(B)(5) (relating to people with IDD), services may not be suspended if doing so would put person at risk of loss of abode. The Department plans to add "or would be in violation of any eviction and appeals processes required under Rule BBB." **Waiver**: CHRP waiver is silent with respect to landlord/tenant rights, etc. for child residential habilitation settings.	**Statute**: See Column A. **Regs**: 12 CCR 2509-8 7.708.33 (for foster care) and 7.714.31 (for SGFs and RCCFs) provide that "[e]very child has the right to a reasonable degree of privacy." As stated at left, the Department plans add a reference to new Rule BBB in the Department's CHRP-specific regulations (10 CCR 2505-10 8.508). **Waiver**: CHRP waiver, App. C-2, provides that "children residing within a group home have access to the same amenities as those children residing in a foster home such as . . . privacy to the extent that is appropriate according to the child's needs." For group homes, CHRP waiver, App. C-2, also refers to CDHS licensing requirements, including "a reasonable degree of privacy." CHRP waiver does not explicitly provide for the detailed privacy criteria set forth in the HCBS Settings Rule.	**Statute**: See Column A. **Regs**: See Column A; the Department plans to add a reference to new Rule BBB in the Department's CHRP-specific regulations (10 CCR 2505-10 8.508). **Waiver**: CHRP waiver is silent with respect to freedom over schedule and access to food.	**Statute**: Under C.R.S. 25.5-10-223, person with IDD has right to reasonable and frequent opportunities to meet with visitors. **Regs**: 12 CCR 2509-8 7.708.33 (for foster care) and 7.714.31 (for SGFs and RCCFs) protect children's right to have convenient opportunities to meet with visitors (but not at any time). As stated at left, the Department plans add a reference to new Rule BBB in the Department's CHRP-specific regulations (10 CCR 2505-10 8.508). **Waiver**: CHRP waiver, App. C-2, provides that in group homes, "[v]isitors are allowed in the home, however, visitation [may be] dependent upon the child's court orders if there are concerns about a child's safety." For CHRP settings generally, CHRP waiver cites the CDHS regulations cited above.	**Statute**: See Column A. **Regs**: See Column A; as stated at left, the Department plans add a reference to new Rule BBB in the Department's CHRP-specific regulations (10 CCR 2505-10 8.508). **Waiver**: See Column C.	**Statute**: See Column A. **Regs**: 10 CCR 2505-10 8.604.3(A) (relating to people with IDD) and 8.608.2 (same) requires that any suspension of rights and restrictive procedures be documented in plan and monitored. Also, 12 CCR 2509-8 7.714.31 (for SGFs and RCCFs, but not foster homes) requires that restriction of certain (not all) rights be documented. As stated at left, the Department plans add a reference to new Rule BBB in the Department's CHRP-specific regulations (10 CCR 2505-10 8.508). **Waiver**: CHRP waiver at App. G-1 provides that certain rights may be restricted by foster homes and group homes/centers (does not refer to RCCFs). The Department plans to work with CDHS to propose redlines to ensure that restrictions do not inappropriately limit rights in Table 1, and limit rights in Table 2 only according to CMS's requirements that limitations be set forth and justified in personal plan.

Type of setting	A. Landlord/tenant rights	B. Privacy in sleeping/living unit	C. Freedom over schedule and access to food	D. Visitors at any time	E. Physically accessible	F. Documented justification for any modification to these conditions
serve children who are not enrolled in the CHRP waiver. **Summary of cited authorities:** C.R.S. 25.5-10-201 *et seq.* sets forth statutory standards and procedures for providing services to individuals with IDD. C.R.S. 26-6-101 *et seq.* is the Child Care Licensing Act. The Department's regulations for CHRP services are set forth in 10 CCR 2505-10 8.508, and its general regulations for the provision of services to individuals with IDD are set forth in 10 CCR 2505-10 8.600 *et seq.* CDHS's regulations for child welfare services and facilities are set forth in 12 CCR 2509 *et seq.*, also known as Staff Manual Volume 7. Within Volume 7, Part 5 (Section 7.401 *et seq.*) addresses reimbursement and provider requirements, and Part 8 (Section 7.700 *et seq.*) addresses child care facility licensing. Several of CDHS's regulations require counties and child welfare providers serving children enrolled in the CHRP waiver to follow the Departments CHRP-specific regulations. See 12 CCR 2509-5 7.406.2(O) as well as 2509-8 7.708.1(A)(3) for foster care, 7.701.2 for SGFs, and 7.705.21(C) for RCCFs). The cited waiver provides for CHRP services.						
4. **Day Habilitation/treatment locations for individuals with IDD**	N/A—this type of setting is not residential.					
5. **Day treatment facilities under BI waiver**	N/A—this type of setting is not residential.					
6. **Group Residential Services and Supports (GRSS) community residential homes for four to eight people** **Summary of cited authorities:** C.R.S. 13-21-101 *et seq.* sets forth provisions on damages in court proceedings. C.R.S. 25.5-6-401 *et seq.* is the Home- and Community-based Services for Persons with Developmental Disabilities Act. C.R.S. 25.5-10-201 *et seq.* sets forth statutory standards and procedures for providing services to individuals with IDD. C.R.S. 27-10.5-104 authorizes services and support for people with IDD. CDPHE's regulations for facilities for individuals with IDD, including group homes, are set forth in 6 CCR 1011-1 Chapter 08. The Department's regulations	**Statute**: C.R.S. 25.5-10-214 is silent with respect to landlord/tenant rights, etc. To ensure compliance with the federal rule, the Department plans to propose redlines to or deletion of C.R.S. 13-21-117.5(7), which provides that "[i]n any civil action brought against a provider, a person with [IDD] who is served in a residential setting owned or leased by a provider shall not be considered a tenant of the provider and statutes regarding landlord-tenant relationships shall not apply. . . . No real property rights shall accrue to a person with [IDD] by virtue of placement in a residential setting." To ensure compliance with the federal rule, the Department plans to propose redlines to or deletion of C.R.S. 13-21-117.5(10), which provides that CCBs and	**Statute**: See Column A. **Regs**: As stated at left, the Department plans to add a reference to new Rule BBB to one or more of its regulations regarding GRSS settings (10 CCR 2505-10 8.500.1, 8.500.5.A(5), 8.609.5, and 8.609.8). 6 CCR 1011-1 Chap 08 regs are silent with respect to privacy in sleeping/living unit. **Waiver**: DD Waiver is silent with respect to privacy in sleeping/living unit.	**Statute**: See Column A. **Regs**: As stated at left, the Department plans to add a reference to new Rule BBB to one or more of its regulations regarding GRSS settings (10 CCR 2505-10 8.500.1, 8.500.5.A(5), 8.609.5, and 8.609.8). 6 CCR 1011-1 Chap 08 section 13.8 requires reasonable access to food supplies and between-meal snacks. Regs are silent with respect to freedom over schedule. **Waiver**: DD Waiver is silent with respect to freedom over schedule and access to food.	**Statute**: Under C.R.S. 25.5-10-223, person with IDD has right to reasonable and frequent opportunities to meet with visitors. The Department interprets reasonable and frequent as meaning unlimited except as modified through the person-centered plan. **Regs**: See Column B; as stated at left, the Department plans to add a reference to new Rule BBB to one or more of its regulations regarding GRSS settings (10 CCR 2505-10 8.500.1, 8.500.5.A(5), 8.609.5, and 8.609.8).	**Statute**: See Column A. **Regs**: No redlines needed beyond adding a reference to new Rule BBB to one or more of the Department's regulations regarding GRSS settings (10 CCR 2505-10 8.500.1, 8.500.5.A(5), 8.609.5, and 8.609.8). 6 CCR 1011-1 Chap 08 section 22.10 protects right to use of and access to dining room, other common areas, and building. **Waiver**: DD Waiver, App. C-2, item c-ii requires accessibility.	**Statute**: See Column A. **Regs**: 10 CCR 2505-10 8.604.3(A) (relating to people with IDD) and 8.608.2 (same) requires that any suspension of rights and restrictive procedures be documented in plan and monitored; the Department plans to propose redlines to require that in addition to the existing regulatory procedures, any restrictions of the rights covered by Rule BBB follow the procedures in Rule BBB. As stated at left, the Department plans to add a reference to new Rule BBB to one or more of its regulations regarding GRSS settings (10 CCR 2505-10 8.500.1, 8.500.5.A(5), 8.609.5, and 8.609.8).

Type of setting	A. Landlord/tenant rights	B. Privacy in sleeping/living unit	C. Freedom over schedule and access to food	D. Visitors at any time	E. Physically accessible	F. Documented justification for any modification to these conditions
for the DD Waiver are set forth at 10 CCR 2505-10 8.500 *et seq.* (see 8.500.1 on GRSS and 8.500.5.A(5) on Residential Habilitation Services and Supports (RHSS)). The Department's general regulations for the provision of services to individuals with IDD are set forth in 10 CCR 2505-10 8.600 *et seq.* (see 8.609.5 on comprehensive services and 8.609.8 on GRSS). The cited waiver provides for GRSS services for individuals with IDD.	service agencies may remove a person with IDD from a residential setting if they believe that the person "may be at risk of abuse, neglect, mistreatment, exploitation, or other harm in such setting," and limits liability for such removals. **Regs**: The Department plans to add a reference to new Rule BBB to one or more of its regulations regarding GRSS settings (10 CCR 2505-10 8.500.1, 8.500.5.A(5), 8.609.5, and 8.609.8). Under 10 CCR 2505-10 8.500.9(A)(4), a provider under the DD waiver may discontinue services only after documented efforts to resolve the situation. The Department plans to add "and only in compliance with any eviction and appeals processes required under Rule BBB." Under 8.604.3(B)(5) (relating to people with IDD), services may not be suspended if doing so would put person at risk of loss of abode. The Department plans to add "or would be in violation of any eviction and appeals processes required under Rule BBB." 8.609.5(B)(8) establishes notice requirements relating to changes in residential placements. The Department plans to add a new paragraph at the end of this subsection, stating that in addition to and notwithstanding the foregoing requirements, changes to residential placements must be in compliance with any eviction and appeals processes required under Rule BBB. In light of all the foregoing changes, similar changes would be duplicative, and are not necessary, for 6 CCR 1011-1 Chap 08 Section 9.1(B) and (C) and 18.3, relating to resident transfers and terminations. **Waiver**: DD Waiver is silent with respect to landlord/tenant rights, etc.			**Waiver**: DD Waiver is silent with respect to right to visitors at any time.		**Waiver**: DD Waiver, App. G-2, item b-i states that rights suspensions must be justified, reviewed, and documented in plan, and that "the informed consent of the participant [or] his/her guardian for the use of the restrictive procedure" must be obtained. But this description relies on 2 CCR 503, Volume 16, which has been repealed (with the transfer of DIDD (then DDS) from CDHS to the Department); citations should be updated.
7. **Individual Residential Services and Supports (IRSS) homes for up to three people** • Host homes • Homes owned or leased by agency • Family homes (see Row 8)	**Statute**: See Row 6, above. **Regs**: 10 CCR 2505-10 8.609.5(B)(8) is silent with respect to landlord/tenant rights, etc. The Department plans to add a reference to new Rule BBB to one or more of its regulations regarding IRSS settings (10 CCR 2505-10 8.500.1, 8.500.5.A(5), 8.609.5, and 8.609.7).	**Statute**: Statute is silent with respect to privacy in sleeping/living unit, etc. **Regs**: See Column A; as stated at left, the Department plans to add a reference to new Rule BBB to one or more of its regulations regarding IRSS	**Statute**: See Column B. **Regs**: See Column A; as stated at left, the Department plans to add a reference to new Rule BBB to one or more of its regulations regarding IRSS settings (10 CCR 2505-10 8.500.1, 8.500.5.A(5), 8.609.5, and 8.609.7).	**Statute**: Under C.R.S. 25.5-10-223, person with IDD has right to reasonable and frequent opportunities to meet with visitors. **Regs**: See Column A; as stated at left, the Department plans to add a reference to new Rule BBB to one or more of its regulations regarding IRSS settings (10 CCR	**Statute**: See Column B. **Regs**: No redlines needed beyond adding a reference to new Rule BBB to one or more of the Department's regulations regarding IRSS settings (10 CCR 2505-10 8.500.1, 8.500.5.A(5), 8.609.5, and 8.609.7). 10 CCR 2505-10	**Statute**: See Column B. **Regs**: 10 CCR 2505-10 8.604.3(A) (relating to people with IDD) and 8.608.2 (same) requires that any suspension of rights and restrictive procedures be documented in plan and monitored; the Department plans to propose redlines to require that in addition to the

Type of setting	A. Landlord/tenant rights	B. Privacy in sleeping/living unit	C. Freedom over schedule and access to food	D. Visitors at any time	E. Physically accessible	F. Documented justification for any modification to these conditions
• Own homes (see Row 8) **Summary of cited authorities:** C.R.S. 13-21-101 *et seq.* sets forth provisions on damages in court proceedings. C.R.S. 25.5-6-401 *et seq.* is the Home- and Community-based Services for Persons with Developmental Disabilities Act. C.R.S. 25.5-10-201 *et seq.* sets forth statutory standards and procedures for providing services to individuals with IDD. The Department's regulations for the DD Waiver are set forth at 10 CCR 2505-10 8.500 *et seq.* (see 8.500.1 on IRSS and 8.500.5.A(5) on Residential Habilitation Services and Supports (RHSS)). The Department's general regulations for the provision of services to individuals with IDD are set forth in 10 CCR 2505-10 8.600 *et seq.* (see 8.609.5 on comprehensive services and 8.609.7 on IRSS). The cited waiver provides for IRSS services for individuals with IDD.	Under 10 CCR 2505-10 8.500.9(A)(4), a provider under the DD waiver may discontinue services only after documented efforts to resolve the situation. The Department plans to add "and only in compliance with any eviction and appeals processes required under Rule BBB." Under 8.604.3(B)(5) (relating to people with IDD), services may not be suspended if doing so would put person at risk of loss of abode. The Department plans to add "or would be in violation of any eviction and appeals processes required under Rule BBB." 8.609.5(B)(8) establishes notice requirements relating to changes in residential placements. The Department plans to add a new paragraph at the end of this subsection, stating that in addition to and notwithstanding the foregoing requirements, changes to residential placements must be in compliance with any eviction and appeals processes required under Rule BBB. **Waiver**: DD Waiver is silent with respect to landlord/tenant rights, etc.	settings (10 CCR 2505-10 8.500.1, 8.500.5.A(5), 8.609.5, and 8.609.7). **Waiver**: DD Waiver is silent with respect to privacy in sleeping/living unit.	**Waiver**: DD Waiver is silent with respect to freedom over schedule and access to food.	2505-10 8.500.1, 8.500.5.A(5), 8.609.5, and 8.609.7). **Waiver**: DD Waiver is silent with respect to right to visitors at any time.	8.609.7(A)(9) requires accessibility. **Waiver**: DD Waiver, App. C-2, item c-ii requires accessibility.	existing regulatory procedures, any restrictions of the rights covered by Rule BBB follow the procedures in Rule BBB. As stated at left, the Department plans to add a reference to new Rule BBB to one or more of its regulations regarding IRSS settings (10 CCR 2505-10 8.500.1, 8.500.5.A(5), 8.609.5, and 8.609.7). **Waiver**: DD Waiver, App. G-2, item b-i states that rights suspensions must be justified, reviewed, and documented in plan, and that "the informed consent of the participant [or] his/her guardian for the use of the restrictive procedure" must be obtained. But this description relies on 2 CCR 503, Volume 16, which has been repealed (with the transfer of DIDD (then DDS) from CDHS to the Department); citations should be updated.
8. **Private homes belonging to clients or their families, professional provider offices, and clinics**	Generally N/A—private homes belonging to clients or their families are not generally provider-owned or –controlled, and professional provider offices and clinics are not residential. As stated above, however, New Rule BBB will generally apply to all provider-owned or controlled residential settings in which HCBS services are provided; hence, it will apply to situations where a family caregiver is a provider and owns the home in which he or she provides services to a family member. For purposes of site-specific assessments (*e.g.*, Provider Transition Plans and site visits), Colorado plans to draw on its understanding of the way most family-caregiver-owned homes operate in presuming that they are compliant with these requirements. Anyone may seek to rebut this presumption by providing information about a particular setting to the Department. For situations where a family caregiver is a provider and owns the home in which he or she provides services to a family member, Colorado plans to test its presumption by conducting site visits at a random selection of family-caregiver-owned homes; assuming the presumption holds, Provider Transition Plans will not be required for all family-caregiver-owned homes.					
9. **Supported Employment/vocational services locations**	N/A—this type of setting is not residential.					
10. **Supported Living Program (SLP) facilities under BI waiver** (note that SLP providers must be licensed as an ALR (see Row 2 above)) *The rules relating to this type of setting are currently being revised.* **Summary of cited authorities:** C.R.S. 25.5-6-701 *et seq.* provides statutory authority for HCBS services for people with brain injuries (BI). Section 703 sets out definitions, including one for supportive care campuses. 10 CCR 2505-10 8.515 *et seq.* regulates services under the BI Waiver, with Section 8.515.85 setting out criteria for the SLP.	**Statute**: C.R.S. 25.5-6-703(9) is silent with respect to landlord/tenant rights, etc. for "supportive care campus." **Regs**: Under 10 CCR 2505-10 8.515.85.F, SLP must put in place a lease or other written agreement that addresses eviction processes and appeals. The Department plans to add a reference to new Rule BBB within 10 CCR 2505-10 8.515.85. Also, the SLP regs currently include a paraphrased restatement of the federal settings criteria (at 8.515.85.F(1)), F(2), and H(1)) and the process for modifying these criteria in particular cases (at F(3)). When it promulgates Rules AAA and BBB, the Department will eliminate this	**Statute**: See Column A. **Regs**: Under 10 CCR 2505-10 8.515.85.F, SLP must ensure privacy in the client's unit including lockable doors, choice of roommates, and freedom to furnish or decorate the unit. See Column A; as stated at left, the Department plans to add a reference to new Rule BBB within its SLP regulation and to eliminate potential duplication or inconsistency between the SLP regulation and new Rule BBB. **Waiver**: BI Waiver at App. C-2, item c(ii) requires SLP facility to be homelike and provide privacy.	**Statute**: See Column A. **Regs**: Under 10 CCR 2505-10 8.515.85.F, SLP must ensure that clients have the freedom and support to control their own schedules and activities, and have access to food at any time. 8.515.85.J(1)(a) limits cooking but not access to food. See Column A; as stated at left, the Department plans to add a reference to new Rule BBB within its SLP regulation and to eliminate potential duplication or inconsistency between the SLP regulation and new Rule BBB.	**Statute**: See Column A. **Regs**: Under 10 CCR 2505-10 8.515.85.F, SLP must enable clients to have visitors of their choosing at any time. See Column A; as stated at left, the Department plans to add a reference to new Rule BBB within its SLP regulation and to eliminate potential duplication or inconsistency between the SLP regulation and new Rule BBB. **Waiver**: See Column A.	**Statute**: See Column A. **Regs**: Under 10 CCR 2505-10 8.515.85.F, SLP must be physically accessible. See Column A; as stated at left, the Department plans to add a reference to new Rule BBB within its SLP regulation and to eliminate potential duplication or inconsistency between the SLP regulation and new Rule BBB. **Waiver**: See Column A.	**Statute**: See Column A. **Regs**: Under 10 CCR 2505-10 8.515.85.F, there must be documentation for modification to conditions. See Column A; as stated at left, the Department plans to add a reference to new Rule BBB within its SLP regulation and to eliminate potential duplication or inconsistency between the SLP regulation and new Rule BBB. **Waiver**: See Column A.

Type of setting	A.Landlord/tenant rights	B.Privacy in sleeping/living unit	C.Freedom over schedule and access to food	D.Visitors at any time	E.Physically accessible	F.Documented justification for any modification to these conditions
The cited waiver provides for SLP services.	restatement in order to avoid duplication and potential inconsistency. **Waiver**: SLP is provided under BI waiver, which is silent with respect to landlord/tenant rights, etc.		**Waiver**: BI Waiver at App. C-2, item c(ii) requires SLP facility to be homelike and provide access to food and kitchen facilities.			
11. **Transitional Living Program (TLP) facilities under BI waiver** (note that TLP providers must be licensed as an ALR (see Row 2 above)) *The rules relating to this type of setting are currently being revised.* **Summary of cited authorities:** C.R.S. 25.5-6-701 *et seq.* provides statutory authority for HCBS services for people with brain injuries (BI). Section 703 sets out definitions, including one for transitional living. 10 CCR 2505-10 8.515 *et seq.* regulates services under the BI Waiver, with Section 8.516.30 setting out criteria for the TLP. The cited waiver provides for TLP services.	**Statute**: C.R.S. 25.5-6-703(10) is silent with respect to landlord/tenant rights, etc. for transitional living facilities. **Regs**: 10 CCR 2505-10 8.516.30 is silent with respect to landlord/tenant rights for TLP facilities. The Department plans to add a reference to new Rule BBB within 10 CCR 2505-10 8.516.30. **Waiver**: TLP is provided under BI waiver, which is silent with respect to landlord/tenant rights, etc.	**Statute**: See Column A. **Regs**: See Column A; as stated at left, the Department plans to add a reference to new Rule BBB within its TLP regulation. **Waiver**: BI Waiver at App. C-2, item c(ii) requires TLP facility to be homelike and provide privacy.	**Statute**: See Column A. **Regs**: See Column A; as stated at left, the Department plans to add a reference to new Rule BBB within its TLP regulation. **Waiver**: BI Waiver at App. C-2, item c(ii) requires TLP facility to be homelike and provide access to food and kitchen facilities.	**Statute**: See Column A. **Regs**: See Column A; as stated at left, the Department plans to add a reference to new Rule BBB within its TLP regulation. **Waiver**: See Column A.	**Statute**: See Column A. **Regs**: See Column A; as stated at left, the Department plans to add a reference to new Rule BBB within its TLP regulation. **Waiver**: See Column A.	**Statute**: See Column A. **Regs**: See Column A; as stated at left, the Department plans to add a reference to new Rule BBB within its TLP regulation. **Waiver**: See Column A.
12. **Youth Day Service settings under the Children's Extensive Support (CES) Waiver**	N/A—this type of service is not residential. To the extent that the service is provided in the child's or provider's home, see Row 8.					

Additional updates: Under the Brain Injury (BI) Waiver, respite is defined as "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." BI Waiver, App. C. The BI Waiver regulations state that "Respite Care means services as defined at Section 8.516.70." 10 CCR 2505-10 8.515.2. The cited regulation, in turn, states that "[a]n individual client shall be authorized for no more than a cumulative total of thirty (30) days of respite care in each certification period unless otherwise authorized by the Department." *Id.* 8.516.70. The Department will propose to add this modifiable 30-day limit to the waiver.

The Supported Living Services (SLS) Waiver states that "Respite services [are] provided on a short-term basis, because of the absence or need for relief to those persons who normally provide care for the participant." SLS Waiver, App. C. In addition, SLS waiver participants can obtain only a limited amount of respite, because they are subject to a Service Plan Authorization Limit (SPAL), that is, "an annual upper payment limit of total funds available to purchase services to meet the client's ongoing needs." *Id.* 8.500.90. The Department will propose to add a modifiable 30-day limit, similar to the one in the BI Waiver regulations, to the SLS Waiver and regulations.

Global updates: in 10 CCR 2505-10 8.500 *et seq.*, 8.500.90 *et seq.*, and 8.503 *et seq.* (regulations for DD, SLS, and CES waivers), and 8.600 *et seq.* (regulations for individuals with IDD), the Department plans to update definitions and references involving the Division for Developmental Disabilities and the Operating Agency (*i.e.*, the former DDD within CDHS) to the Division for Intellectual & Developmental Disabilities (*i.e.*, the current DIDD within HCPF). In these regulatory sections and in 10 CCR 2505-10 8.100.1 (Definitions), the Department also plans to update references involving intermediate care facilities for the mentally retarded (ICF/MRs or ICF-MRs) to intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs).

COLORADO
Department of Human Services

Attachment C

Senator Ray Scott, Chair
Senate State, Veterans, and Military
Affairs Committee
State Capitol
200 East Colfax
Denver, CO 80203

Representative Su Ryden, Chair
House State, Veterans, and Military
Affairs Committee
State Capitol
200 East Colfax
Denver, CO 80203

December 14, 2016

Dear Senator Scott and Representative Ryden:

The Colorado Department of Human Services (Department) is pleased to provide the following update as required in HB 16-1397 3 weeks in advance of the statutory deadline.

The intent of this letter is to convey the recommendations for development on the Fitzsimons Campus provided by the Fitzsimons Development Advisory Group; and to outline the Department's final recommendation for development of the Fitzsimons site under the requirements of HB 16-1397.

HB 16-1397 stipulates that the Department "shall seek input, as appropriate, from the Board of Commissioners of Veterans Community Living Centers created pursuant to section 26-12-402, the state Board of Veterans Affairs, and a statewide coalition of veterans organizations." In response to this mandate, the Department convened an eight-member Advisory Group comprised of representatives from various veterans groups, as well as representatives of the Eastern Colorado Veterans Administration Health System, Aurora City Government, the Department of Local Affairs, and elected officials from Arapahoe County and the Colorado Legislature.

Subsequent to the formation of the Advisory Group, the Department contracted with three specialty consultants in order to help inform the Advisory Group's discussion and development of recommendations. The consultants that were engaged on this project are as follows:

- RNL Design -RNL is the Department of Personnel Administration, Office of the State Architect's planning consultant. RNL's architects and engineers evaluated the Fitzsimons land, building codes, drainage, and other factors to identify the facility types and sizes that could be accommodated on the property.
- Public Consulting Group (PCG) -PCG analyzed multiple veteran focused programing options based on geographic need, projected population growth and financial viability. PCG's analysis was utilized to assist in the selection of programs intended to provide a continuum of care on the Fitzsimons campus.

- SB Clark - SB Clark is a public finance consulting firm with experience in identifying financing options and solutions for public and non-profit entities. SB Clark presented public financing options for the construction of facilities intended to house multiple programs including affordable housing, human services, and healthcare providers. SB Clark analyzed potential sources and mechanisms available to finance the construction costs of developing new facilities on the Fitzsimons campus.

Utilizing the consultants' reports and their own expertise, the Advisory Group crafted twenty-one recommendations related to the development of the Fitzsimons site. The Advisory Group's primary recommendations to the Department are as follows:

1. Use a private developer to develop the southern portion of the Fitzsimons campus to provide Permanent Supportive Housing and low-income housing for homeless veterans and chronically ill veterans. This would include the Department entering into a long term lease with a developer for the southern portion of the site after selecting a highly qualified developer through a competitive Request for Proposal process.

   Implementaiton of this particular advisory group recommendation requires no General Fund contribution and shortens the standard timeline for State managed construction by up to 18 months.

2. Develop the northern portion of the Fitzsimons campus to provide for a continuum of services for veterans that include Green House/Eldercare Model skilled nursing and dementia care.

The full text of the Advisory Group report is included in Attachment A.

The Department intends to pursue the Advisory Group's recommendations. Furthermore, the Department, in cooperation with the Advisory Group, has established timelines for developing both portions of the site, in an expeditious manner, and in accordance with the attached report.

Upon submission of this report the Department intends to publish a Request for Proposal to solicit a permanent supportive housing developer for the Southern portion of the Fitzsimons campus. The Department will immediately set to work on engaging additional resources focused upon securing financing and selecting a continuum of veterans services for the development of the northern portion.

In addition to the Advisory Group Report, the Department's quarterly report for the period of October 1, 2016 through December 31, 2016 is included in Attachment B. Section 26-12-201.5(6), C.R.S., directs the Department to include progress updates on the Fitzsimons project in its annual report and to provide quarterly progress updates to the members of the State, Veterans, and Military Affairs Committees of the Colorado House of Representatives and the Senate, or any successor committees, on or before September 30, 2016; December 31, 2016; March 31, 2017; and June 30, 2017.

If you have any questions about either of these reports, please contact Tony Gherardini, Director of the Office of Administrative Solutions, at 303-866-5725, or by email at Tony.Gherardini@state.co.us.

The Department looks forward to dialogue with members of the relevant legislative committees to help ensure that subsequent development steps represent the best potential outcomes for the State's veterans.

Respectfully,

Reggie Bicha
Executive Director

CC: Senator Jerry Sonnenberg, Vice Chair
Senator Owen Hill
Senator Matt Jones
Senator Jessie Ulibarri

Representative Susan Lontine, Vice Chair
Representative Mike Foote
Representative Patrick Neville
Representative Cole Wist
Representative Steve Humphrey
Representative Dianne Primavera
Representative Timothy Leonard
Representative Max Tyler

Attachments:
Attachment A Fitzsimons State Veterans Community Living Center Site Advisory Group Report
Attachment B House Bill 16-1397 Fitzsimons Development Project Quarterly Progress report

COLORADO
Department of Human Services

House Bill 16-1397 Fitzsimons Development Project
Quarterly Progress Report
December 31, 2016

Progress Update:
Since the September 30, 2016 update, three separate teams of expert consultants completed their evaluations of how the site could be optimally used for veterans, how construction of the facilities might best be financed, and what services would best serve the expected populations of veterans in the coming years in a way that is both programmatically and fiscally sustainable. The Advisory Group that started meeting in September drew from these expert studies to develop their report that includes 21 recommendations on the development of both portions of the site, the services that should be offered, how to finance the development, and the steps that are necessary to pursue complete development. The Colorado Department of Human Services (Department) is implementing the procurement measures to proceed with development of both portions of the Fitzsimons site.

Outcomes of Expert Consultancies
As described in the September 30, 2016 quarterly report, three expert consultants were engaged and a project manager was brought under contract. The expert consultants provided final reports to the Department and the Advisory Group and the first phase of the project manager's scope has been completed.

Project Management: Singleton Strategies LLC coordinated the expert consultant teams, assisted with engagement with relevant local, state and federal agencies, and facilitated the Advisory Group. Singleton Strategies will continue in the role of project manager by assisting the Department in developing a Request for Proposal (RFP) for the southern portion and identifying the optimal mix of services to be offered on the northern portion, including the development of a financing strategy. The project manager is working with the Department to define the scope of a new phase of the Advisory Group.

Site Assessment: The Office of the State Architect assisted the Department in engaging RNL Design to conduct an assessment of the Fitzsimons site. The RNL Design team's evaluation included nearby infrastructure, relevant zoning practices, and other key considerations for development of the site. The site assessment found that there are no significant impediments to development of either portion of the site. The site assessment also confirmed physical capacity will not be a limiting factor for development.

Financing: The Department engaged SB Clark Associates to provide information on financing options for developing various types of services on the site. The SB Clark team completed their evaluation with options for the Department to seek private development of both portions of the site through the use of financing tools such as the Low Income Housing Tax Credit and the New Market Tax Credit. The report highlighted a number of different financing options, including the potential of the Department to use

enterprise funds to invest in the facilities, recovering the funding over a set period of time and to utilize its role as owner of the site to ensure the sustained quality of services.

Service Needs Assessment: The Public Consulting Group (PCG) built upon its previous consultancy with the Department to evaluate the fiscal and programmatic sustainability of various types of services and facilities to meet the needs of Colorado's current and future veteran population. PCG interviewed experts on practices in state veterans homes in peer states, analyzed demographic trends, and developed an evaluation methodology for determining how fee reimbursement and market demand indicate the optimal mix of services. The study found that a mixture of Green House Model skilled nursing and dementia care is a potentially financially and programmatically sustainable mix of services.

Completion of the Advisory Group Report

As is referenced earlier in this letter, the eight-member Advisory Group developed its consensus report and provided it to the Department for review and finalization in November. In addition to the recommendations based on the information that was provided from the expert consultancies, the Advisory Group included the factors that they consider to be important to ensure that the quality of care on the site is optimized for residents of the existing Veterans Community Living Center and the new facilities. The Advisory Group provided recommendations on the target populations for the facilities on the two portions of the site and suggested ways of optimizing the utility of the site overall.

Next Steps

The Department will work with the project manager and relevant agencies to develop the two portions of the Fitzsimons site. Immediate next steps are to:

- Release an RFP for the development of a Permanent Supportive Housing and low income housing facility on the southern portion. This RFP will be posted on the State's procurement system (BIDS) in December with a scheduled submittal of proposals in late January. Award of the RFP to the successful candidate would occur in mid-February.
- Re-engage with the finance consultant, SB Clark, to develop a financing strategy for the northern portion that may include Green House Model skilled nursing, dementia care and a long-term lease of a portion of the facility to the Veterans Administration.
- Develop a scope for a reconstituted advisory committee to help inform the subsequent development decisions.

More detailed timelines and steps to development are included in the body of the Advisory Group Report (Attached).

Fitzsimons State Veterans Community Living Center
Site Advisory Group Report

Submitted to:

Colorado Department of Human Services

On

November 30, 2016

Advisory Group Members:

Jason Batchelor	City of Aurora, Colorado
James C. Bobick	United Veterans Committee
Alison George	CO Department of Local Affairs – Housing Division
Sallie Houser-Hanfelder	Eastern Colorado VA System
Nancy Jackson	Arapahoe County Board of Commissioners
Marvin Meyers	United Veterans Committee
William "Robby" Robinson	CO Board of Veterans Affairs, VCLC Commission
Su Ryden	CO General Assembly

Executive summary of recommendations

The following is a synopsis of the recommendations in this report that were developed by the Fitzsimons State Veterans Community Living Center Site Advisory Group.

Recommendation 1: Southern Portion: We recommend that the southern portion of the site be developed as Permanent Supportive Housing through a competitive RFP that stipulates conditions on the development while also seeking to benefit from the experience and creativity of the successful applicant. The Department should exercise further oversight over the project by including requirements in a ground lease. Timing is important for the prospective developer to obtain the favorable tax credits that would make the project more viable. This project should move forward as quickly as possible; with the project developer selected through a competitive RFP in early 2017.

Recommendation 2: Northern Portion: We recommend that the northern portion should be developed as an integrated facility (or cohort of facilities) that provide a continuum of care for veterans seeking increased level of care as they age. While the means of developing the northern portion is not as clear as the southern portion, partnerships will be important and the site could also potentially benefit from private – RFP enabled development. Progress on developing the northern portion should be pursued as vigorously as the southern portion but further work is necessary to make sure that the conditions are right for moving forward. These steps include defining a partnership between CDHS and the Eastern Colorado VA Health Systems, determining whether a private company is best suited to develop the northern portion, and/or identifying the successful combination of financing for construction and services to be offered.

The two approaches for development of the northern and southern portions are put forward with the hope that the readers will consult the rest of the report in order to understand the context and details for how development should occur. We urge that the two approaches should not be taken out of context from the analysis and recommendations that follow.

Recommendation 3: Phasing development: The Advisory Group recommends developing the southern portion of the site first with Permanent Supportive Housing because of the potential that financing for the project can be obtained more quickly and the mix of services can be defined as part of the dialogue between the Department as owner/landlord of the site and the developer. The development of the northern portion should go on a parallel but independent track that seeks to define the right configuration and partnerships that can shape the services that are provided. For instance, if a partnership with the VA can be created in which it leases a portion of the new development for skilled nursing, this could help guide other services and could open up financing opportunities. Finally, phasing the two projects makes sense because construction of both at the same time could be overwhelming for the residents of the VCLC and could compromise the facility's ability to provide a high quality experience.

I. Introduction

The Fitzsimons State Veterans Community Living Center Site Advisory Group – a consensus-based, collaborative group – was convened to advise the Colorado Department of Human Services (CDHS or the Department) on how to implement HB 16-1397. The Bill, which was signed by Governor Hickenlooper in May 2016, instructs CDHS to "work expeditiously to develop the vacant parcels of land to the north and south of the Fitzsimons State Veterans Community Living Center."

The site, that is the focus of the Bill, is a 15-acre parcel at Peoria Street and Montview Boulevard in Aurora, Colorado. The site was given to CDHS by the Department of Defense with the stipulation, under a memorandum of agreement, that the site should be used for the exclusive benefit of veterans. The site can be considered in three parts. The central part contains the existing State Veterans Community Living Center (VCLC) – a skilled nursing facility – that was constructed in 2002. It is a highly regarded skilled nursing facility, which provides excellent care to some of Colorado's most distinguished veterans. The portions of the site to the north and south of the skilled nursing facility have not yet been developed.

This report was commissioned by the Colorado Department of Human Services (CDHS or the Department) to help inform the decision making of its Executive Director, Reggie Bicha, and the members of the Department's Executive Management Team. The Advisory Group writes this report with the knowledge that the secondary audience for the report may include individuals with diverse viewpoints.

This report provides the Advisory Group's consensus recommendations to CDHS. We acknowledge that the Department is the decision-maker in accordance with HB 16-1397 and the Memorandum of Agreement. The Advisory Group is comprised of eight members from relevant agencies, veterans groups, and local jurisdictions. Our group includes veterans, elected officials and experts in the delivery of services to the homeless and elderly. More information on the Advisory Group, its membership, scope and process is in Section VII of this report.

Vision

As part of the discussions of the Advisory Group, we determined that a vision statement would help others understand the context of the recommendations as well as the overarching perspective for how the site should be developed. The recommendations that are reviewed in this report are intended to support this vision. The recommended vision statement for the Fitzsimons site is:

> *The Fitzsimons State Veteran's Community Living Center site will be financially sustainable while providing needed services on a continuum of care, including assisted living, dementia care, skilled nursing care, permanent supportive housing, and housing and services for homeless veterans. The modular and expandable components will be built as expeditiously as possible and provide for a network of partnering organizations.*

In addition to the expertise, experiences and perspectives from the Advisory Group membership, three consultant teams informed the recommendations and conclusions of this report. The consultant teams evaluated:

- The site and its capacities, infrastructure and physical qualities (RNL Design);
- Financing strategies for construction of the range of potential facilities from Permanent Supportive Housing to the full continuum of care from assisted living to skilled nursing (SB Clark);
- The financial and programmatic viability of different service options based on other states' experiences and an assessment of the population of veterans in the five-county metro area (Public Consulting Group).

These reports go to a great level of detail and are attached as appendices to this document.

This report provides the recommendations of the Advisory Group, which were greatly informed by the aforementioned reports.

The Advisory Group members believe a combination of services will create an integrated community of veterans who live in a culture of honor and comfort together. Proactive and strategic oversight will be is necessary to carry the process through subsequent steps. The Advisory Group members support the Department in making this veterans' community a reality.

Organization of this report

This report is organized to provide the most important information first. Background about the process is at the end. Briefly, this report is divided into the following sections:

I. Introduction and definitions
II. Identified needs and populations that could benefit from the site
III. Site overview and its capacity
IV. Development of the southern portion with detailed recommendations
V. Development of the northern portion with detailed recommendations
VI. Steps for moving forward
VII. The Advisory Group and its process

Definitions
The following terms are pertinent to this report:

Assisted Living: Housing for elderly or disabled people that provides nursing care, housekeeping, and prepared meals as needed.

Green House Model: The Green House Model "creates 'caring homes for meaningful lives' for elders where residents have private rooms and baths, can move freely through the home, build deep knowing relationships with each other more and even participate in preparing their own meals. It is based on a philosophy seeking to reverse the "enforced dependency" of life in a traditional nursing home by creating small intentional communities of 7-10 elders designed to foster late-life development and growth. (Source: Wikipedia)

Chronically Ill: A person certified as lacking some physical or mental ability essential for living independently. (Black's Law Dictionary)

Dementia Care: Dementia is a general term for a decline in mental ability severe enough to interfere with daily life. For the purpose of this report, dementia care refers to facilities that are oriented toward caring for those with dementia including the ability for the facilities to be secured.

Domiciliary: For the purpose of this report, the terms domiciliary and assisted living are synonymous.

Homelessness: For the purpose of this report, a homeless individual is defined according to the McKinney Homeless Assistance Act (as amended) because this is the legislation that stipulates requirements for VASH vouchers. The Act can be accessed by following this link. There are numerous definitions under the act but the two top defining clauses are: "an individual who lacks a fixed, regular, and adequate nighttime residence;" and "an individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeting accommodation for human beings, including car, park, abandoned building, bus or train station, airport, or camping ground;"

VASH voucher: A Housing and Urban Development/ VA program that stands for Veterans Affairs Supportive Housing.

Veteran: Title 38 of the Code of Federal Regulations defines a veteran as "a person who served in the active military, naval, or air service and who was discharged or released under conditions other than dishonorable."

II. The identified needs and populations that could benefit

The Advisory Group heard a number of perspectives on the populations of individuals who could benefit from the site. The clearest articulated need, based on the input from consultants and agencies include:

- A substantial and growing homeless veteran population; many who are chronically ill;
- An aging population of veterans who require continual medical care;
- Substantial numbers of veterans with dementia or traumatic brain injury.

Because the Department has the same access that we do to the information that we are drawing from, instead of recounting the extensive information found in existing reports, we are providing what we believe are the relevant conclusions. This section briefly reviews our conclusions based on hearing from Kristin Toombs, Manager of Homelessness for the Department of Local Affairs, Jonathan Kerr of the Eastern Colorado VA Health System, and the Public Consulting Group.

Overall Veteran Population

Jonathan Kerr of the Eastern Colorado VA Health System reviewed the overall number of veterans who are enrolled in the VA health care system. The VA was asked to provide their population estimates for the part of the state that would most likely take advantage of services offered at the Fitzsimons site – those in the 21 counties found in the northeast Colorado. Over the last ten years, overall population of enrolled veterans in the northeast quadrant of our state has increased 65% from 74,000 to 122,000. The highest growth has been seen in those who are under 45, growing from 14,500 in 2006 to 34,000 today – 133% change. The cohorts of senior citizens over the age of 65 have increased by 80+%.

Looking forward, the VA projects that enrollment will increase by 13% in the next ten years with the highest demographic being those between 65 – 84 years old; a 32% increase. The overall population of veterans in the state is expected to decrease over the next ten years by 10% with the most significant decrease of those who are between the ages of 45 and 64; an 18% decrease.

Colorado is an attractive place for veterans to call home after their service. The current increase in population shows that many who are under 45 decide to stay in Colorado. This population has a greater likelihood of traumatic brain injury and post-traumatic stress syndrome; meaning that their immediate needs are complex and distinct from those who need typical geriatric skilled nursing and assisted living services.

Homeless Veterans

Kristin Toombs, of the Department of Local Affairs Program on Homelessness, cited data that shows that despite concerted efforts to house homeless veterans, the population continues to grow. The January 2016 census counted almost 1200 homeless veterans in Colorado, up from 950 in 2015. The number of homeless veterans in the Denver Metro Area increased from 494 in 2015 to 722 in 2016 despite 1000 veterans being put into housing since 2015. This explains the political and policy imperative to utilize a portion of the site for permanent supportive housing.

Through the discussions of the group, we have come to believe that the Fitzsimons site can serve specific segments of the homeless veterans population that would benefit from the location (near the VA hospital) and from the other services that can be accessed nearby. This population

includes individuals who suffer from chronic illness who may be older than the average homeless population. These individuals are medically vulnerable or fragile putting them in great danger if they continue to live on the streets. There could also be an opportunity to serve those who seek a sober living environment and those who need housing as they go through the 18-month programs associated with the veterans' treatment or problem solving courts.

Aging and medically infirm veterans

Many in our group know that there is a strong need for assisted-living services. This is part of the original intent of the Memorandum of Agreement and is also an important driver for HB 16-1397. Aging and capable but infirm veterans should be able to live in a comfortable environment with the assurance that they can access more acute care when they need it.

The information provided by Christian Jones and Peter Haney of the Public Consulting Group was surprising. Their projections, based on VA data, indicate that demand for assisted living (or domiciliary care) in the five-county area surrounding Denver is going to be relatively low – going from 176 in 2021 to 168 in 2036. This is surprising to us but it may indicate that our veteran population is either choosing or unable to transition to assisted living before they need skilled nursing. They are staying at home until they absolutely have to leave. It is possible that those who have low income could benefit from living arrangements on the site that could provide them with some services and enable them to transition to more acute care when they need it.

There appears to be strong need for more skilled nursing and an especially high need for dementia care. PCG predicts that demand for skilled nursing will remain constant over the next twenty years at around 650 and that demand for dementia care will remain above 2200 for the same period, despite decreases in overall veteran population. The demand for dementia care also aligns with the significant number of traumatic brain injury cases and seems to apply across a broader range of age groups than some of the other types of service needs.

Services for female veterans

The gender composition of our veteran population is changing. More women require care and will be a growing part of the service population in the future. Women will require the same types of care as well as unique types of care. Facilities will need to evolve to accommodate both genders. Women already represent nearly 20% of active duty in the Air Force and Navy, and 15% of all military branches. Women are exposed to the dangers of battle including traumatic brain injuries. The Advisory Group discussed the value of examining what women will need and specifically accommodating those needs in both portions of the site.

Women who are homeless are more likely to have children than male veterans. A new development at 1702 Paris Street – across the street from the Fitzsimons site – is going to include a substantial number of two and three bedroom units. Through proper coordination with Brothers Redevelopment and the services that are provided at the development – the PSH that would be built on the Fitzsimons site and 1702 Paris Street could complement each other by providing a useful mix of housing options for women.

Short-term skilled nursing and the potential replacement of the VA's CLC
The VA is going to be closing their short-term skilled nursing facility – the Community Living Center – when it moves from Clermont Street to the new hospital at the Anschutz campus. The current 32-bed VA facility provides rehabilitation, respite, GEM Geriatric Evaluation and MGMT, skilled nursing, and hospice care for veterans who are in the VA system and medically and psychiatrically stable. The budget for the construction of a facility for skilled nursing beds at the new VA Medical Center was cut as part of cost saving measures. ECOVA is now looking for a short-term and long-term replacement for this facility near Fitzsimons so that it can provide step-down care to patients, using their existing staff, who no longer need to be in the hospital.

What we don't know
We do not know what the exact combination of assisted living and skilled nursing services should be, given the information that we have seen on the relatively low demand for assisted living coupled with the wide array of other assisted living service providers that are in Denver. If the Department determines that assisted living should be included among the services offered on the Fitzsimons site, it would be useful to do a more in-depth market analysis and consider how assisted living capacity could be included using payment methods other than VA reimbursement. This may include a low-income housing strategy as well as private pay from individuals and couples who would like to take advantage of assisted living.

III. Site overview and its capacity

The Advisory Group's first discussion and engagement with expert consultants was on the Fitzsimons site, its physical qualities and its potential capacity to contain the buildings that could serve veterans. At that first meeting, the Group walked around the site as a group and discussed the surroundings that should be considered in developing the two portions of the site.

Through the Office of the State Architect, the Department engaged RNL Design to analyze the infrastructure and capacity of the site. This analysis was shared with the Advisory Group as a draft at the first meeting. Alex Thome and Jordon Block of RNL Design provided the highlights of their report that led the Group to the following conclusions.

Both the northern and southern portions of the site can be fully developed. A portion of the northern portion is currently being used for stormwater catchment for the developed portions of the site. Initial concerns about where further stormwater would go raised questions about the appropriateness of developing the northern portion. Aurora has confirmed that it plans to convey stormwater to a central collection pond offsite – opening up both portions for full development.

Site capacity is unlikely to be a limiting factor. The RNL analysis used nearby zoning regulations and accepted practices to determine the potential capacity of the two portions. The potential size of the buildings that can be accommodated appear to far outstrip the desirability of providing services on a site that enhances the lives of the existing VCLC residents and those who will occupy the new developments.

Recommendation 4: Consider the site as a whole to determine what integrated approaches could maximize green space on the site. For instance, a central entrance on Peoria might maximize the quality of the space for all three portions.

Recommendation 5: Consider consolidating parking among the three facilities to maximize green space. Alternatively, parking could be put on the ground level of new buildings.

The northern portion could take longer and cost slightly more to develop than the southern portion. The southern portion is ready for immediate development. The parcel is level and existing infrastructure for sewer, water and other utilities will require minimal modification. This is one reason the development that would be on a quicker timeline should be put on the southern portion. Preparing the northern portion for development require more time and investment. Stormwater will need to be rerouted to the new off-site collection pond, the site will need to be regraded to provide a level building site, utility trunk lines will need to be connected to the external infrastructure.

Recommendation 6: Begin immediate discussions with Aurora on diverting stormwater to avoid delayed development of the northern portion and engage in ongoing coordination so that any infrastructure needs can be identified well in advance of construction. It may be advantageous to obtain "will serve" commitments from Aurora early in the process so that LIHTC application requirements can be met.

IV. Southern Portion

Permanent Supportive Housing for a targeted population

The Advisory Group recommends that the southern portion of the site be developed to serve primarily as permanent supportive housing for eligible homeless veterans. The Advisory Group also urges that the Department consider impacts on the current residents in the state VCLC and the future composition of the overall site. Other potential residents could be individuals who need some assisted living services and individuals who participate in veterans' treatment courts. The facility should be developed by an outside entity through a competitive bidding process administered by the Department. There are similar developments ranging from 24 – 55 units, but the winning proposal should stipulate the most sustainable number of exclusively VASH funded units. As a group we discussed the potential of phasing in the project – starting with a smaller number of units than would be ultimately planned. In the end this is part of the Department's decision-making on how best to oversee the site's development. There may be some number that will make the development financially viable while also observing the need to limit number of units on the site.

The Department should seek a plan from the developer that includes supportive services on the street level. A partnership with the VA may be an excellent way of providing the services on the ground floor since the VA has supportive programs for homeless veterans. The Advisory Group members discussed other developments that include medical and dental clinics and, if warranted given the location, this could be a good approach for the Fitzsimons development because of the

orientation of the building toward medical needs. Thinking about the types of services for the ground floor that could promote constructive engagement from the VCLC residents and those who use services on the northern site could also be important.

Define the PSH to include populations that are compatible with the existing skilled nursing facility. Concern over maintaining the high quality of care of the existing VCLC prompted a discussion about how to find tenants that will align with the mission of the VCLC and the development of the northern portion of the site.

> **Recommendation 7 (south):** Include homeless veterans who are chronically ill as a principal focus of the PSH facility.
>
> **Recommendation 8 (south):** A floor (or other separated portion) of the site should be committed to those who agree to be part of a sober program as has been implemented at other facilities in the Denver area.
>
> **Recommendation 9 (south):** Coordinate with the courts in Adams and Arapahoe Counties to make units available for veterans who are undergoing "veterans' treatment court" programs. Treatment courts are a way of helping stabilize veterans who are non-violent but have been charged with a crime. It is a proven way of stabilizing and restoring veterans to being more contributing members of society. These veterans often find it difficult to find housing while they are going through the 18-month treatment program.
>
> **Recommendation 10 (south):** If possible, some of the units of the southern portion could also be used for low-income veterans who might need some assistance in daily living. This could be a good option for including assisted living if it is not possible for the northern portion.
>
> **Recommendation 11 (south):** Design facilities that can be flexible for future needs. The composition of residents of the southern portion may need to change over time as the demographic trends of the area change. Facilities should be designed to be adaptable to these changes.
>
> **Recommendation 12 (south):** In addition to defining the population of residents that would reside at the Fitzsimons site southern portion, the Department should use design, security measures and staff structuring to create a secure environment for the residents in PSH as well as others.

Financing & partnerships

The Advisory Group recommends that the PSH be developed through a private contractor chosen through a competitive process. A Request for Proposals (RFP) should include broad parameters such as: serving homeless or formerly homeless veterans at less than 50% of MFI; provide a numerical range of mostly 1 bedroom units; allow for future expansion/phasing of the site; etc. The RFP should also provide enough flexibility for respondents to bring their ideas and creativity to the development process.

We recommend that the Department provide a long-term (at least 25 years), low/no cost ground lease to the successful respondent. The successful respondent would be responsible for financing the capital construction costs of the project. The respondents should be encouraged to seek a 9% Low Income Housing Tax Credit, as well as additional means to underwrite the capital financing needs, potentially including gap financing from state and local agencies. The successful respondent would also operate or partner with others to operate the housing and provide supportive services to the veteran residents. The Department may also choose to stipulate that the successful respondent will not seek direct State General Funds for either construction or operations.

The SB Clark team emphasized the importance of obtaining a Low Income Housing Tax Credit that could finance two thirds of the construction costs. Obtaining VASH vouchers is also highly competitive but could be the most important assurance that PSH is financially viable over the long-term. We also support the idea of having some units that would be Section 8 – low-income housing – for chronically ill veterans who need a supportive environment, even if they aren't homeless.

> **Recommendation 13 (south):** Release an RFP as soon as possible and send it to a list of leading providers. The RFP should stipulate a 2017 application for the LIHTC. Even though the report to the General Assembly from the Department is due at the end of December, it will be important to get started on selecting a developer as soon as possible because of the extensive preparation that must go into an LIHTC application. The RFP should include a notice that some of the details may change with input from the Legislature in January. The Advisory Group hopes that selection of the service provider could be accomplished early in 2017.

Maintaining oversight over the facility

There are a number of ways in which the Department can actively steer the design, construction and operation of the southern portion. Three approaches are particularly important. These are:

- Develop a specific RFP that clearly sets expectations for the target population and aspects of the development that can assure long-term quality.
- Consider being an investor in the project so that the Department can have an ongoing stake and say in how the PSH programs are administered.
- Exercise authority through a lease that includes the specific provisions that might entail a violation of the lease or that would allow for the development to be reverted back to the Department if it failed financially.

Steps to development and timeline

The Advisory Group sees no barrier to moving forward with a quick development of the southern portion of the Fitzsimons site – especially if the developer is able to apply for the 9% LIHTC in June. The following steps enable that to occur:

December:	Release a general RFP to a list of eligible profit and non-profit providers and host a briefing session to orient potential respondents to the project and the elements of a successful proposal. Clarify that the RFP will be updated and refined based on possible feedback from the December submittal of the plan to the Legislature.
December:	Include the general RFP in the report to the legislature.
2017	
January:	Revise the RFP with more specific refinements. Deadline for submittal of proposals in late January.
February:	Before the end of the second week, award the RFP to the successful bidder.
March – April:	Negotiation of contract with developer. Draft lease with clear stipulations that allow the Department to have control over key quality aspects on the site.
March – December:	Design process and partnerships for supportive services ensure a successful development.
June:	Developer submits proposal for the LIHTC.
August:	Execute southern portion site lease.
2018	
January	Ceremonial groundbreaking
December	PSH facility opens

V. Northern Portion

The intent of the HB 16-1397 is to provide a "continuum of care" for veterans. Discussions in the Advisory Group repeatedly touched on the importance of providing a diversity of services for individuals or couples who enter with the ability to live somewhat independently and then transition to more acute levels of care. If combined with some low-income housing provided on the southern site, this continuity of care can provide comfort for those who are otherwise uncertain about their futures by providing a path through the stages of aging – from Greenhouse/elder care and assisted living, to day services for those who cannot be left unsupervised at home, to recovery from hospital stays. With the combination of the VCLC, the northern portion could also provide skilled nursing and potential additional capacity for dementia care.

Based on what the Advisory Group heard from PCG as well as the data that was provided by VA personnel, we believe that the optimal configuration of the northern portion will include Green House Model skilled nursing, dementia care, as well as significant dedicated space for a long-term lease that the VA would take to replace its CLC facility.

We anticipate that the process to develop the northern portion will be more complex than the PSH on the southern portion. It will need to move forward on its own timeline that is dependent on a few factors:

- Determining the optimal mix of services through further programmatic investigation;
- If the Department determines that it should use a private developer, the release of an RFP. If the Department determines that it should be the developer, following the process of

Operational Program Planning, Facilities Program Planning, request for necessary general funds and/or authorization by the Capital Development Committee to spend funds out of the VCLC Enterprise Fund;

- The establishment of a partnership between the Department and the Eastern Colorado Veterans Administration Health System for the VA to establish a long-term lease for its CLC facility;
- Creating a viable "financing stack" that combines (most likely) New Market Tax Credits, investment from the Department, financing that leverages the long-term VA lease and other elements.

The SB Clark team emphasized that having an integrated plan developed before financing is sought can help "tell a compelling story" and open up new opportunities for delivering a very high quality development. The "continuum of care" facilities on the northern part of the site should be on a timeline that allows developing the right set of services as well as modularity for changes that will come in the future.

Recommendation 14 (north): Utilize the Green House / Eldercare model as the basis for planning and developing the skilled nursing and dementia care facilities and operating model. There are two examples of Green House model being developed in Colorado and the interviews conducted by PCG show that the approach can be successful for veterans' homes.

Recommendation 15 (north): Provide dementia care. The Fitzsimons VCLC has some dementia care capacity but more is needed as demonstrated by the PCG population analysis.

Recommendation 16 (north): Explore an agreement with the VA in which it would lease a portion of the new building to the VA in a long-term lease for its CLC.

Recommendation 17 (north): As part of the budgeting for the new facility, resources should be included in advance for personnel to staff the facility early in the design and construction. Hiring senior staff to help guide design and construction will help assure high-quality care once the facility opens. These individuals can provide the daily capacity that deepens the partnerships with other institutions and develops the operational plans that will get the facility up and running quickly once construction is complete.

Best practices example

It is likely that development of this mixture of services on the northern site will require a multi-story building. While the usual concept of the Green House Model is to have housing units clustered in "neighborhoods", there are examples of successful developments that stack the residential units in a multi-story building. The Leonard Florence Center for Living is a Green House Model nursing care facility in Chelsea, MA that could serve as an example of such an approach. Click this link to see a video of the Chelsea project.

Financing & partnerships

There are two general options for the Department to consider in financing a multi-use facility that provides a spectrum of care for veterans. The main difference between each option is who

will finance the construction and own the facility.

Option 1 - Enterprise Model: Under this option, the Department would finance the building of the facility (either through Certificates of Participation or through Revenue Bonds). The Department would also then own the facility and the land. The Department would service the debt for the facility through tenant leases; leasing space to different partners to provide a variety of targeted services (dementia care, assisted living, etc.). One tenant could be the VA, providing space for a Community Living Center. The advantages of this financing arrangement are that the Department would have a greater control over what is constructed and how the space is programmed. The risks associated with this financing arrangement are that the Department would be responsible for the debt; therefore if lease payments were not sufficient to cover the debt service, other sources of funds would be needed to make up shortfalls. Additionally, the Department would need to arrange for the construction on the site (either through normal state construction processes, or potentially through a fee developer), with the risks and capacity requirements that that entails.

Option 2 – P3 Model: Similar to the process for the south portion, the Department could issue an RFP for a developer or other entity to construct and operate the facility. It is possible that the same developer that successfully competes for the south portion RFP could also develop the northern portion. Under this option, the Department would issue a long-term lease to the successful respondent and the Department would not own the facility. In this financing alternative, the Department may have less of control over exactly how the facility is programmed and constructed. Because the developer would need to ensure that operating revenues are sufficient to debt service, operations costs, and profit (and necessary profit margins would be greater given the need to provide a return on cost of capital as well as operating profits), the developer may be less willing to provide services with lower profit margins. An advantage of this option is that this financing model does minimize risk to the Department associated with capital construction as well as covering debt service payments.

> **Recommendation 18 (north):** Combining the right mix of financing for this facility will be complex. We recommend hiring an expert consultant who can help the Department develop a successful financing "stack."

> **Recommendation 19 (north):** The lease with the VA should be seen as an opportunity to forge a deeper relationship in which the VA utilizes the VCLC for long-term skilled nursing more, the care given at the new and old facilities are coordinated and the VA provides mobility services to the hospital.

Steps to development and timeline

While we believe that identifying the right mix of services may entail some more planning and while development of the northern sight may be slightly more complicated, we hope that the Department will move forward with developing the northern portion as aggressively as possible while still ending with a quality facility that provides sustainable services. We do not want to have development of the northern site languish and would hope that the Department can finalize architectural and engineering plans by January 2018.

December	CDHS informs the Capital Development Committee on its process plan for and construct the northern portion as a combination of skilled nursing and dementia care.
2017	
January	Hire a financing specialist to help develop the financing stack for the facility. Also, engage Green House Model experts for some facility program that could inform whether the Department should develop the facility itself or engage a private entity (through an RFP) to build and operate the facility.
February – May	CDHS and ECOVA define the parameters of a potential partnership agreement in which the VA would have a long-term lease in the facility for its CLC.
June	Release RFP for development of the northern portion or seek authority from the Capital Development Committee to commence with building the facility.
2018	
January	Sign off on architectural and engineering plans

VI. Steps for moving forward

There are some actions that would help raise the profile of the Fitzsimons site and ensure that development and operations of the facilities continue to have the support of veterans and other stakeholders. The Advisory Group has the following recommendations:

Recommendation 20: We suggest that the Department ask for the Governor's 2017 State of the State speech to highlight the need for housing and supportive services for homeless veterans. This project could be an example of cross-jurisdictional cooperation to help homeless veterans.

Recommendation 21: Create an oversight body that will help guide steps in development and implementation. An oversight advisory group could be helpful to the Department in bringing expertise to the steps of development for both portions of the site and to keep communications open with the various constituencies who are monitoring the development. The Department may choose to identify the phases of the project that might require an advisory board to have different areas of expertise.

VII. The Fitzsimons Veterans Site Advisory Group process

The Colorado Department of Human Services convened the Advisory Group to inform its decision-making on the development of the north and south portions of the parcel. The Advisory Group was asked to make recommendations on aspects of the projects' development that are programmatically appropriate, financially feasible and politically viable to provide a continuum of quality care for veterans. The Advisory group met five times from September - November 2016.

Membership – Consensus Members
There are eight named consensus members of the Advisory group. These individuals are:

Name	Affiliation
Jason Batchelor	City of Aurora Colorado
James C. Bobick	United Veterans Committee
Alison George	CO Department of Local Affairs – Housing Division
Sallie Houser-Hanfelder	Eastern CO VA System
Nancy Jackson	Arapahoe County Board of Commissioners
Marvin Meyers	United Veterans Committee,
William "Robby" Robinson	CO Board of Veterans Affairs, VCLC Commission
Su Ryden	CO General Assembly

In addition to the consensus members, the Department named Aaron Termain, Director of the Division of Veterans Community Living Centers to participate as a resource and touch stone for the Advisory Group. Mr. Termain did not participate in the consensus decisions of the Advisory Group. Sarah Wager, Deputy Director of the Office of Administrative Services was a resource for the Advisory Group.

William Singleton of Singleton Strategies, a consultant to the Colorado Department of Human Services, facilitated the Advisory Group and collaborated with the Advisory Group members to draft this report.

Recommended Appendices

1. *HB 16-1397*
2. *1998 Memorandum of Agreement*
3. *RNL Report*
4. *SB Clark Report*
5. *PCG Report*
6. *Advisory Group Scope*
7. *Finalized Summaries of the Five Meetings*

Joint Budget Committee Hearing: Office of Community Living

January 5, 2017

Susan E. Birch, MBA, BSN, RN, Executive Director

Our Mission

Improving health care access and outcomes for the **people** we serve while demonstrating sound stewardship of financial **resources**

Medicaid Waivers

- Certain federal rules for the Medicaid State Plan can be waived.

Brain Injury Waiver	Children with Autism Waiver	Children with Life Limiting Illness Waiver	Children's Habilitation Residential Program Waiver
Children's Home and Community-Based Services Waiver	Community Mental Health Support Waiver	Elderly, Blind, and Disabled Waiver	Spinal Cord Injury Waiver
Children's Extensive Support Waiver	Persons with Developmental Disabilities Waiver	Supported Living Services Waiver	

History

2012

Gov. Hickenlooper issued Executive Order establishing Office of Community Living (OCL) and Community Living Advisory Group (CLAG)

2013

- **HB 13-1314**: Transfer administration of services for persons with I/DD from DHS to HCPF to create OCL
- **SB 13-230**: Eliminated waiting list for Home and Community Based Services Children's Extensive Supports (HCBS-CES) waiver

2014

- CLAG submitted final recommendations to redesign LTSS system
- **HB 14-1252** and **HB 14-1051**: Eliminated the HCBS-Supported Living Services waiver waiting list and asked for a plan to eliminate HCBS-Persons with Developmental Disabilities waiver waiting list
- **HB 14-1338**: Created Regional Center Task Force (RCTF)

2015

- RCTF submitted final recommendations
- **HB 15-1318**: Developed plan for CFCM and created single waiver for adults with I/DD
- **HB 15-1368**: Cross-system crisis response and stabilization services pilot created for individuals with co-occurring I/DD and behavioral health conditions

2016

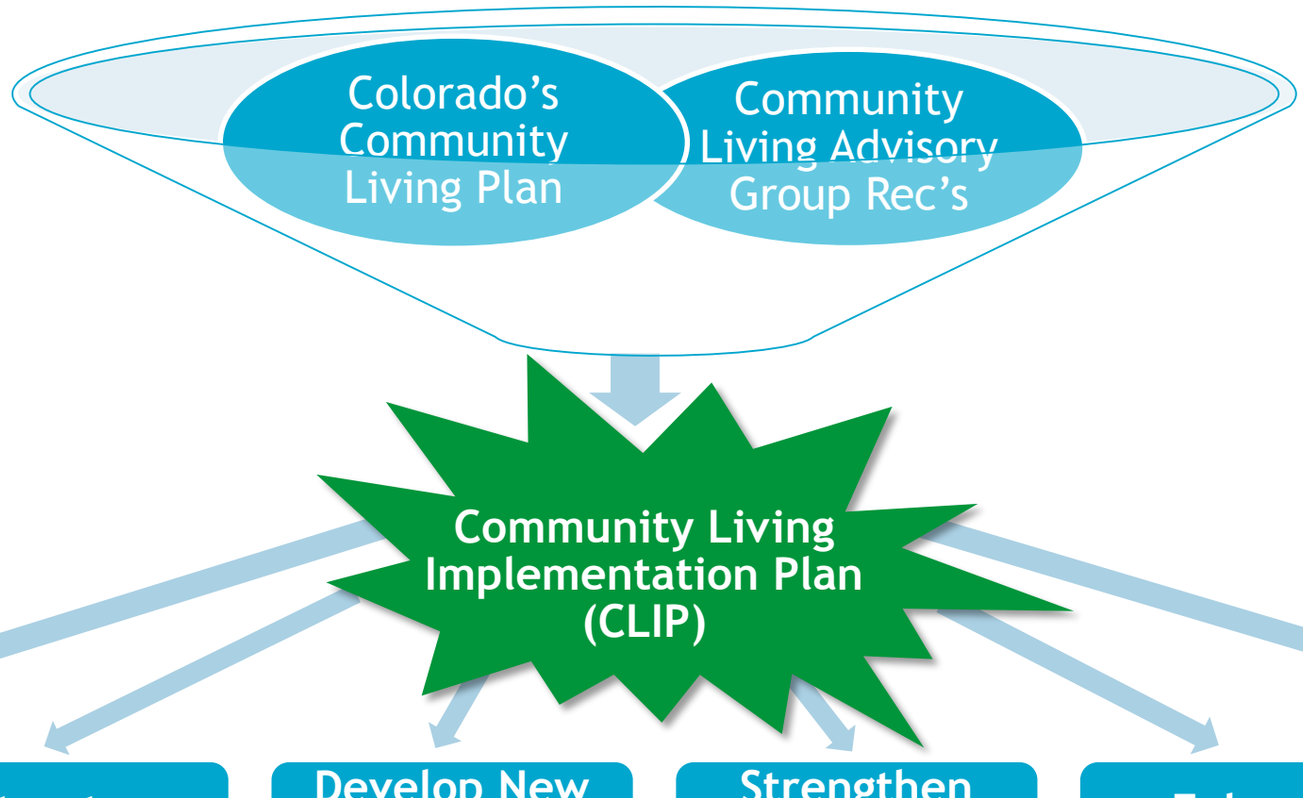
Developed Community Living Implementation Plan to encompass all work related to enhancing person-centeredness and community living

Looking Back: Colorado has a strong history of providing services for people in the community

Moving Forward: Implementing CLIP to redesign LTSS system to be more person-centered

Office of Community Living Highlights

Community Living Implementation Plan

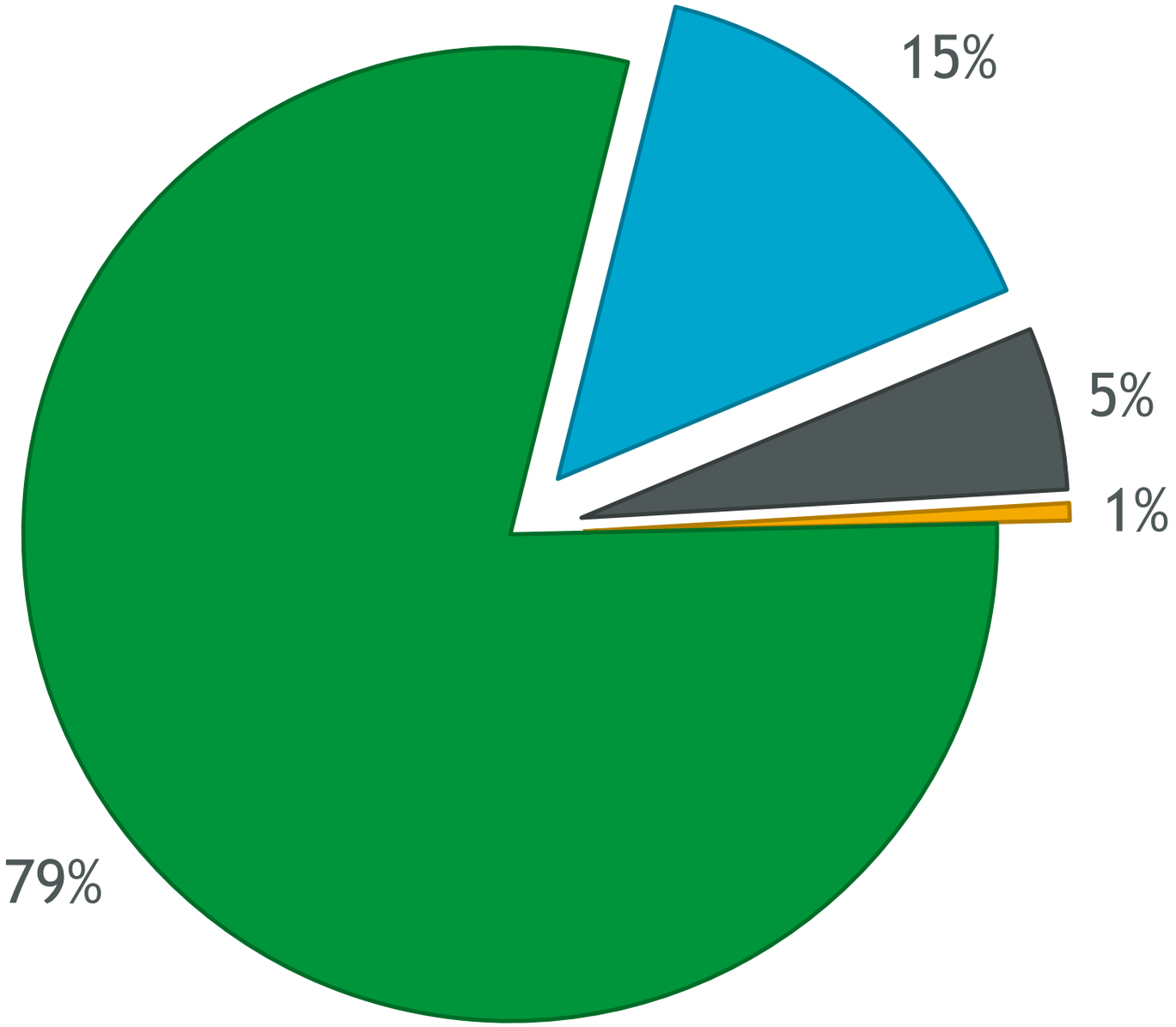


Community Living Implementation Plan (CLIP)

Streamline Access to LTSS	**Restructure Case Management**	**Develop New Assessment Tool and Support Plan**	**Strengthen Choice for Self-Directed Services**	**Enhance Community Supports**	**Redesign HCBS Benefits**
e.g. No Wrong Door	e.g. Conflict-Free Case Management	e.g. New functional assessment tool	e.g. Consumer directed services expansion	e.g. Colorado Choice Transitions	e.g. Community First Choice

Monitoring and Evaluation | Quality Improvement
Workforce Training and Development | Statutes and Regulation Changes

Office of Community Living Services Expenditures



FY 2016-17 Projected Long Term Care Services Expenditure as a Proportion of Total Services ($8.5 billion)

Individuals with Intellectual and Development Disabilities Waivers

Children's Extensive Support Waiver

- Current Enrollment: 1,587
- Average Cost Per Enrollment: $17,562

Adult Supported Living Services Waiver

- Current Enrollment: 4,608
- Average Cost Per Enrollment: $13,675

Adult Persons with Developmental Disabilities Waiver

- Current Enrollment: 5,058
- Average Cost Per Enrollment: $68,340

Source: Community Contract Management System, September 30, 2016

Intellectual and Developmental Disability Waivers General Questions 1-7

Intellectual and Developmental Disability Waivers Waiting List Questions 8-9

Individuals with Intellectual and Development Disabilities Waivers

Children's Extensive Support Waiver

Current Wait List: 0

Adult Supported Living Services Waiver

Current Wait List: 0

Adult Persons with Developmental Disabilities Waiver

Current Wait List: 2,684

88% on the wait list are getting services such as physician care, dental services, medical transportation & prescription drug coverage

72% on wait list are getting services from other waivers

Source: Community Contract Management System, September 30, 2016

Intellectual and Developmental Disability Waivers Caseload and Provider Availability Questions 10-11

Conflict-Free Case Management Questions 12-16

History of Colorado Conflict-Free Case Management (CFCM)

Community Engagement

2007
University of Southern Maine study, gathered stakeholder input

2010
Conflict of Interest (COI) Task Force based on the Office of the State Auditor audit findings

2014
COI Task Group initiated by the Department

2015-16
6 meetings with CCBs
15 Town Hall Meetings
4 Regional Forums
1 statewide webinar

State

2007
University of Southern Maine Report

2009
Office of State Auditor's Audit

2010
Convened COI Task Force

2014
Convened CFCM Task Group

2015-2016
HB 15-1318 passed, contracted with Navigant to develop a CFCM implementation plan

Federal

Pre-2007
CMS inquired about potential COI and expressed concern

2009
CMS initiated rule-making process, which included person-centered planning rules

2014
CMS released final rule, which added separation of case management from service provision

Colorado Conflict-Free Case Management (CFCM) Implementation Plan

Phase 1: Planning
1-2 years

- Conduct specific analyses to inform key decisions identified in this report
- Assess which statutes, regulations, waiver amendments and other policies must change in order to implement the proposed plan
- Initiate collaborations with stakeholders to move forward with implementation
- CCBs will decide which of the four options they will take to transition to CFCM and develop business continuity plans

Phase 2: Design
1-2 years

- Develop and submit revisions to existing statutes, regulations, waiver amendments and other policies governing case management
- Set specific requirements for compliance with CFCM based on revisions to statutes, the Medicaid State Plan and waivers
- CCBs will begin implementing components of their business continuity plans, including any applicable divestment

Phase 3: Implementation
1 year

- Regulatory and policy changes
- Provider development and outreach
- Communication priorities
- Quality and evaluation

Source: Colorado Conflict-Free Case Management for Home and Community Based Services Implementation Plan (HB 15-1318), Navigant Consulting, July 1, 2016.

Joint Questions with Human Services and Health Care Policy & Financing

Regional Centers and R10

Questions 17-19

Thank You

COLORADO
Department of Human Services

FY 2017-18 Joint Budget Committee Hearing

Department of Human Services: Office of Operations, & Services for People with Disabilities

January 5, 2017

Mission, Vision, and Values

Mission

Collaborating with our partners, our mission is to design and deliver high quality human services and health care that improve the safety, independence, and well-being of the people of Colorado.

Vision

The people of Colorado are safe, healthy and are prepared to achieve their greatest aspirations.

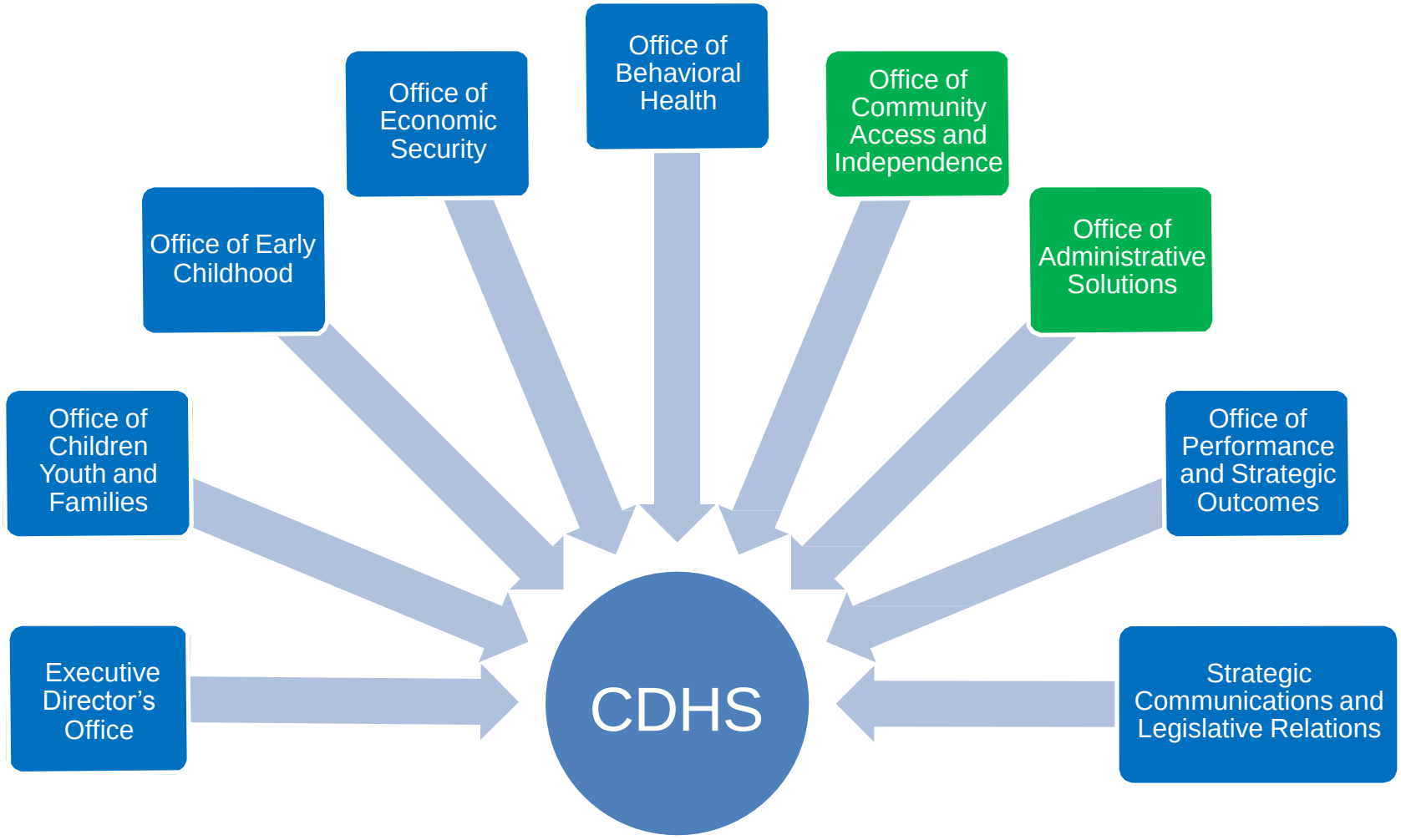
Values

The Colorado Department of Human Services will:

- Make decisions with and act in the best interests of the people we serve because Colorado's success depends on their well-being.
- Share information, seek input, and explain our actions because we value accountability and transparency.
- Manage our resources efficiently because we value responsible stewardship.
- Promote a positive work environment, and support and develop employees, because their performance is essential to Colorado's success.
- Meaningfully engage our partners and the people we serve because we must work together to achieve the best outcomes.
- Commit to continuous learning because Coloradans deserve effective solutions today and forward-looking innovation for tomorrow.

At the Colorado Department of Human Services, we are People Who Help People:

- Thrive in the community of their choice
- Achieve economic security through meaningful work
- Prepare for educational success throughout their lives



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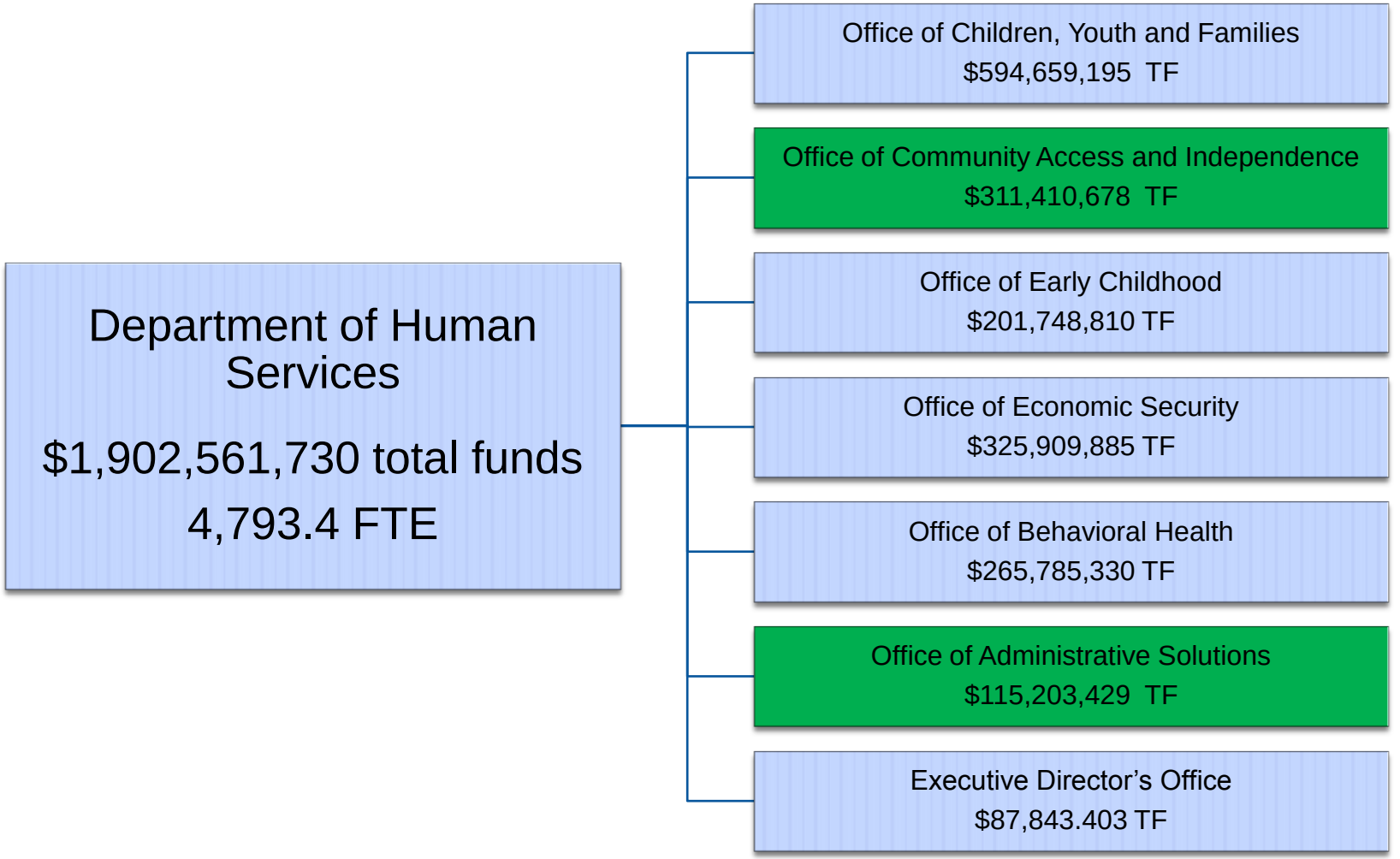
FY 2016-17 Department Appropriation



Colorado Department of Human Services FY 2017-18 Budget Requests

Office of Community Access and Independence

- State Adult Protective Services Quality Assurance Staff: $430,000 and 4.6 FTE
- State Unit on Aging, Aging & Disability Resources for Colorado Claiming $0.5 million
- **Regional Center Electronic Health Record System: $3.0 million**
- **Regional Center Depreciation Fund Capital Improvements: $1.0 million**
- **Fitzsimons Development Project: $15.0 million**
- **New Homes to Relocate Grand Junction Regional Center Intermediate Care Facility: $12.0 million**

Administrative Solutions

- **Department Indirect Costs: $3.1 million and 6.9 FTE**
- **Department of Corrections/Department of Human Services Interagency Agreement True-up: $1.2 million and 1.0 FTE**
- **Mount View Youth Services Center Ditch Repair: $473,000**
- Staff Training Long Bill Adjustment: ($14,000)
- Interoperability Phase 3 of 5: $10.6 million
- Department-Wide (Facility) Master Plan: $1.1 million

Office of Community Access and Independence

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Department of Human Services

Office of Community Access and Independence FY 2017-18 Budget Requests

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Office of Community Access and Independence

Division of Regional Center Operations

Regional Centers

Grand Junction

HCBS Beds: 80

HCBS Census: 53
HBCS Group Homes: 10

(1 offline)

ICF Beds:46

ICF Census: 23

ICF Campus: 4 Dorms

Services: Residential and Day Habilitation

Pueblo

HBCS Beds: 88

HCBS Census - HCBS: 52
HBCS Group Homes: 11

(3 offline)

Services: Residential and Day Habilitation

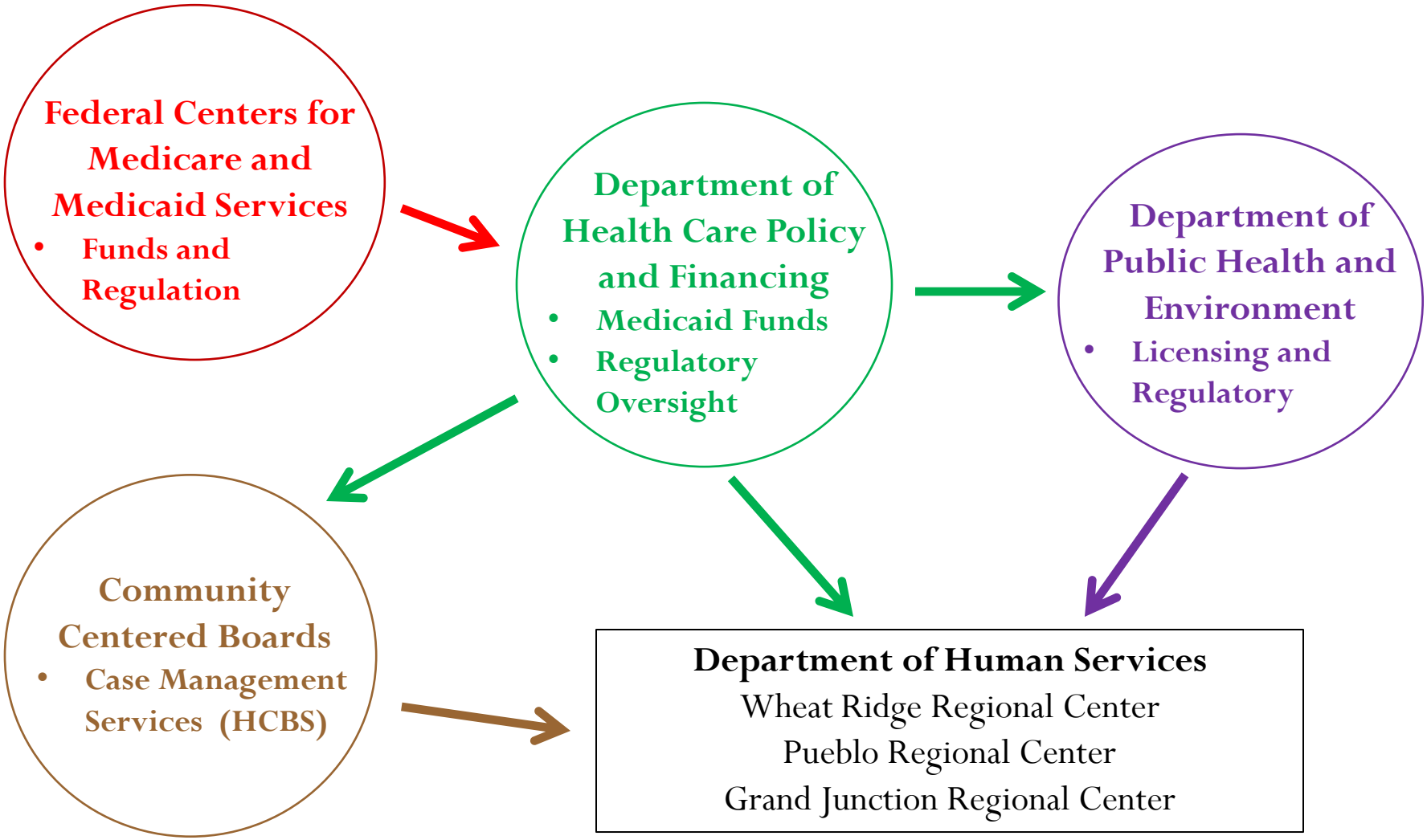
Wheat Ridge

ICF Beds: 142

ICF Census: 129
ICF Group Homes: 19
(1 offline)

Services: Residential and Day Habilitation

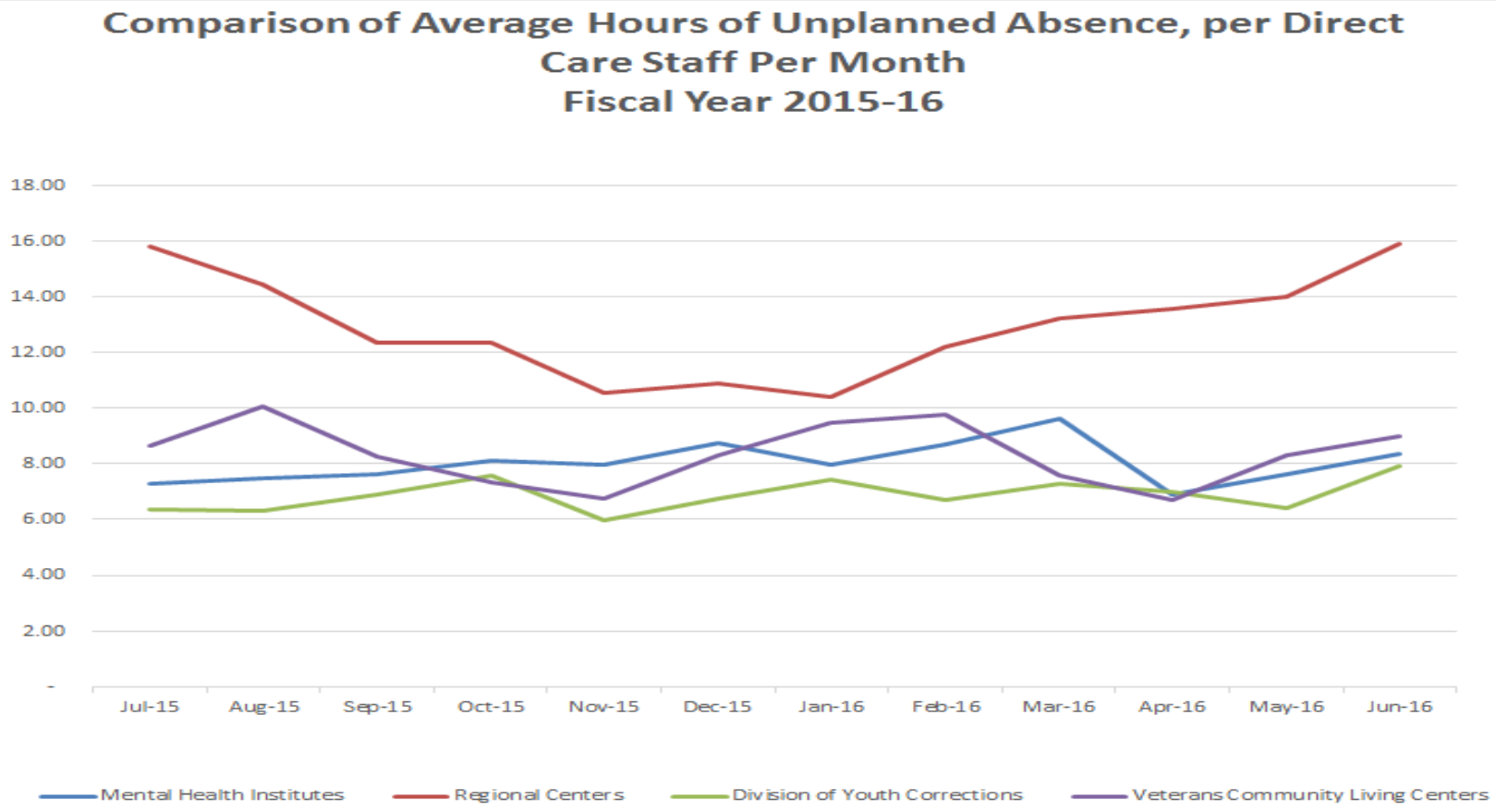
Regional Center Oversight



Historical Turnover Rates

Regional Center Staff Turnover Percentage by Campus FY 2013-14 - FY 2015-16			
Regional Center	**FY 2013-14**	**FY 2014-15**	**FY 2015-16**
Grand Junction	19%	20%	19%
Pueblo	18%	20%	53%
Wheat Ridge	23%	35%	36%
Source: Colorado Personnel and Payroll System			

24/7 Facilities and Unplanned Absences



Source: KRONOS timekeeping data for FY 2015-16.
[1] Unplanned absences is defined as administrative leave, bereavement, jury leave, sick leave, unpaid leave, and worker's comp leave.

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Addressing Staffing Needs of the Regional Centers

- Open competitive recruitment for direct care positions
- Increased recruitment efforts
- Implementing hiring and new employee orientation on a weekly and/or bi-weekly basis
- Implementing referral, signing and retention bonuses
- Implementing new job classifications to provide for career advancement
- Hiring a staff consultant to improve staff scheduling
- Exploring options for tuition reimbursement, continuing education credits
- Developing goal to increase percentage of staffing coverage with regular work hours to reduce need for overtime or extended shifts

Pay Adjustments at the Regional Centers

Consultation with DPA Personnel

- Review of FY 2017-18 Annual Compensation Report
- State Personnel Director's Administrative Procedure 3-9
- "The appointing authority shall determine the hiring salary within the pay grade for a new employee, including one returning after resignation, which is typically the grade minimum unless recruitment difficulty or other unusual conditions exist."

Spending Authority Consultation with HCPF

- Spending authority – historical under expenditures for FY 2011-12 to FY 2015-16
- Cost-based reimbursement model

Pay Adjustments Initiated

- Effective November 1, 2016
- Existing Direct Care Staff moved to the pay range midpoint of their classification
- New Hires – starting pay is at midpoint of classification

Early Results

- Vacancy rates have decreased
  - Pueblo decreased - 29% to 14%
  - Wheat Ridge decreased - 15% to 10%
  - Grand Junction decreased - 8% to 5%
- Separations
  - 43 from September 12, 2016 and November 1, 2016
  - 20 since the pay increases went into effect
- New Hires - 83

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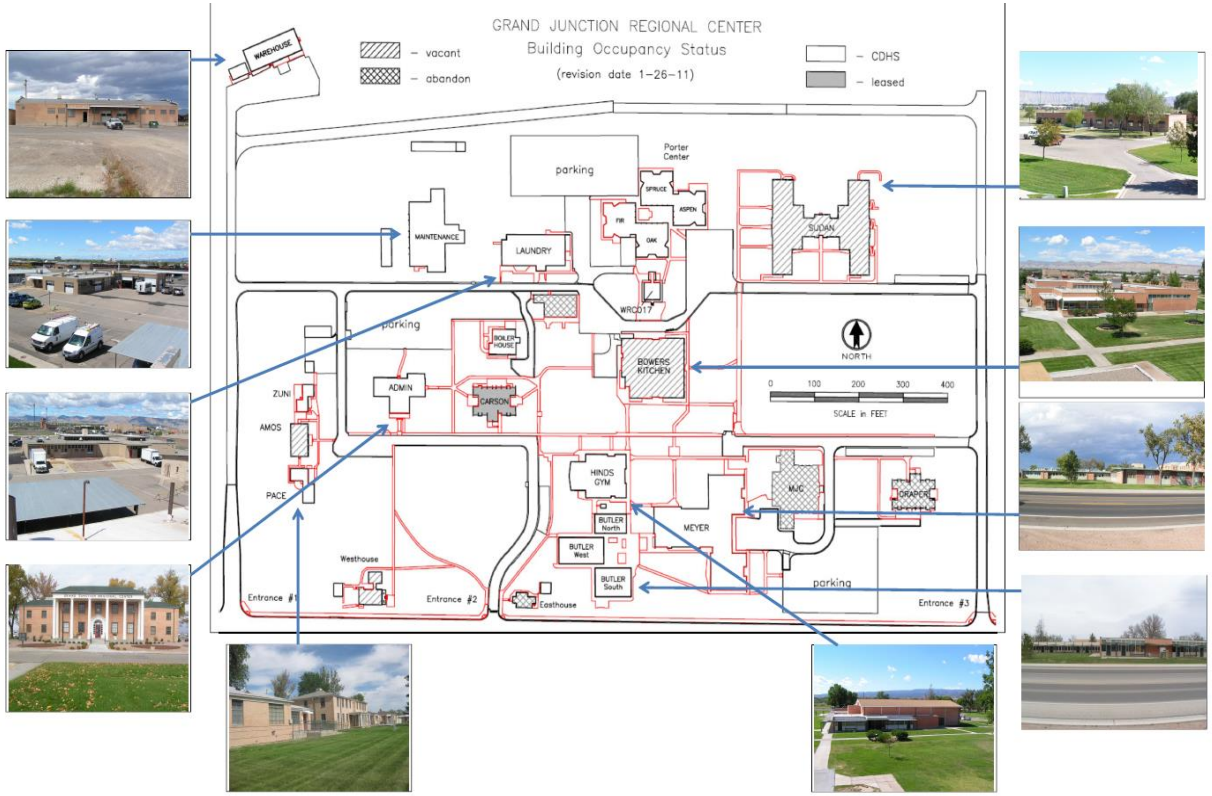
Office of Community Access and Independence

Grand Junction Regional Center Campus
SB 16-178

16-178 New Homes to Relocate Grand Junction

- SB 16-178 Directed the Department to convene an Advisory Group to help the Department to develop a plan to vacate the campus.

- Recommendations submitted December 10, 2016
  - Recommends the Department relocate 22 ICF/IDD residents to 4 new 6-bed homes and remodel an existing home to create 32 ICF beds operated by the Grand Junction Regional Center



- CDHS will reconvene the Advisory Group in 2017 to develop additional recommendations and to consider utilization study findings and recommendations from the Regional Center Task Force, concerns addressed by DLC and ARC of Colorado, existing capacity throughout the Regional Center system, State's financial constraints as expressed by the CDC

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Office of Community Access and Independence

Pueblo Regional Center – Incident Reporting

Critical Incident Report Tracking System

2015

- Reinforced agency-wide procedure requiring reports of critical incidents be sent to management

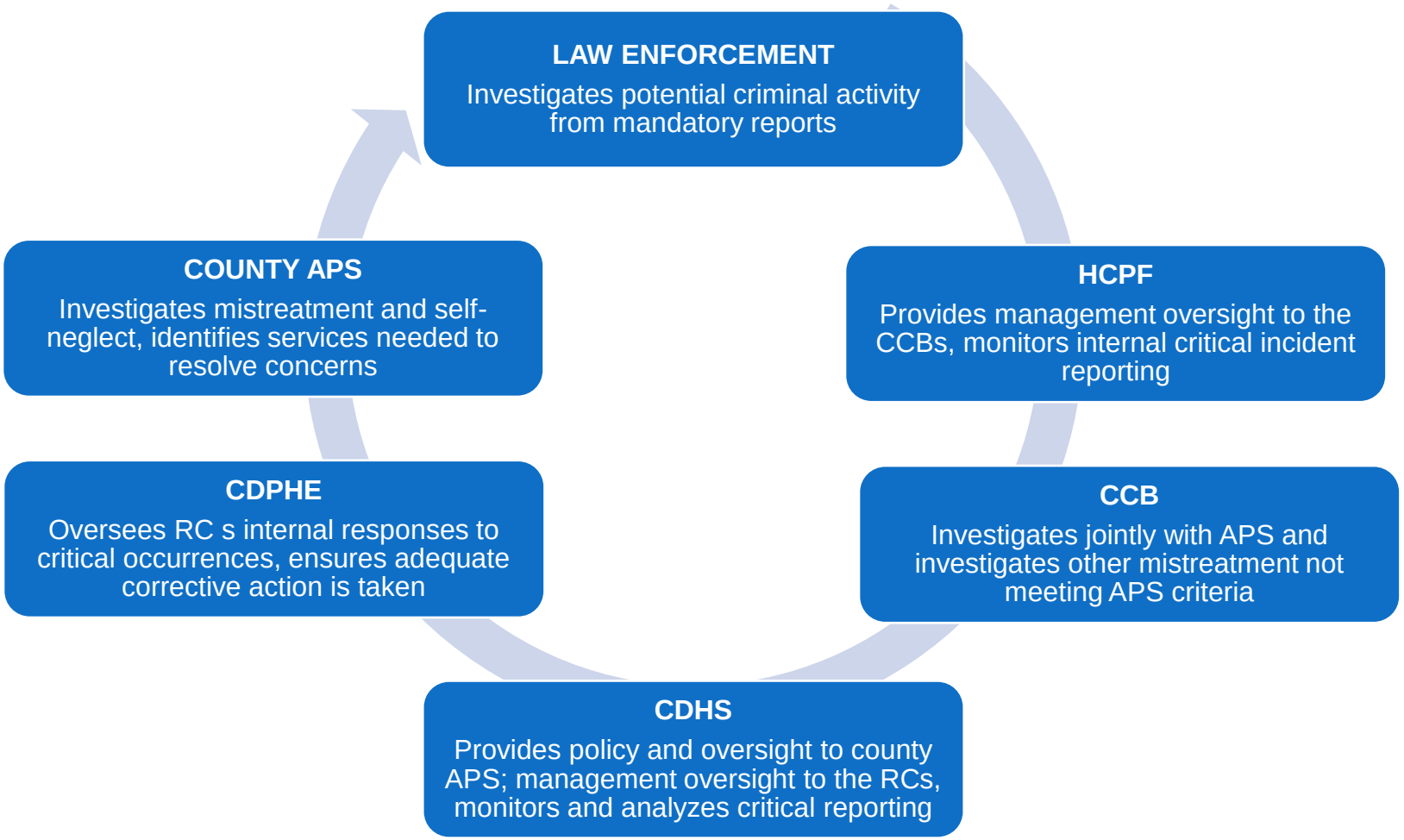
2016

- Created and implemented (with OIT) an electronic incident report tracking system (ECAM) to support consistent reporting of information

2017

- ECAM will be expanded to all of the Department's 24/7 facilities

Adult Protective Services System



Office of Administrative Solutions

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Office of Administrative Solutions FY 2017-18 Budget Request

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Office of Administrative Solution

Department Indirect Costs

What are Indirect Costs?

Personnel Costs

Provide support to multiple offices within the Department

- Financial Services
- Contracts and Procurement
- Employment Affairs
- Executive Director
- Deputy Executive Directors
- Legislative Liaison
- County Liaisons
- Budget Director
- Controller

Operational Costs

Expenses billed through common policy

- Information Technology – hardware and software
- Statewide Indirect Costs
- Capital Complex leased space
- Phones
- Office Supplies

Indirect Costs

Indirect Costs
(including but not limited to)

Personnel:
- Financial Services
- Contracts and Procurement
- Employment Affairs
- Executive Director
- Deputy Executive Directors
- Legislative Liaison
- County Liaisons
- Budget Director
- Controller

Operating:
- Information Technology – hardware and software
- Capital Complex leased space
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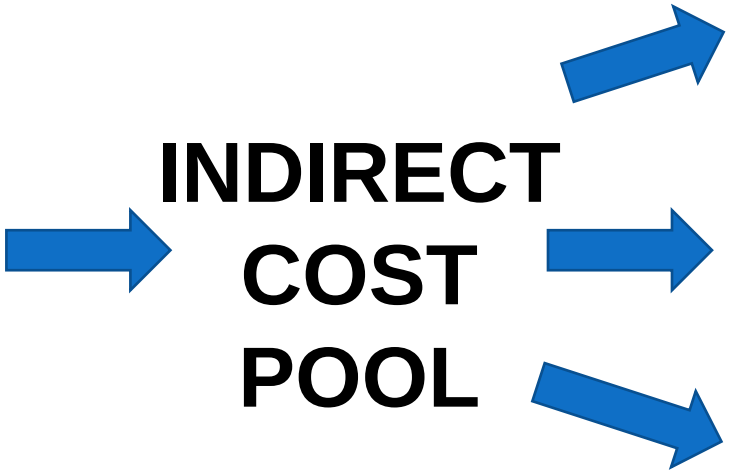
- Office Supplies



Cost Allocation **Shared** by Federal and State Funding Sources

- General Fund
- Child Care Development Funds
- Temporary Assistance for Needy Families
- Supplemental Nutrition Assistance Program
- Regional Centers
- Substance Abuse Treatment Block Grant
- Older Americans Act
- Child Welfare – Title IV-E
- Vocational Rehabilitation

How are Indirect Costs Allocated?

- Public Assistance Cost Allocation Plan (PACAP) per federal regulations
  - Submitted to Federal Department of Cost Allocation Services
  - Approved annually by 8 different federal oversight agencies

- Administrative costs are allocated to programs based on…
  - Number of Transactions (i.e. checks, contracts, purchase orders)
  - Number of FTE by program
  - Random Moment Sampling
  - Other methodologies per federal regulations

Multi Pronged Approach to Maximize Indirect Cost Collection

Program	Limitation	Impact of These Actions
TANF	Federal TANF funds are capped in the Long Bill	$1,288,649
CCDF	Federal CCDF are capped in the Long Bill.	$14,356
Regional Centers	Regional Center indirect costs are capped in the Long Bill due to letter note restrictions and spending authority restrictions in the HCPF appropriations.	$1,301,180
Child Welfare (Title IV-B and Title XX)	Policy decision dating to at least 2003 to not charge indirect costs to Child Welfare	$5,643,322
OIT Fund Splits	Office of Information Technology, Purchase of Services-Computer Center/Payments to OIT	$2,275,811
DVR Request	Loss of revenues to support indirect costs due to transfer of DVR to Department of Labor and Employment	$1,094,283
	Error in transfer of DVR	$680,123

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Office of Community Access and Independence

Commission for the Deaf and Hard of Hearing

SB 00-94 established the Commission within CDHS

Function as a liaison between the deaf and hard of hearing community and the General Assembly, the Governor, and State Agencies

Commission for the Deaf and Hard of Hearing

Services for deaf-blind:

- Telecommunications distribution program
- Arrangement of auxiliary services (sign language interpreting and captioning)
- Aids to allow participation effectively in court proceedings or programs

SB 16-1414 Implementation

- Deaf-Blind Services Coordinator – start date 1/9/217
- Outreach Consultant reposted to complete second search by Feb 2017

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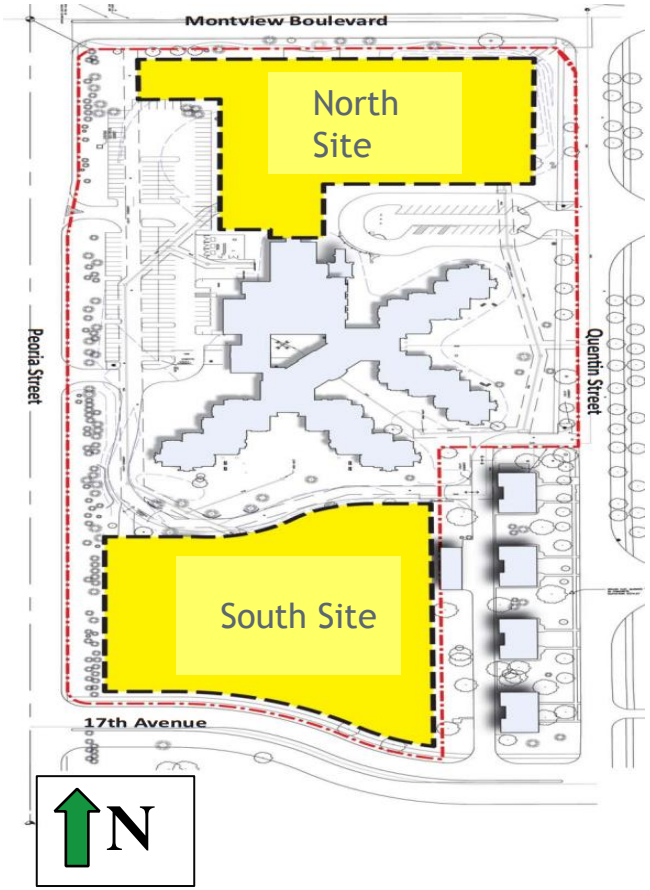
Office of Community Access and Independence

Veterans Community Living Centers

HB 16-1397 Fitzsimons Development Project ($15.0 Million – North Site)

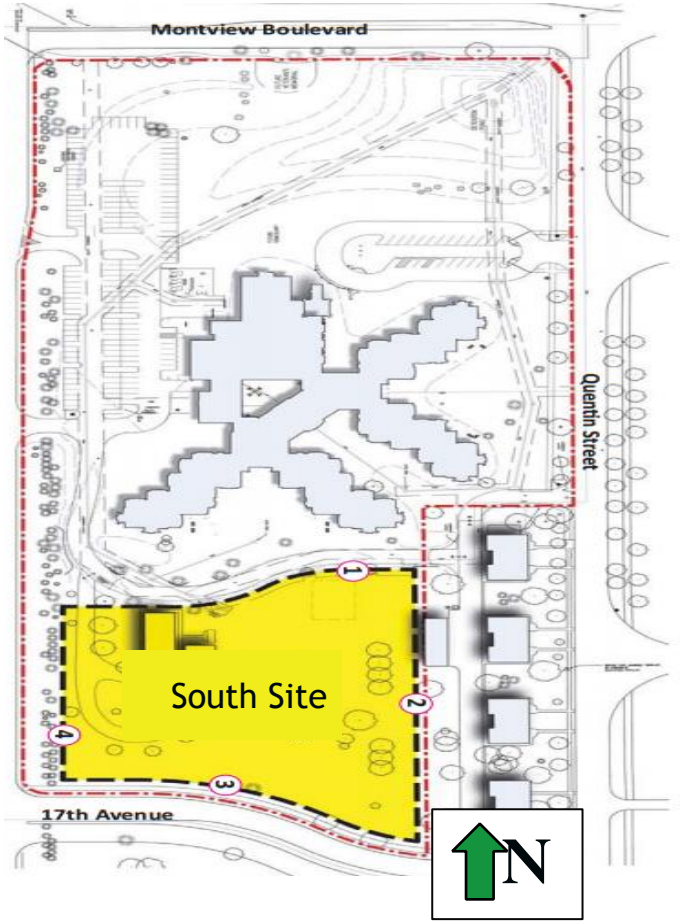


What We Have Done:

- Completed a site analysis to identify possible uses for the north and south sides of the campus.
- Convened a stakeholder group (advisory group) that provided recommendations in December 2016, including developing both sides of the property:
  - **North:** Develop a continuum of care for veterans, to include skilled care and dementia care provided in a green-house model.
  - **South:** Competitive selection of developer to build and operate permanent supportive housing for veterans.
- Submitted advisory group report to the House and Senate Veterans Affairs Committees, JBC, and CDC in December.

HB 16-1397 Fitzsimons Development Project: South Site

South Site: Through competitive process, lease site to developer to build and operate a Permanent Supportive Housing facility.	Estimated Cost to State
• **December 2016:** Issued request for proposal to select a qualified site developer. • **February 2017:** Select site developer. • **April 2017:** Complete long term lease contract with developer. • **June 2017:** Developer submits proposal for low income housing tax credit to finance project. • **January 2018:** Groundbreaking of Permanent Supportive Housing project. • **December 2019:** Permanent Supportive Housing for veterans opens at Fitzsimons.	$0



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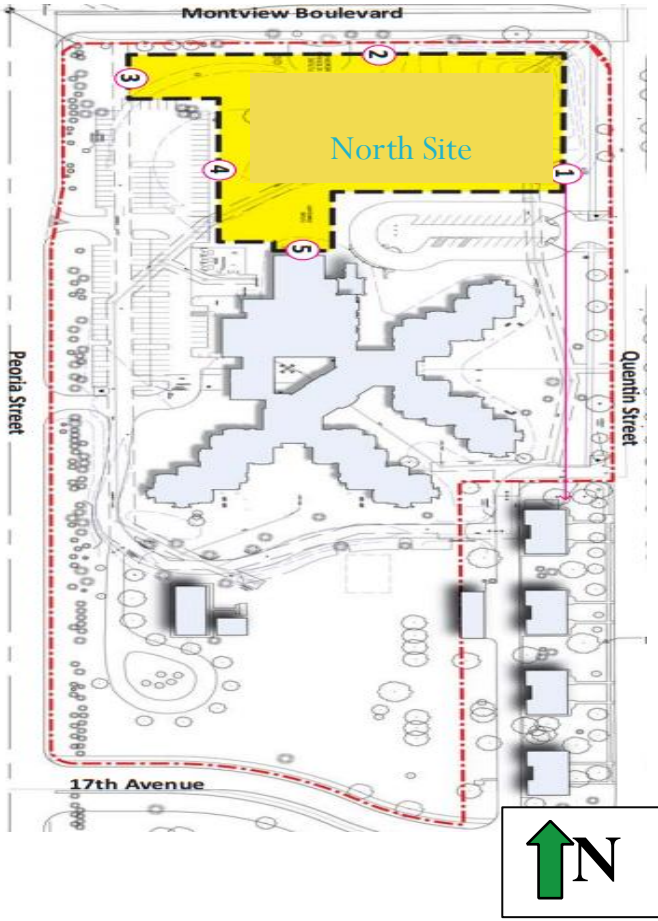
HB 16-1397 Fitzsimons Development Project: North Site ($15.0 million)

North Site: Develop skilled and dementia care for veterans in a Green-house model.	Estimated Cost to State
• **December 2016:** Presented recommendations for development of site to Legislative Committees.	
• **January 2017:** Hire financing specialist to help develop the financing stack for the facility. Engage with Green House Model expert to develop plan for development and operation of facility (state developed vs. private developed).	~ $150,000 to hire financing specialist
• **June 2017:** Proceed with development of facility – either through RFP for developer (similar to South site) or through traditional state building process.	
• **January 2018:** Have architectural/engineering plans completed for North site.	~ $2,000,000-$4,000,000



COLORADO
Department of Human Services

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Department of Human Services

January 5, 2017

The following are two questions the Department is requested to provide responses to at the January 5, 2017 hearing.

1 **Please provide the average monthly ICF census at the Grand Junction Regional Center for the past four years (FY 2012-13 thru FY 2015-16).**

Fiscal Year 2012-2013

Facility Type	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13
Grand Junction (ICF/IID)	41	41	41	41	41	40	42	42	36	38	39	38

Fiscal Year 2013-2014

Facility Type	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14
Grand Junction (ICF/IID)	38	40	41	38	36	36	36	37	33	31	31	29

Fiscal Year 2014-2015

Facility Type	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Grand Junction (ICF/IID)	27	27	26	26	26	23	23	23	23	23	23	22

Fiscal Year 2015-2016

Facility Type	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Grand Junction (ICF/IID)	23	23	25	25	27	28	28	29	29	29	29	28

Fiscal Year 2016-2017

Facility Type	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Grand Junction (ICF/IID)	28	27	27	25	24	23

2 **Please discuss whether the Department plans to life the moratorium on new admissions at the Grand Junction Regional Center. If the Department is going to lift the moratorium when will that occur? If the Department is not going to lift the moratorium, why not?**

The Department has not implemented a moratorium on all new admissions at the Grand Junction Regional Center. The moratorium on new admissions applies only to the Intermediate Care Facility (ICF) program located on the Grand Junction Regional Center campus. The Department initiated the moratorium as part of the implementation of Senate Bill 16-178. This bill mandates that the Department vacate the Grand Junction Regional Center campus. The moratorium is an administrative action designed to assist in planning and development of alternative ICF program locations and minimize disruption to those served in the ICF program.

In 2016, Grand Junction Regional Center received 2 referrals from CCB's on the Western slope. This includes one referral for admission from Strive and one from Mountain Valley. There have been a total of 7 referrals for admissions from CCB's on the Western slope since June of 2014. A breakdown of the referrals for admission is as follows:

Quarter 1 in 2014:	no data
Quarter 2 (June only):	0
Quarter 3 in 2014:	1 (Mountain Valley)
Quarter 4 in 2014:	1 (Mountain Valley)
Quarter 1 in 2015:	0
Quarter 2 in 2015:	0
Quarter 3 in 2015:	2 (Community Connections)
Quarter 4 in 2015:	1 (Strive)
Quarter 1 in 2016:	0
Quarter 2 in 2016:	1 (Mountain Valley)
Quarter 3 in 2016:	0
Quarter 4 in 2016:	1 (Strive)

The moratorium does not apply to the 10 Home and Community Based Homes (HCBS) operated by the Department at the Grand Junction Regional Center. Currently, one home is offline and not being utilized. These single family style homes are distributed throughout the Grand Junction community. The homes are currently licensed as HCBS homes and have an 8-bed capacity each, resulting in a total capacity of 80 beds. The current census of this program as of December 1, 2016 is 54. Admissions are being accepted by the Grand Junction Regional Center HCBS program at this time and there is ample capacity to do so.

Those currently served in the Grand Junction ICF program and their guardians, participated in a service selection process designed to establish the scope and number of beds to be developed. This service selection process was facilitated by Health Care Policy and Financing and completed through the Interdisciplinary Teams of those supported in the Grand Junction ICF program.

22 people opted to remain in Grand Junction ICF program care. In response to this, the Department is working with the Office of the State Architect, the Capital Development Committee and the Senate Bill 16-178 advisory group to develop options for new ICF program locations. A preliminary plan is for the Department to develop up to four, six bedroom homes licensed as ICF programs in accordance with the guiding principles of Senate Bill 16-178. This would result in a program capacity of 24 ICF beds. This appears to be consistent with recent needed capacity on the Western slope.

The Department believes admissions to the Grand Junction campus are contrary to the best interest of residents given the lack of need based on referrals and the realities of Senate Bill 16-178 implementation.